

**PROVIDENCE TARZANA MEDICAL CENTER  
MEDICAL STAFF BYLAWS**

**ARTICLE I PURPOSE/MISSION STATEMENT**

- 1.1 The Medical Staff of Providence Tarzana Medical Center (hereafter, Medical Staff) is organized to promote quality patient care and to assure that care meets relevant standards. The Medical Staff organizes itself for the purpose of self-governance in conformity with these bylaws so that it can fulfill its responsibility for quality of care and education. These bylaws are binding on the Medical Staff, Governing Board, and the Hospital.
- 1.2 The Medical Staff's right of self-governance includes, but is not limited to:
- 1.2.1 Initiating, developing and adopting medical staff bylaws, rules and regulations, policies and procedures, and amendments thereto, subject to the approval of the Governing Board, which approval will not be unreasonably withheld. Additionally, the medical staff will establish and enforce criteria and standards for Medical Staff membership and clinical privileges.
  - 1.2.2 Establishing in bylaws, rules and regulations, and policies and procedures, clinical criteria and standards to oversee and manage quality improvement and other medical staff activities including, but not limited to **proctoring, FPPE, OPPE**, peer review, other review and analysis of patient medical records, and periodic meetings of the medical staff and its committees, departments and divisions.
  - 1.2.3 The selection and removal of medical staff officers and department chairs.
  - 1.2.4 Assessing Medical Staff dues and utilizing these funds as appropriate for the purposes of the medical staff.
  - 1.2.5 The ability to retain and be represented by independent legal counsel.
  - 1.2.6 Initiating, developing, and adopting medical staff bylaws, rules and regulations, policies and procedures, and amendments thereto, subject to the approval of the Governing Board, which approval will not be unreasonably withheld.
  - 1.2.6 Establishing a mechanism for resolving conflicts between the Medical Staff and Governing Board.
  - 1.2.7 Establishing a mechanism for resolving conflicts between the Medical Staff and Medical Executive Committee.
- 1.3 These bylaws recognize that the organized medical staff has the authority to establish and maintain patient care standards, including full participation in the development of hospital-wide policy, involving the oversight of care, treatment, and services provided by members and others in the hospital. The medical staff is also responsible for and involved with all aspects of delivery of health care within the hospital including, but not limited to, the treatment and services delivered by practitioners credentialed and privileged through the mechanisms described in these bylaws and the functions of credentialing and peer review.
- 1.4 These bylaws acknowledge that the provision of quality medical care in the hospital depends on the mutual accountability, interdependence, and responsibility of the medical staff and the hospital governing board for the proper performance of their respective obligations.

The Medical Staff operates as a Professional Association within the meaning of Section 23701e of the California Revenue and Taxation Code and is recognized by the United States Internal Revenue Service as a non-profit 501c6 organization. The Medical Staff organization does not contemplate pecuniary gain or profit to the members thereof and is organized for non-profit purposes. Notwithstanding any of the above statements of purposes and powers, this Medical Staff will not, except to an insubstantial degree, engage in any activities or exercise any powers that are not in furtherance of the specific purposes of the Medical Staff.

## ARTICLE II RESPONSIBILITIES

The responsibilities of the Medical Staff include, but are not limited to:

### **Section 2.1**

To account for the quality and appropriateness of patient care rendered by all physicians and allied health professionals (AHP) authorized to practice in the Hospital through the following measures:

- 2.1.1 Participation in the determination of the qualifications of the radiology staff who utilizes equipment and administers procedures via review and approval of policies related to these qualifications.
- 2.1.2 Providing approval of the nuclear services director's specifications for the qualifications, training, functions, and responsibilities of the nuclear medicine staff via review and approval of policies related to these qualifications.
- 2.1.3 A credentials program including mechanisms for appointment, FPPE, OPPE and reappointment and the matching of clinical privileges to be exercised, or of specific services to be performed, with the verified qualifications, performance, credentials and current competence demonstrated by the applicant, staff member, or AHP.
- 2.1.4 A continuing medical education program (CME) which addresses the needs demonstrated through the patient care monitoring and other quality maintenance programs and other issues identified from time to time.
- 2.1.5 A process consisting of concurrent and/or retrospective review and evaluation of the quality of patient care through a valid and reliable patient care monitoring procedure.
- 2.1.6 Participation in the monitoring of an effective care management review program for the allocation of medical services based upon patient-specific determinations of individual medical needs.

### **Section 2.2**

To recommend to the Governing Board, action with respect to appointments, reappointments, staff category, provisional status, department assignments, clinical privileges, specified services for AHP's, corrective action and, as appropriate, department, service and/or assignment.

### **Section 2.3**

To communicate to the Governing Board regarding the quality and efficiency of medical care rendered to patients in the hospital through regular reports and recommendations concerning implementation, operation and results of the patient care monitoring. Formal reports from the Medical Executive Committee to the Governing Board will be made at least quarterly, or more often, if necessary.

### **Section 2.4**

To initiate and pursue corrective action with respect to physicians and AHP's, when warranted.

### **Section 2.5**

To assist the Hospital and its Governing Board in identifying and monitoring community health needs of all patients and assisting in the implementation of programs to meet those needs.

### **Section 2.6**

To develop, administer, and seek compliance with the medical staff bylaws, rules and regulations of the medical staff, and other medical care related hospital policies that have been approved by the Medical Staff.

### **Section 2.7**

To recommend to the Governing Board and Hospital Administration, capital budget items, or to initiate new programs and services, or to maintain or improve existing programs and services.

### **Section 2.8**

The Medical history and physical examination will be completed and documented by a physician or designee as per privileges.

- 2.8.1 An oral surgeon is responsible for a detailed oral surgery history justifying the hospital admission and detailed description of the examination of the operative site and pre-operative

diagnosis. A physician is responsible for the medical history pertinent to the patients' general health and a physical examination to determine the patients' condition prior to anesthesia and surgery.

**2.8.2** A dentist is responsible for the part of their patient's history and physical examination that relates to dentistry. A physician is responsible for the medical history pertinent to the patient's general health and a physical examination to determine the patients' condition prior to anesthesia and surgery.

**2.8.3** Podiatrists may dictate histories and physicals for patients they are admitting to the hospital for a surgical procedure(s). The admitting podiatrist would be responsible for assuring appropriate medical back-up, either by the patient's primary physician, if a member of the medical staff, or a hospitalist, for any medical problem that may arise during hospitalization.

**2.8.4** The following components are required for a complete History and Physical Examination:

**2.8.4.1** Identifying data

**2.8.4.2** Chief complaint stated in the patient's own words

**2.8.4.3** Present illness including date of onset

**2.8.4.4** Past Medical and Surgical History,

**2.8.4.5** Social History as relevant to the age of the patient

**2.8.4.6** Family History as relevant to the age of the patient; Includes psychosocial assessment of the patient's family relationships as appropriate

**2.8.4.7** Allergies to medications, sensitivities

**2.8.4.8** Medications

**2.8.4.9** Review of Systems

**2.8.4.10** For children and adolescents, an evaluation of the patient's Developmental age and a report of patient's immunization status

**2.8.4.11** Physical Exam

2.8.4.11.1 General and vital signs

2.8.4.11.2 HEENT

2.8.4.11.3 Neck

2.8.4.11.4 Breast/Chest, if applicable

2.8.4.11.5 Lungs

2.8.4.11.6 Abdomen

2.8.4.11.7 Genitalia (if deferred, a reason must be stated)

2.8.4.11.8 Rectal (if deferred, a reason must be stated)

**2.8.4.12** Assessment and Plan

**2.8.4.13** Exceptions to the requirements for a complete history and physical would include the following (should be documented as unobtainable as appropriate)

2.8.4.13.1 Pediatrics through age 16, unless known to be sexually active

**2.8.4.13.2** Emergency cases

## **ARTICLE III. MEDICAL STAFF MEMBERSHIP**

### **Section 3.1 Medical Staff Membership**

**3.1.1** Appointment to the Medical Staff of the Hospital is a privilege that will be extended only to professionals who provide a level of care required by the Medical Staff and continuously meet the qualifications, standards, and requirements set forth in the Medical Staff's Bylaws and Rules and Regulations and policies and in the policies of the hospital that have been approved by the Medical Staff. Appointment to and membership on the Medical Staff will confer on the member only such clinical privileges and rights as have been granted by the governing board in accordance with these bylaws. (See general rules and regulations for further delineation of requirements).

- 3.1.2 No individual is automatically entitled to initial or continued membership on the medical staff or to the exercise of any clinical privilege in the hospital merely because he or she is licensed to practice in this or any other state, because he or she has previously been a member of this medical staff, because he or she had, or now has membership or privileges at this or another health care facility or another practice setting, or because he or she is a member of any professional organization.
- 3.1.3 Medical staff membership does not create an employment or agency relationship between the practitioner and the hospital.

### **Section 3.2 Qualifications for Membership**

Section 3.2.1 Except for emeritus staff, only physicians with a Doctor of Medicine, or Doctor of Osteopathy degree, dentists, podiatrists, or clinical psychologists, holding a license to practice in the State of California, who can:

- 3.2.1.1 document clinical background, expertise, training, judgment, individual character, and current clinical competence,
- 3.2.1.2 document physical and mental capabilities (subject to any necessary reasonable accommodation) in order to carry out privileges requested,
- 3.2.1.3 demonstrate ability to work cooperatively with others, refraining from discrimination or harassment, and disruptive behavior,
- 3.2.1.4 demonstrate adherence to the ethics of their profession,
- 3.2.1.5 possess a DEA with a full schedule (2,2N,3,3N,4,5) with the exception of Clinical Psychologists, Pathologists, Telemedicine physicians, Physicians with surgical assist privileges only and physicians who do not hold in-patient care privileges. Allied Health Professionals under the category of Nurse Practitioner are required to hold a full schedule DEA.
- 3.2.1.6 demonstrate a history of timely completion of medical records,
- 3.2.1.7 comply with the rules and regulations and policies and procedures, which have been approved by the medical staff,
- 3.2.1.8 submit proof of his/her current professional liability insurance in amounts , not less than One Million Dollars (\$1,000,000) per claim and Three Million Dollars (\$3,000,000) per year or such amounts as may from time-to-time be recommended by the Medical Executive Committee and approved by the Governing Board.

**Section 3.2.2** To be qualified for medical staff membership all new applicants for membership seeking clinical privileges (e.g. physicians, podiatrists, dentists, and clinical psychologists must: (original requirement for certification put into place April 7, 2005.)

3.2.2.1 **Membership:** Appointees to the Medical Staff, with the exception of Clinical Psychologists, must be Board Certified. Physician must become board certified within five (5) years of completion of specialty and/or sub-specialty training completion (**Accredited** Residency or Fellowship, whichever is the final training completed) specific to privileges for which the physician is applying. Physicians who have not successfully completed board certification within five (5) years will be considered to have automatically resigned their medical staff membership and clinical privileges without hearing rights. A physician submitting an application to the medical staff within one year after voluntarily resigning for an administrative reason, who was previously on the medical staff prior to April 7, 2005, will not be required to meet the aforementioned requirement.

A physician submitting a new application within one year after being deemed to have voluntarily resigned for failure to timely submit a reappointment application will be exempt from the board certification requirement.

3.2.2.2 Oral and Maxillofacial Surgeons must have successfully completed a Commission on Dental Accreditation approved residency program or have successfully completed a minimum of twelve (12) months as a senior resident at an American Board of Oral and Maxillofacial Surgery program accredited by the commission on Dental Accreditation, and be a board diplomat or a candidate to become a diplomat of the American Board of Oral and Maxillofacial Surgery.

- 3.2.2.3 Dentists must have graduated from an American Dental Association approved School of Dentistry accredited by the Commission of Dental Accreditation.
- 3.2.2.4 Podiatrists (DPM) must have successfully completed a three-year Residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA) and be board certified or a board candidate of the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedic and Primary Podiatric Medicine. Board Certification must be completed within five (5) years of completion of specialty and/or sub-specialty training completion (Accredited Residency or Fellowship, whichever is the final training completed) specific to privileges for which the physician is applying. If certification is not successfully completed within five (5) years, the physician will be considered to have automatically resigned their medical staff membership and clinical privileges without hearing rights.
- 3.2.2.5 **Membership:** Appointees to the Medical Staff, with the exception of Clinical Psychologists, must be Board Certified. Physician must become board certified within five (5) years of completion of specialty and/or sub-specialty training completion (Residency or Fellowship, whichever is the final training completed) specific to privileges for which the physician is applying. Physicians who have not successfully completed board certification within five (5) years will be considered to have automatically resigned their medical staff membership and clinical privileges without hearing rights. A physician submitting an application to the medical staff within one year after voluntarily resigning for an administrative reason, who was previously on the medical staff prior to April 7, 2005, will not be required to meet the aforementioned requirement.
- 3.2.2.6 **Clinical Privileges:** For clinical privileges, physicians must meet the qualifications for membership noted above. Office and residence must be located closely enough to the hospital to provide continuous and timely care to their patients. Telehealth practitioners will not be required to meet the office and residence requirements.
- 3.2.2.7 **Distance from Hospital:** The distance may vary depending upon the Staff category and privileges that are involved and may be further defined in Medical Staff Policies and Procedures.
- 3.2.2.8 Suspension, exclusion, sanctions, or debarment under the Medicare or Medicaid program will disqualify a physician/ahp from applying to the Medical or Allied Health Professional Staff for membership or clinical privileges and for existing members of the medical staff will result in automatic termination without hearing rights. Members and/or applicants for membership on the medical or allied health professional staff are required to notify the Medical Staff, via the Medical Staff Office, within 15-days if they receive notice that the OIG or GSA is excluding, intends to exclude, or proposes to exclude them from participation in Medicare and/or other federal or state health care program.
- 3.2.2.9 Demonstrate to the Medical Staff and Governing Board that any patient treated by them in the hospital or in any of its facilities will be given care of the professional level or quality and efficiency as recommended by the Medical Staff and approved by the Governing Board.
- 3.2.2.10 Conviction of a felony, including pleading guilty or no contest, disqualifies a physician/ahp from applying for membership and/or clinical privileges and for those already on staff, will result in automatic termination, without hearing rights.
- 3.2.2.11 Conviction of any healthcare related offense, including pleading guilty or no contest, will exclude the physician/ahp from qualifying to apply for membership and privileges, and if a member of the medical staff, from maintaining membership and/or clinical privileges. This would be deemed an automatic termination without hearing rights.
- 3.2.2.12 **FAILURE TO DISCLOSE ANY ADVERSE INFORMATION MAY RESULT IN THE DENIAL OF MEMBERSHIP ON THE MEDICAL STAFF, OR IF MEMBERSHIP OR PRIVILEGES HAVE BEEN GRANTED, MAY RESULT IN CORRECTIVE ACTION UNDER THESE BYLAWS.**
- 3.2.2.13 Each Medical Staff member will be required to promptly inform the Medical Staff whenever there are:
- 3.2.2.13.1 Any changes to a member's physical or mental health status that affect his/her ability to perform his/her privileges
  - 3.2.2.13.2 Any cancellation or restriction of professional liability coverage, or
  - 3.2.2.13.3 Any and all adverse actions listed in the Corrective Action section of these Bylaws or another hospital, healthcare facility or other peer review body, and any actions taken or commenced by any medical society, licensing board, or the DEA to

restrict, suspend, revoke, impose probation or limit the member's professional activities.

**FAILURE TO REPORT ANY OF THE ABOVE CHANGES WILL RESULT IN IMMEDIATE LOSS OF MEDICAL STAFF/AHP MEMBERSHIP AND CLINICAL PRIVILEGES AND WOULD REQUIRE THE PHYSICIAN/AHP TO APPLY AS A NEW APPLICANT. APPLICATION MAY NOT BE MADE FOR MINIMUM OF ONE TWO YEARS FOLLOWING THE LOSS OF MEMBERSHIP, UNLESS EXCUSED FOR DEMONSTRATED GOOD CAUSE. LOSS OF MEMBERSHIP AND CLINICAL PRIVILEGES, PURSUANT TO THIS SECTION BASED UPON FAILURE TO REPORT IS NOT SUBJECT TO A HEARING OR APPEAL, UNLESS IT MUST BE REPORTED PURSUANT TO CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 805.**

### **3.2.3 NON-DISCRIMINATION**

3.2.3.1 The hospital and medical staff will not discriminate in granting staff appointment and/or clinical privileges on the basis of race, religion, color, national origin, ancestry, disability (unless such disability is such that reasonable accommodations could not be made in order to allow the practitioner to carry out privileges as requested), marital status, sex, gender, age, sexual orientation, or other healthcare organizational affiliations.

3.2.3.2 Additionally, acceptance of membership on the staff constitutes the staff member's agreement that s/he will admit and treat all patients on a non-discriminatory basis, without regard to race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender, age or sexual orientation, except as the foregoing may be applicable to the member's clinical privileges granted or relevant in the determination of appropriate care.

### **3.2.4 CONDITIONS AND DURATION OF APPOINTMENT**

3.2.4.1.1 Initial appointments and reappointments to the medical staff are made by the Governing Board. The Governing Board will act on appointments and reappointments only after there has been a recommendation from the medical staff in accordance with the Bylaws, Rules and Regulations and Policies of the Medical Staff. Appointments to the staff will be for no more than twenty-four (24) calendar months as delineated in the Medical Staff Rules and Regulations.

3.2.4.2.1 Should any concern be identified during the credentialing process, a recommendation may be made to provide "Conditional Appointment" in accordance with the Medical Staff Rules and Regulations. Should a practitioner who has been conditionally appointed fail to meet the requirements of the conditional appointment, they will be voluntarily resigned from the Medical Staff without hearing rights, unless such resignation must be reported to the Medical Board of California, pursuant to California Business and Professions Code Section 805 and/or the National Practitioner Data Bank.

3.2.4.1.1.1 Appointment to the Medical Staff will confirm on the appointee only such clinical privileges as have been granted by the Governing Board in accordance with requirements of the Medical Staff Bylaws.

3.2.4.1.1.2 Appointment to the Medical Staff is subject to demonstration of participation in continuing medical education, relating to clinical privileges requested as required by the Medical Board of California. The number of continuing medical education hours required will be the same as those required to maintain current licensure. Notwithstanding the foregoing, appointment and reappointment may be subject to satisfying continuing medical education requirements that are particular to the practitioner, the specialty, or other designated group that must be satisfied by the deadline specified upon such appointment or reappointment.

3.2.4.2 All new members of the Medical staff must attend the Physician Orientation Program, prior to providing care to any patient in the hospital. Physicians who are requesting Temporary Privileges

will be required to attend the New Physician Orientation prior to final approval of their Temporary privileges, unless the Temporary privilege is for an emergency situation, as recommended for approval by the Chief of the Clinical Department or designee and the Chief of Staff or Designee. Physicians who are new applicants because of their voluntary/automatic resignation for administrative reasons within one year of their new application, will be exempt from attending a New Physician Orientation.

- 3.2.4.3 Members and/or applicants for membership and/or clinical privileges are required to notify the Chief of Staff within 15-days if they receive notice that the OIG or GSA is excluding, intends to exclude, or proposes to exclude them from participation in Medicare and/or other federal or state healthcare programs.
- 3.2.4.3 Members and/or applicants confirmed to be on the OIG or GSA list as excluded are not eligible for membership and/or clinical privileges at Providence Tarzana Medical Center. Existing members of the medical staff found to be on the excluded list will be considered to be automatically terminated from the Medical Staff without hearing rights.

### **3.2.5 STAFF DUES**

- 3.2.5.1 Annual Medical Staff, Allied Health Professional, and Education Staff dues, Special Assessments, and fines will be determined by the most recent recommendation of the Medical Executive Committee. Payment of dues may be waived by the Medical Executive Committee for good cause.
- 3.2.5.2 Emeritus staff members will not be required to pay dues.  
Physicians on Leave of Absence will not be required to pay medical staff dues during the period they are on a leave. Dues will be assessed at the time of return.  
Dues will be payable by July 1<sup>st</sup> of each year. If the Medical Staff Office has not received Medical/AHP Staff dues by 5:00 p.m., July 1<sup>st</sup> (or if July 1<sup>st</sup> falls on a weekend, then the next business day), the practitioner's Medical Staff/ AHP membership and/or clinical privileges will be automatically suspended as of 5:00 p.m., July 1<sup>st</sup> (or if July 1<sup>st</sup> falls on a weekend, than 5:00 p.m. on the next business day). If the Medical Staff Office does not receive the delinquent dues within three (3) months of the due date, the practitioner will be deemed to have voluntarily resigned from the Medical/AHP Staff without hearing rights.
- 3.2.5.3 Physicians who have not paid medical staff dues by July 1<sup>st</sup> or the first business day following and have been placed on automatic suspension will be required to pay the amount of the dues plus a late fee equal to the amount of the dues payment.

### **3.2.6 RESPONSIBILITIES OF MEMBERSHIP**

Except for Emeritus Members and Non-Admitting staff, each Medical Staff member must continuously meet all of the following responsibilities:

- 3.2.6.1 Direct the care of his or her patients and supervise the work of any Allied Health Professional(s) under his/her direction as per the Bylaws and Rules and Regulations of the Medical Staff.
- 3.2.6.2 Act in an ethical, professional, and courteous manner, while providing his/her patients with care that meets the Medical Staff's requirements for quality and efficiency.
- 3.2.6.3 Treat employees, patients, visitors, and other physicians in a dignified and courteous manner, refrain from any disruptive behavior or any discrimination or harassment or disruptive behavior against any person (including any patient, hospital employee, volunteers, hospital independent contractor, medical staff/allied health professional member, or visitor) based upon the person's race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender, age, sexual orientation, health status, ability to pay, or source of payment.
- 3.2.6.4 Abide by the Medical Staff Bylaws, Rules and Regulations, Policies and by Hospital Policies that have been approved by the Medical Executive Committee and Governing Board.
- 3.2.6.5 Discharge such medical staff, department, section, committee, and service functions for which s/he is responsible by appointment, election, or otherwise.
- 3.2.6.6 Prepare and complete, in a timely manner, the medical and other required records for all patients to whom the practitioner in any way provides services in the hospital.
- 3.2.6.7 Refrain from unlawful fee splitting or unlawful inducements relating to patient referral.
- 3.2.6.8 Seek medical consultation by a qualified specialist as defined elsewhere in these Bylaws

- whenever warranted by the patient's condition or when required by the Rules and Regulations of the Medical Staff.
- 3.2.6.9 Cooperate with the Medical Staff in assisting the Hospital to fulfill its obligations related to patient care, including, but not limited to, performance improvement, peer review, utilization management, quality evaluation, and related monitoring activities required of the medical staff and in discharging such other functions as may be required of the Medical Staff from time to time.
  - 3.2.6.10 Upon request, provide information from his/her office records or from outside sources as necessary to facilitate the care of, or review of the care of specific patients.
  - 3.2.6.11 Communicate with appropriate Medical Staff Officers and/or Department Chiefs, or Well-Being Committee Chair, when s/he obtains credible information indicating that a fellow practitioner may have engaged in unprofessional or unethical conduct or may have a health condition which poses a significant risk to the well-being or care of patients or others at the hospital, and then cooperate as reasonably necessary toward the appropriate resolution of any such matter.
  - 3.2.6.12 Must participate in proctoring new members of the Medical Staff must complete proctoring within one year. Physicians may request one six (6) month extension in which to complete their proctoring. Physicians who do not complete proctoring within eighteen (18) months will be deemed a voluntary resignation, without hearing rights.
  - 3.2.6.13 Demonstrate satisfactory current health status, which may include but not be limited to, mental and/or physical examination, including but not limited to, body fluid testing, by a professional designated by the Medical Executive Committee, if the Medical Executive Committee determines there is a reasonable concern that a member's mental or physical health status may interfere with his/her ability to exercise privileges which have been granted or requested or to fulfill essential responsibilities of the Medical Staff or if the Medical Executive Committee determines it needs additional information to evaluate potential accommodations to enable the physician to exercise such privileges and fulfill essential responsibilities. If an application is pending, failure to comply with the request by the Medical Executive Committee or its designee within a reasonable time as designated by the Medical Executive Committee will result in the appointment/reappointment being considered incomplete.
  - 3.2.6.14 Maintain the confidentiality of all medical staff peer review matters and all individual patient identifiable information in accordance with State and Federal laws and regulations and pursuant to these Bylaws. The Hospital will defend and indemnify in accordance with Article XIX of these Bylaws.
  - 3.2.6.15 Authorize the Hospital and Medical Staff to consult with and receive information and documents from members of the Medical Staffs of other Hospitals and from other peer review bodies with which the applicant has been associated and with others who may have information bearing on his/her competence, skill, character, ethics, and other qualifications.
  - 3.2.6.16 Consent to the Hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications for clinical privileges s/he requests as well as his/her moral and ethical qualifications for staff membership.
  - 3.2.6.17 Release, to the fullest extent permitted by law, all persons from any liability for their actions performed in connection with the investigation and evaluation of the applicant and his/her credentials and all individuals and organizations who provide information regarding the applicant, including otherwise confidential information.
  - 3.2.6.18 Consent to disclosure to other health care entities, medical associations, licensing boards, and other organizations, any information regarding the practitioner, including but no limited to otherwise confidential information regarding his/her professional performance and/or or ethical standing, and release the Medical Staff and Hospital from liability to the fullest extent permitted by law.
  - 3.2.6.19 Provide copies of medical records and office records requested by the Medical Staff for review as part of the credentialing or peer review process.
  - 3.2.6.20 Wear Hospital Identification Badge whenever in the Hospital.
  - 3.2.6.21 Assure that the Medical Staff is always provided with the most current demographic information including, but not limited to, current address, telephone number, fax number, and e-mail address.
  - 3.2.6.22 Assure that requirements for Histories and Physicals are completed as required by the Medical Bylaws/Staff Rules and Regulations.
  - 3.2.6.23 Each member of the Medical Staff recognizes and as a condition to this appointment agrees to



respect the fact that the Medical Center is a Catholic institution and will be administered in accordance with the *Ethical and Religious Directives for Catholic Health Facilities* and that no medical conduct or procedures within the Medical Center will be permitted which are contrary to or incompatible with said Directives.

### **3.2.7 CLINICAL PRIVILEGES**

3.2.7.1 Clinical privileges are to be delineated for every practitioner by the appropriate clinical department. Every practitioner providing direct clinical services, including but not limited to telemedicine services at this hospital will be entitled to exercise only those clinical privileges specifically granted to him/her by the governing board following a recommendation from the Medical Staff, except as provided in these bylaws, for temporary, emergency, and disaster privileges. Under no circumstances will clinical privileges be granted solely upon board certification, fellowship, or membership in a specialty, body, or society. Such clinical privileges may be probationary, may require adequate supervision or approval, or be otherwise qualified or limited at the discretion of the governing board.

Every initial application for staff appointment, whether for medical staff, allied health professional staff, telemedicine, or locum tenens privileges, will contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests will be based upon the applicant's education, training, experience, demonstrated competence, references, and other relevant information including an appraisal by the department in which such privileges are sought. The applicant will have the burden of establishing his/her qualifications and competency in the clinical privileges s/he requests.

3.2.7.3 The privilege processing will begin in the Credentials Committee, confirmed and/or further defined by the appropriate clinical department. The clinical department will determine the review or observation procedures to be used in the department which may consist of a significant number of cases reviewed and procedures observed, if applicable. The observer or proctor may act as an assistant.

3.2.7.3.1 The applicant acknowledges the right of the proctor to take over the case whenever the proctor feels it is necessary to safeguard the patient's health and well-being. The applicant will have no cause to complain against the proctor who takes over a case and is acting in good faith and without malice. This provision does not constitute a restriction of the member's privileges and does not constitute grounds for appeal based on this action. The proctor will promptly report to the Department Chair any time the proctor takes over a case.

3.2.7.3.2 If the clinical department has a standing peer review committee, that committee will report its recommendations to the clinical department and the clinical department will in turn report to the Medical Executive Committee as to whether the provisional status of the applicant for medical staff is to continue. This duration will not be longer than permitted for provisional appointments. If the recommendation is to advance the practitioner from provisional staff status, the clinical departmental report will recommend the applicant's proposed staff status. If the applicant is to remain subject to ongoing proctoring, the report will include which clinical privileges will continue to be proctored.

### **3.2.7.2 CLINICAL PRIVILEGES FOR ORAL SURGEONS AND DENTISTS**

3.2.7.3.1 Privileges granted to Oral Surgeons and Dentists will be based on training, experience, education, and demonstrated competence, judgment, and health status as it pertains to the ability to practice in the area privileges are sought. The scope and extent of surgical procedures that each Oral Surgeon and Dentist may perform will be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by Oral Surgeons and Dentists will be under the overall supervision of the Chief of Surgery. All oral surgery and

dental surgery patients will receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the staff will be responsible for admission history and physical and the care of any medical problem that may be present at the time of admission or that may arise during hospitalization. An Oral Surgeon or Dentist is responsible for the part of a patient's history and physical examination that relates to oral surgery or dentistry.

- 3.2.7.3.2 Oral surgeons may admit a patient to the hospital for a surgical procedure.
- 3.2.7.3.3 Dentists may not admit patients to the hospital. They may consult on patients and perform procedures as requested by a physician member of the medical staff.
- 3.2.7.3.4 Periodic re-determination of clinical privileges may be based upon the direct observation of care provided, review of the records of patients treated at the practitioner's office, at this or other facilities, and/or review of records which document or evaluate the member's current participation in the delivery of care for the desired privileges.

#### 3.2.7.5 CLINICAL PRIVILEGES FOR PODIATRISTS

Privileges granted to Podiatrists will be based on training, experience, education, and demonstrated competence, judgment, and health status as it pertains to the ability to practice in the area privileges are sought. The scope and extent of surgical procedures that each podiatrist may perform will be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by podiatrists are governed by the requirements of the Department of Surgery rules and regulations. A physician member of the staff must be responsible for admission history and physical and the care of any medical problem that may be present at the time of admission or that may arise during hospitalization. A Podiatrist is responsible for the part of the patient's history and physical examination that relates to the podiatric problem.

A Podiatrist may admit a patient to the hospital for surgical procedure.

### **3.2.8 EXCLUSIVE CONTRACTS, SELECTION & TERMINATION**

#### 3.2.8.1. DECISION TO INITIALLY GRANT AN EXCLUSIVE CONTRACT

A decision to close a department or service pursuant to the granting of an exclusive contract will be made by the Governing Board, subject to the terms and conditions set forth in this section and in accordance with State and Federal law. Prior to deciding whether to close a department or service pursuant to an exclusive contract, the Board, through the Chief Executive Officer, will notify the Medical Executive Committee, who will review the request and provide an explicit vote with recommendation(s) to be forwarded to the Governing Board. Also to be notified would be each Department Chair and each practitioner whose clinical privileges would be subject to the proposed exclusive contract that the Board is considering awarding an exclusive contract for the designated services. The notice will be in writing and provide each of the recipients at least thirty (30) days notice of the date, time, and place of the meeting of the board or its appointed committee, which will be convened to receive comments and recommendations regarding the proposed exclusive contract. The notice will inform the recipients that comments will be restricted to the appropriateness of granting the exclusive contract and that testimony will not be permitted regarding the qualifications of individual practitioners. The notice will also invite members of the medical staff to submit written comments regarding the proposed exclusive contract.

After evaluating information provided to it, the board will determine whether to grant the proposed exclusive contract, considering whether less extreme measures would address or remedy the Medical Staff and Board's concerns. The board will not act in an arbitrary or capricious manner in the conduct of its review or in making its determination.

### 3.2.8.2 SELECTION

- 3.2.8.2.1 The Medical Staff, through its Medical Executive Committee, will establish the quality of care criteria and evaluate the quality of any proposed hospital-based physicians or medical groups, e.g. Radiology, Pathology, Anesthesiology, Emergency Medicine, and any physician(s) or medical group(s) who is contracted with the hospital to provide clinical services or to become a Director of a Clinical Service.
- 3.2.8.2.2 The Governing Board, through the Hospital Administration, will submit the names, to the Medical Executive Committee, of any physician(s) or medical group(s) who or which is being considered by the Governing Board to contract with the hospital as hospital-based physicians, to provide clinical services or to become a medical director of a clinical service. The Medical Executive Committee will advise and consent to the choice(s).
- 3.2.8.2.3 Within sixty days after receipt from the Governing Board of the name(s) of the proposed contract candidate(s), including the CV's of the proposed individuals who will provide the services and such other information as reasonably requested by the Medical Executive Committee, the Medical Executive Committee will submit its recommendation to the Governing Board. In the case of more than one candidate being submitted by the Governing Board, the Medical Executive Committee may approve more than one candidate and may, but need not, indicate its preference. If none of the candidates submitted are approved, the Governing Board will submit new candidates for evaluation. If the Medical Executive Committee fails to make a recommendation within sixty days, the Medical Executive Committee will be deemed to have approved each of the proposed contract candidates, unless the Governing Board excuses the delay based upon a finding of good cause. The Governing Board will make the final selection of candidates from among all approved candidates. The Governing Board, through the Hospital Administration, has the executive right to negotiate contractual fees, hiring, and termination of contracting physicians or medical groups.
- 3.2.8.2.4 Prior to making its report and recommendation, the Medical Executive Committee, or its designee, will submit the candidates' names and applicable information regarding the candidates received from the Governing Board to the Credentials Committee for its review and evaluation of the candidates' professional qualifications and suitability. The Credentials Committee, or its designee, will submit to the Medical Executive Committee a report and make recommendations to the Medical Executive Committee within sixty days of receipt of the names and applicable information regarding the candidates to enable the Medical Executive Committee to make its recommendation within ninety days to the Governing Board. Consideration of qualifications and suitability to contract with the hospital will include:
- The experience of the candidate consistent with the needs and requirements of the Hospital
  - The administrative and supervisory abilities in the candidates' specialty
  - The candidates' compatibility with the Medical and Hospital staff to render effective patient care.
  - Whether the consultative and diagnostic techniques of the candidate meet the professional requirements of the medical staff in order to render quality effective patient care, and,
  - Other criteria as may be deemed appropriate.
- 3.2.8.2.5 This review and evaluation will be independent of and without prejudice to any candidates' or candidates' employee's application for medical staff membership. Such application for medical staff membership and clinical privileges will be in accordance with the requirements of these Bylaws. A determination or recommendation by the Medical Executive Committee regarding contracts for hospital-based physicians or medical group, to provide clinical services and/or to

become a Director of a clinical service will be final and without right of hearing or appeal by the candidate.

### 3.2.8.3 TERMINATION/REDUCTION OF PRIVILEGES

Prior to the Hospital's unilateral termination of a contract with a hospital-based physician or medical group, the Chief Executive Officer will formally consult with the Medical Executive Committee who will vote on the action recommended.

Practice at the Hospital is always contingent upon the clinical privileges granted. The right of a practitioner who is providing contract services to practice at the hospital is automatically terminated when s/he no longer is a member of the Medical Staff and/or no longer has clinical privileges at the hospital. Similarly, his or her right to render services under the contract is automatically limited to the extent that his/her clinical privileges are reduced, restricted, terminated, for whatever reason.

All practitioners may apply for privileges not under exclusive contract for which they are qualified.

Termination of an exclusive contract does not constitute automatic loss of medical staff membership. However, it is the responsibility of the physician to assure that privileges outside of the contract for which they are qualified are requested, otherwise if no privileges are requested, membership and clinical privileges will be deemed voluntarily resigned based on the lack of affiliation with the contract service.

## ARTICLE IV. APPLICATION FOR APPOINTMENT

### Section 4.1

Upon receiving a request for an application to the medical staff, the medical staff office will ask the applicant to specify the specialty of clinical privileges for which the individual wishes to apply. If all of the clinical privileges so identified are not available at hospital or are the subject of an exclusive contract or a closed service, the medical staff office will so advise the individual and no application will be provided the individual. If the clinical privileges so identified are not available or are the subject of a closed service or exclusive contract, but other privileges are available, the medical staff office will so advise the individual. Applications will only be issued to candidates who seek privileges which are available to be exercised at the hospital. The individual will not be entitled to a hearing pursuant to Article VIII, due to the inability to provide such individual an application. Notwithstanding the foregoing, if the individual or group which holds the exclusive contract or has the right to exclusive use informs the medical staff office, in writing, that the applicant is or will be allowed to exercise the privileges which are the subject of the exclusive contract or exclusive use policy, subject to the credentialing process, the Medical Staff Office will provide the individual with an application.

### Section 4.2

All applications for appointment to the staff must be:

- 4.2.1 Completed legibly
- 4.2.2 Signed off by the applicant
- 4.2.3 Submitted on a form recommended by the Medical Executive Committee and approved by the Governing Board.
- 4.2.4 Contain applicant's specific acknowledgment of his/her obligations to provide continuous care and supervision of patients, to abide by the Medical Staff Bylaws, Rules and Regulations, and Policies and Procedures, and have been approved by the Medical Executive Committee.
- 4.2.5 To accept committee assignments
- 4.2.6 To accept consultation assignments
- 4.2.7 To abide by current Hospital Policies that apply to activities as a medical staff or allied health professional member.

### **Section 4.3**

The application form will require detailed information which must include, but not be limited to the following:

- 4.3.1** Applicant's professional qualifications including:
  - 4.3.1.1 undergraduate education, postgraduate education, and professional degrees with membership dates
  - 4.3.1.2 internship, residency/fellowship
  - 4.3.1.3 all past and present hospital and other healthcare entity affiliations (including hospitals, surgical centers and clinics) An exception would be for Telemedicine physicians who would be required to list all past and present hospital and other healthcare entity affiliations but only require that a maximum of 10, randomly selected affiliations be verified with the primary source in order to demonstrate current clinical competence.
  - 4.3.1.4 membership in professional associations, societies, academies, college, and faculty/training appointments
  - 4.3.1.5 specialty/sub-specialty board certification
  - 4.3.1.6 state licensure(s) with expiration date(s)
  - 4.3.1.7 DEA with expiration date and schedule
  - 4.3.1.8 Any gaps in education, training, service, or work experience must be fully explained in writing.
  - 4.3.1.9 An e-mail address (added 11/16/09)
  - 4.3.1.10 A valid home address
  - 4.3.1.11 A valid office address
  
- 4.3.2** Names of at least three (3) persons who have had experience in observing and/or working with the applicant and who can provide adequate references pertaining to the applicant's ethical character, current competence, health status (subject to any necessary reasonable accommodation to the extent required by laws), and the ability to work cooperatively with others. These individuals should be peers of the applicant, in the same professional discipline and can not be family members. The peer must be someone who is not financially affiliated with the physician. The appropriate clinical department and/or credentials committee may request additional references if deemed necessary.
  
- 4.3.3** Responses to the following questions:
  - 4.3.3.1 Has any professional license of yours, in any jurisdiction, or your DEA registration ever been denied, limited (either voluntarily or involuntarily), suspended, revoked, voluntarily surrendered or otherwise acted against or is any such action pending?
  - 4.3.3.2 Have your clinical privileges (including but not limited to temporary, admitting, covering, consulting, and assisting) or membership at any health care facility, surgical center or healthcare clinic ever been limited, suspended, reduced, denied, modified, revoked, not renewed, voluntarily relinquished or limited, or otherwise adversely acted upon or is any such action pending?
  - 4.3.3.3 Have you ever been convicted of a felony or misdemeanor (other than minor traffic offenses) or is any such action pending?
  - 4.3.3.4 Have you ever entered into a plea agreement or a no contest to avoid conviction of a felony or misdemeanor? On a separate piece of paper list the details and the court involved.
  - 4.3.3.5 Are there any professional liability cases, including lawsuits and arbitrations, against you or has any judgment, settlement, or award been made against you in a professional liability case? If so, on a separate sheet, list the complete case name, the court in which the case was filed, the date of loss, the date you first received notice of the claim, the date of resolution, your

insurance carrier and the amount of judgment or settlement paid on your behalf for each judgment or settlement.

- 4.3.3.6 Other than the cases described in response to the preceding question in which a professional liability case is pending or a judgment, settlement, or award has been made, has any professional liability insurance claim been filed against you or have you reported any malpractice claims to your insurance carrier or have you received any letter of intent to sue?
  - 4.3.3.7 Has any professional liability insurance carrier canceled, refused coverage, excluded specific procedures from your coverage, or has your insurance been rated up or has a surcharge been imposed by your insurance carrier, or is any such action pending?
  - 4.3.3.8 Have you ever discontinued practice for any reason (other than for routine vacation or formal education/training) for one month or more? The applicant must account for all time gaps.
  - 4.3.3.9 Have you ever been suspended, excluded, debarred, or sanctioned under the Medicare or Medicaid program or by any professional governmental licensing agency, convicted of any offense related to health care, or listed by a federal or state agency as debarred, excluded, or otherwise been deemed ineligible for federal or state program payment or participation?
  - 4.3.3.10 Do you have any physical and/or mental health issues which cannot be reasonably accommodated and which may inhibit or otherwise impact your ability to meet your obligations under these bylaws, and exercise the clinical privileges requested, safely and competently? On a separate sheet of paper, please specify any accommodations which you may require and the basis thereof.
  - 4.3.3.11 Have you ever had a reduction of privileges or formal counselings during any training program? If so, the applicant may be excluded from being granted staff membership based on the outcome of a review of the circumstances of such action. Full disclosure is required.
- 4.3.4** Every application for staff appointment must be accompanied by:
- 4.3.4.1 Copies of applicant's licenses to practice (upon application)
  - 4.3.4.2 A copy of the applicant's narcotics license, if applicable
  - 4.3.4.3 Continuing medical education activities reflecting documentation pertinent to privileges requested and in accordance with Medical Board of California requirements
  - 4.3.4.4 A non-refundable application fee as determined by the Medical Executive Committee
  - 4.3.4.5 Copy of current certification, as required by the clinical department and based on clinical privileges requested (e.g. ACLS, PALS, Certificate of Neonatal Resuscitation, Fluoroscopy License)
  - 4.3.4.6 Evidence of current malpractice insurance coverage in amounts as set forth in these bylaws and as approved by the governing board. Shared policies are not accepted.
  - 4.3.4.7 All information requested regarding professional liability history for the past five (5) years, including final judgments, awards and settlements made against the applicant in professional liability cases and any filed cases pending
  - 4.3.4.8 Proof that the applicant maintains clinical coverage by a physician who holds the same clinical privileges. Any exceptions would be on a case-by-case basis.
  - 4.3.4.9 Non-Admitting physicians (except Telemedicine physicians), and those with Surgical Assist privileges only, do not require a covering physician.
  - 4.3.4.10 OB/GYN physicians are required to maintain two (2) covering physicians.
  - 4.3.4.11 Physicians who provide consultations only may not be required to have a covering physician. Determination of the need for coverage will be at the

discretion of the Medical Executive Committee upon recommendation of the Credentials Committee and Clinical Department.

- 4.3.4.12 Physicians whose covering physician is suspended or no longer on staff are required to provide the Medical Staff Office with the name of their new covering physician(s). Failure to meet coverage requirements will be grounds for voluntary resignation from the Medical Staff without hearing right.
- 4.3.4.13 A written statement, executed by the applicant acknowledging his/her agreement to comply with all applicable bylaws, rules and regulations, policies, requirements and standards adopted by the medical staff at the hospital
- 4.3.4.14 A signed copy of the Medical Staff Expectations
- 4.3.4.15 Medicare Attestation (signed)
- 4.3.4.16 A signed and dated Confidentiality Statement
- 4.3.4.17 A detailed list of cases treated or procedures performed to support privileges requested.
- 4.3.4.18 Consent to undergo a criminal background check
- 4.3.4.19 Photo (passport size) for identification purposes to be sent with verifications (11/09)
- 4.3.4.20 Curriculum Vitae (CV) (added 11.16.09)
- 4.3.4.21 Positive identification – applicant must show government approved identification with the exception of Non-Admitting physicians
- 4.3.4.22 Emergency Department Physicians are required to complete a color vision deficiency test.
- 4.3.4.23 Emergency Department Physicians are required to complete Stroke Education and complete the Stroke Education Examination in order to deem their application complete. They are also required to submit an acknowledgement of receipt of the EMTALA Educational Package and Current Practices.

#### **Section 4.4**

- 4.4.1 Neither the Medical Staff Office, Medical Staff, nor Governing Board will have any obligation to review an application until the application is complete in all respects and the applicant submits all required information and supporting material that may be requested based upon the information received by the Medical Staff. .
  - 4.4.1.1 Any committee or individual charged under these bylaws with the responsibility of reviewing an application for appointment, reappointment, or new clinical privileges may, upon review of the application deem any such application incomplete.
  - 4.4.1.2 The fact that an application is deemed completed by the Medical Staff Office or a Department or Committee does not preclude a Committee or Department, which subsequently reviews the application from deeming it incomplete.
  - 4.4.1.3 If an application is deemed incomplete, it will not be processed.
  - 4.4.1.4 The Committee or Department that deems an application incomplete may request further documentation or clarification from the applicant. Such Committee or Department requesting further documentation or clarification will notify the applicant in writing and will afford the applicant a set period of time to respond. Such period of time will be established by the requesting body but will not exceed sixty (60) calendar days from the applicant's receipt of the request for information.
  - 4.4.1.5 Failure of an applicant to timely produce all of the requested information, documents, and explanations will result in the application being deemed incomplete and voluntarily withdrawn. Unless required by applicable law, such action will not result in the filing of a report with the applicable state licensing agency nor the National Practitioner Data Bank and will not be grounds for a hearing.
  - 4.4.1.6 However, if within thirty (30) days of notification of the withdrawal of the application, the applicant requests an appearance before the Medical Executive Committee, the applicant will be permitted to appear before the Medical Executive Committee to demonstrate good cause for the failure to provide the requested information.

- 4.4.2 The Medical Staff Office will collect and verify the information required in 4.2 and 4.3 of this Article and seek any additional information as required by the Credentials Committee, Medical Executive Committee or Clinical Department. The hospital's authorized representative will query the Nation Practitioner Data Bank regarding the applicant member and submit any resulting information to the Credentials Committee for inclusion in the applicant's credential file. The applicant will be notified of any problems in obtaining the information required.
- 4.4.3 It is the applicant's obligation to assist the medical staff in obtaining the required information, if so requested. The applicant will have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics and other qualifications, for resolving any doubts about such qualifications and assuring information deemed relevant to the applicant's qualifications is received in a timely manner. The applicant is required to submit any evidence of current mental or physical health status that may be reasonably requested by the Medical Executive Committee and may be required to submit to a physical examination or psychiatric evaluation by a practitioner designed by the Medical Staff at the applicant's expense.
- 4.4.4 Significant misrepresentation or omission of information in the application process will be grounds for denial of the application, or if membership or clinical privileges have been granted, for corrective action under these bylaws.
- 4.4.5 After collecting the references and other material deemed pertinent, the Medical Staff Office will transmit the application and all supporting materials to the Credentials Committee and the appropriate department(s) for evaluation.
- 4.4.6 By applying for appointment to the staff, each applicant thereby signifies his/her willingness to appear for interviews in regard to his/her application, authorizes the hospital to consult with members of the Medical Staff of other hospitals with which the applicant has been associated and with others who may have information bearing on his/her competence, character and ethical qualifications, consents to the Medical Staff's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges s/he requests or which pertain to his/her moral and ethical qualifications for medical staff membership, and to the fullest extent permitted by law, releases from liability all representatives of the hospital and its medical staff for the acts performed in connection with the evaluation of the applicant and hi/her credentials and, to the fullest extent permitted by law, releases from any liability all individuals and organizations who provide information to the hospital concerning the applicant's competence, ethics, character, and other qualifications for staff appointment and clinical privileges, including otherwise privileged and confidential information.
- 4.4.7 The application form will include a statement that the applicant has received the Bylaws, Rules and Regulations, and Policies and Procedures of the Medical Staff, that s/he agrees to be bound by the terms thereof and the current Hospital policies that apply to his/her activities as a medical staff member that are consistent with the Medical Staff Bylaws.
- 4.4.8 The application form will include a statement wherein the applicant verifies that all answers, statements, and information provided by the applicant on the application and during the application review process are and will continue to be true and correct, that the applicant will promptly update such answers, statements and information provided on the application or in the application review process, and that any material omission or misstatement on the application or in the application review process and/or failure to promptly update information on the application will be grounds to deny the application or to terminate membership and/or privileges.
- 4.4.9 Individuals whose function is medico-administrative in nature, e.g. Medical Director, must apply for medical staff membership. The applicant will be appointed through the same procedure used for all other medical staff applicants. Physicians directly employed by Providence may not apply for membership on the Medical Staff.
- 4.4.10 If the applicant does not complete the application within ninety (90) days after submission of an incomplete application, including submission of such supporting information and



documents as reasonably requested by the Medical Staff Office, the applicant will be notified that his/her application will be filed as incomplete in 30 days, and that if s/he wishes to reapply after that date, a new medical staff application will be required and additional application payment fee equal to that of the original application fee will be required. Practitioners may reapply only once after withdrawal of an application. The physician must wait for two (2) years after the date of being voluntarily withdrawn in order to reapply to the Medical Staff.

## ARTICLE V. APPOINTMENT PROCESS

### Section 5.1

5.1.1 All applications will require verification directly from the primary sources. However, if the American Medical Association reports that it has verified the reference, the Medical Staff may elect not to further pursue verification directly from the source. The verifications which must be obtained directly, and those items for which the Medical Staff Office might accept verification from the AMA are:

- 5.1.1.1 Licensure to be verified directly with the Medical Board of California. All other state licensures will be verified with the individual state agencies;
- 5.1.1.2 Malpractice coverage and claims history to be verified with the carrier directly;
- 5.1.1.3 National Practitioner's Data Bank, queried directly;
- 5.1.1.4 American Medical Association;
- 5.1.1.5 Professional medical references (peer references), queried directly;
- 5.1.1.6 Medical School (AMA statement that reference was verified may be sufficient);
- 5.1.1.7 Internship(s) (AMA statement that reference was verified may be sufficient);
- 5.1.1.8 Residency(s) (AMA statement that reference was verified may be sufficient);
- 5.1.1.9 Fellowships, if applicable (AMA statement that reference was verified may be sufficient);
- 5.1.1.10 ECFMG, if applicable, queried directly;
- 5.1.1.11 Hospital affiliations, current and past, queried directly;
- 5.1.1.12 Any other professional training or experience disclosure on the application (AMA statement that reference was verified may be sufficient);
- 5.1.1.13 Criminal Background Evaluation (FACIS or other corporation as chosen by the Medical Staff, queried directly);
- 5.1.1.14 OIG, GSA, and any other governmental agencies as deemed necessary.
- 5.1.1.15 Any other information deemed necessary by the Medical Staff Office
- 5.1.1.16 To ensure that the individual requesting approval is the same individual applying for medical staff or allied health staff membership and privileges, the applicant will be required to follow the process below:
  - 5.1.1.16.1 Applicant is required to arrange a time with the Medical Staff Office for an in-person identification verification via photo ID through a valid United States issued ID. A current expiration date must be noted on the photo ID. The Medical Staff Office staff will document, via completion of the Positive Identification Process Form, that positive identity was confirmed. Failure to provide proof of identity during the credentialing process will constitute an incomplete application and will be considered withdrawn. (4/04)

### Section 5.2

Once the application is deemed complete by the Medical Staff Office, the Credentials Committee will:

- Determine whether the application is complete or if additional information or documentation should be obtained in order to enable the committee to make its recommendation.
- Forward the applicant's request for specific clinical privileges to the department or departments with jurisdiction over these privileges.

### Section 5.3

Application processing:

As soon as practical after receipt of the complete application for membership, the Credentials Committee will examine the evidence of character, professional competence, qualifications, and ethical standing of the practitioner. The committee may elect to interview the applicant and seek additional information. It will determine, through information contained in references given by the practitioner and from other sources available to the Credentials Committee, whether the applicant has established and met all of the membership requirements. The Credentials Committee will make a written report of its investigation and forward it to each clinical department wherein the applicant is seeking clinical privileges. The report will include

- A recommendation that the practitioner be provisionally appointed to the medical staff,
- Be rejected for medical staff membership (including the reason for rejection),
- Be conditionally appointed (as defined in the rules and regulations) or,
- That the application be deferred for further consideration.

The clinical department may elect to interview the applicant and seek additional information. Each department will make a written report, including specific written recommendations for delineating the practitioner's clinical privileges. The Credentials Committee and Clinical Departments will transmit their recommendation(s) to the Medical Executive Committee.

The Medical Executive Committee will resolve any conflicts as to which privileges fall within the jurisdiction of each department.

#### **Section 5.4**

If practical at its next regular meeting (after receipt of the application, report and recommendation of the Credentials Committee and each of the Clinical Departments), the Medical Executive Committee will determine whether to recommend to the Governing Board:

5.4.1 That the practitioner be provisionally appointed to the medical staff

5.4.2 That s/he be rejected from the medical staff membership (including the reason for rejection),

5.4.3 That his/her application be deferred for further consideration.

5.4.4 The Medical Executive Committee may request additional information,

5.4.5 Elect to interview the applicant and/or return the matter to a Clinical Department and/or the Credentials Committee.

#### **Section 5.5**

When the recommendation of the Medical Executive Committee is to defer the application for further consideration, absent good cause for an extension of the deferral, it must be followed up within ninety (90) days with a subsequent recommendation for provisional appointment with specified clinical privileges, or for rejection of membership.

#### **Section 5.6**

When the recommendation of the Medical Executive Committee is favorable one, the recommendation will be promptly forwarded to the Governing Board.

#### **Section 5.7**

If the Medical Executive Committee's recommendation is to deny the application for appointment to the medical staff or to deny any clinical privileges requested in the application, the Medical Executive Committee will include the reason for its recommendation.

- Should the denial be for clinical privileges requested which are either outside of the scope of practice at this facility or under an exclusive contract, the applicant will be so notified and will not be accorded hearing rights. The applicant will be notified of the adverse recommendation by mail as defined in these bylaws.
- Should denial of the application be for reasons other than those noted above, and if the denial is grounds for a hearing as provided in by the Medical Staff Bylaws, then a notice will be sent to inform the applicant of his or her rights to a hearing to review the adverse recommendation pursuant to these bylaws.

## Section 5.8

If practical, at its next regular meeting after receipt of a favorable recommendation, the Governing Board will act on the matter. If the Governing Board's decision is favorable to the practitioner, it will be final and the Chief Executive Officer will send a notice of the decision to the Chief of Staff, the Chief of the Department concerned, and will notify the practitioner concerned. If the Governing Board's tentative decision is adverse to the practitioner with respect to either appointment or clinical privileges, and if the adverse decision is grounds for a hearing, the Governing Board will refer its concerns and tentative recommendation to the Medical Executive Committee for reconsideration including a reasonable period of time for the Medical Executive Committee to reconsider and make a subsequent recommendation. If after such referral back to the Medical Executive Committee the Governing Board and Medical Executive Committee still do not agree, the dispute will be submitted to the Ad Hoc Dispute Resolution Committee. If after consideration by the Ad Hoc Dispute Resolution committee, the Governing Board's decision remains adverse to the practitioner and the Medical Executive Committee's recommendation is favorable to the practitioner, the Chief Executive Officer will promptly notify him/her of such adverse decision by mail, and such adverse decision will be held in abeyance until the practitioner has exercised, or has been deemed to have waived, his/her rights under the medical staff hearing rights section of the bylaws. In making their recommendation, the Governing Board will give great weight to the recommendation of the medical staff and will not act arbitrarily or unreasonably.

## Section 5.9

Each step in the review process will be completed as promptly as is reasonably possible in view of the duty to exercise due care in the review of the applicants. Whenever the Chief of Staff finds that the review process has been unduly delayed at any particular step, s/he may direct the review to be advanced to the next applicable step.

## Section 5.10

Any applicant who:

- 5.10.1 Has received a final adverse decision regarding an application for membership and/or request for privileges, or;
- 5.10.2 Withdrew his/her application or request for membership or privileges following an adverse recommendation by the Medical Executive Committee or the Governing Board, **OR**
- 5.10.3 A member or former Medical Staff member who has:
  - 5.10.3.1 Received a final adverse decision resulting in termination of Medical Staff Membership and/or clinical privileges or resulting in restriction of Medical Staff membership or privileges or resulting in restriction of Medical Staff membership or privileges, or;
  - 5.10.3.2 Resigned from the Medical Staff while an investigation was pending, or following issuance by the Medical Executive Committee or Governing Board of , relinquished or agreed to restrictions on clinical privileges following notice of a pending investigation or commencement of an investigation, or following a recommendation adverse to the member's Medical Staff membership and/or clinical privileges;

Will not be eligible to apply for Medical Staff membership and will not be eligible to apply for the clinical privileges affected by the previous action for a period of at least three (3) years from the date the adverse decision became final, the date the application or request was withdrawn, or the date that the former medical staff member's resignation, relinquishment or agreement to restrict privileges became effective, whichever is applicable. A member who has requested additional clinical privileges is deemed an applicant for such privileges. Notwithstanding the foregoing, if the final adverse decision was only for a specific duration or until specified conditions are satisfied (such as completion of retraining), then the automatic waiting period will be as specified in the final adverse decision, at which time the individual may submit an application for membership or request for privileges that would be processed as and subject to the standards of an initial applicant.

### **Section 5.11**

A decision or recommendation will be considered adverse only if it is based on medical disciplinary cause or reason, unethical conduct, disruptive behavior or discrimination or harassment, or failure to meet minimum professional standards. Actions which are not considered to be adverse for the purpose of **Section 5.10** including actions based on failure to maintain a practice in this area which can be cured by a move, failure to maintain appropriate amounts of malpractice insurance which can be cured by securing insurance, failure to complete medical records which can be cured by completing medical records, or failure to pay medical staff dues which can be cured by submission of a complete application and payment of an application fee. Further, for the purpose of Section 5.10, an adverse decision will be considered final at the time of completion of all hearing and appellate review proceedings as provided in medical staff bylaws provisions and any subsequent reviews through the courts.

### **Section 5.12**

After the three (3) year waiting period specified in Section 5.10, the former applicant, former or current medical staff member may submit an application for such medical staff membership and/or clinical privileges which will be processed, and be subject to the standards of an initial application for such membership and/or clinical privileges. The individual must also furnish evidence that the basis for the earlier adverse recommendation or action no longer exists and/or of reasonable rehabilitation in those areas which formed the basis for the previous adverse recommendation or action, whichever is applicable.

### **Section 5.13**

Any practitioner who resigns or has been deemed to have voluntarily resigned from the medical staff who subsequently applies for medical staff membership or clinical privileges will be processed as an initial applicant and will not be entitled to apply for appointment if s/he has any unfulfilled obligations under these bylaws or the rules and regulations, including, but not limited to, the need to complete medical records. Once the unfulfilled obligations are completed, consideration as to providing an application will be made.

### **Section 5.14**

Physicians who have resigned, been deemed voluntarily resigned, or who have been terminated must submit an initial application and pay an initial application fee. Physicians who were members of the medical staff prior to 2005 when the board certification requirement was instituted, would not be held to the board certification requirement for medical staff membership and clinical privileges.

### **Section 5.15**

Notwithstanding the terms and conditions of Article V, upon the approval of the department, the Medical Executive Committee, and the Governing Board, a process may be established for expedited credentialing of applicants for appointment and reappointment who meet specified criteria in accordance with the Medical Staff Rules and Regulations.

## **ARTICLE VI. REAPPOINTMENT PROCESS**

### **Section 6.1**

Members of the medical staff must be reappointed at least every two (2) years. At least 180 days prior to the expiration of the member's appointment, a member will be sent a reappointment application ~~by mail~~. The member **must** return the completed application within sixty (60) days of the date it was received in the practitioner's office. If the application is received within 60 days but is not complete, a missing items letter will be sent to the practitioner's office via certified mail providing them thirty (30) days from the date

of receipt of the incomplete application to submit the required information to deem the application complete.

Receipt of reapplication or requested missing information subsequent to the above referenced 60 day period will not be accepted. The practitioner would need to complete a new application packet as an initial applicant, with application fees, in order to be processed as a new applicant. This fee is exclusive of annual dues. This new application would be sent on the 61<sup>st</sup> day, or the first business day following 61 days, along with a letter explaining the need to complete the documentation for processing as a new applicant. No exceptions will be made to the required application fee. Privileges and membership would be maintained until such time as the original appointment expires. Should the new appointment request be completed prior to the time of expiration, membership and privileges will be maintained with the approval date being that of the newly approved application.

A practitioner who fails to return the form or to supply all of the required information within, the required time period will be deemed to have resigned his/her medical staff membership, effective as of the date of the expiration of his/her current appointment. A practitioner who is deemed to have resigned under this section will not be entitled to the hearing and appeal rights under these bylaws. Notwithstanding the foregoing, a practitioner whose privileges and membership have been deemed to be voluntarily relinquished for failure to timely complete and submit the required application or failure to timely submit additional information required in order for the application to be deemed complete may petition to appear before the Medical Executive Committee for the sole purpose of establishing "good cause" for the failure to timely complete or the failure to timely submit the additional information requested in order for the application to be deemed complete. This will not be deemed a hearing or give rise to other rights pursuant to these bylaws. The Medical Executive Committee will not grant the petition if it determines that the delay may result in the Medical Staff and Governing Board not completing the reappointment process before the expiration of the practitioner's present appointment. The decision of the Medical Executive Committee will be final.

The applicant will have the burden of timely producing adequate information for a proper evaluation of his/her competence, character, ethics, and other qualifications, for resolving any doubts about such qualifications and for timely providing information and documents requested regarding the applicant's qualifications.

The reappointment application must be in a format approved by the Medical Executive Committee, and it should require detailed information concerning the changes in the applicant's qualifications since last review. Information required on the reappointment application must include, but not be limited to, all of the information and certifications requested in the appointment application form, except the information regarding the members pre-medical and medical education, internship, residency, and fellowship training (unless additional training has been undertaken since the time of last appointment), date of birth, etc. This form will also require information as to whether the applicant requests any change in his/her staff status and/or clinical privileges, including any reduction, deletion or additional privileges. Requests for additional privileges must be supported by evidence of continuing medical education and or experience, type and nature of evidence, which would be necessary for such privileges to be granted. The applicant is responsible for providing all required documentation in order to satisfy the committee reviewing the request. The medical staff member is required to submit reasonable evidence of current health status, if requested by the Medical Executive Committee. The member must supply malpractice claims history during the last period of reappointment, which may include a detailed list from the practitioner as well as from his/her malpractice carrier. The malpractice information will be compared with information received from the National Practitioner Data Bank. The applicant is responsible for explaining, to the Medical Staff's satisfaction, any discrepancies identified.

If the staff member's level of clinical activity at this hospital is not sufficient to permit the Medical Staff and Governing Board to evaluate his/her competence to exercise the clinical privileges requested in order for the application to be deemed complete, the staff member will have the burden of providing evidence of clinical performance at his/her principal institution or from office records as directed by the Medical Staff

Office with or without consultation with the Credentials Committee Chair, Department Chair, Medical Executive Committee or Governing Board. Should the reappointment application be complete with the exception of documentation of current clinical competence in a specific privilege or privileges, the Credentials Committee or Department Chair may choose to process the reappointment application and defer those privileges necessitating additional documentation.

Neither the Medical Staff Office, Medical Staff, nor Governing Board will have any obligation to review a reappointment until it is complete in all respects and the applicant has submitted all required information and supporting material.

## **Section 6.2**

The medical staff will, in a timely fashion, seek to verify the additional information made available on each reappointment application form and to collect any other materials or information deemed pertinent by the Credentials Committee, Medical Executive Committee or Clinical Department/Department Chair. Such additional information will address, without limitation:

- 6.2.1 Patterns of care and utilization as demonstrated in the findings of Quality Review, Risk Management, Utilization Management, Clinical Pertinence, and Department activities;
- 6.2.2 Participation in relevant continuing medical education activities;
- 6.2.3 Nature and volume of clinical activity (patient care contacts) at the hospital or another accredited hospital, healthcare facility, or office setting, if requested;
- 6.2.4 Corrective actions or disciplinary actions/issues, and details thereof;
- 6.2.5 Health status including the completion, at the practitioner's expense, of a physical examination, neurologic examination, or psychiatric evaluation to be completed by a physician who is acceptable to the Medical Executive Committee, when so requested by the Medical Executive Committee;
- 6.2.6 Attendance at Medical Staff Department and Committee meetings, where required;
- 6.2.7 Timely and accurate completion and preparation of medical records;
- 6.2.8 Professional conduct in working with other practitioners, hospital personnel, patients in the hospital, and families;
- 6.2.9 Professional liability claims experience, including being named as a party in any professional liability claims and the disposition of any pending claims;
- 6.2.10 Compliance with Medical Staff Bylaws, Policies, Rules and Regulations, and with Hospital Policies approved by the Medical Executive Committee;
- 6.2.11 Any other pertinent information including staff member's activities at other hospitals and his/her medical practice outside the hospital; and
- 6.2.12 Information concerning the member from the Medical Board of California, the National Practitioner Data Bank and from OIG, GSA or other governmental entities.
- 6.2.13 Information concerning the member obtained via a Criminal Background Check.

Physicians requesting reappointment to the Medical Staff will be required to obtain a peer recommendation from a physician who is familiar with their work and who is not financially

associated with the applicant. Peer recommendation may be from another physician in the same clinical department.

The Medical Staff Office will transmit the completed reappointment application and supporting materials to the Credentials Committee, to the Chair of the Clinical Department to which the staff member belongs, and to the Chair of any other Department in which the member has or requests privileges.

### **Section 6.3**

The Credentials Committee meets at least quarterly to review the applications and all pertinent information available on each member who is being considered for reappointment and transmit its recommendation(s) to the applicable Department Chair and Medical Executive Committee. Depending upon the timing of meetings, the Reappointment application may be submitted to the Clinical Department prior to submission to the Credentials Committee.

### **Section 6.4**

The Department Chair will review the application and the staff member's file and transmit to the Medical Executive Committee his/her report and recommendations.

### **Section 6.5**

The Medical Executive Committee will review the Department Chair and Credentials Committee reports, all other relevant information available to it, and will forward to the Governing Board its reports and recommendations.

### **Section 6.6**

The Department Chair, Credentials Committee, and Medical Executive Committee reports and recommendations will be submitted in the form prescribed by the Medical Executive Committee. Each report and recommendation will specify whether the applicant's appointment should be renewed, renewed with modified membership category, be conditionally reappointed (as defined in the Rules and Regulations), department affiliation, clinical privileges, and/or whether membership and/or clinical privileges should be terminated. Where non-reappointment, denial of requested privileges, a reduction in status, or a change in clinical privileges is recommended, the reason for such recommendation must be stated.

### **Section 6.7**

Each recommendation concerning the reappointment of a medical staff member and the clinical privileges to be granted upon reappointment will be based on whether such member has met the qualifications specified in these Bylaws, Rules and Regulations, and Policies and Procedures.

### **Section 6.8**

If the Medical Executive Committee recommends adverse action, as defined in these Bylaws, with respect to reappointment and/or clinical privileges, the Chief of Staff will provide the applicant written notice of the adverse recommendation. If the adverse recommendation is grounds for a hearing, the notice also will advise the applicant of his/her right to request a hearing in the manner specified in the Hearing and Appellate Review portion of these Bylaws, and the applicant will be entitled to procedural rights.

The Governing Board will be informed of, but not take action on, the pending recommendation until the applicant has exhausted or waived his/her procedural rights.

Thereafter, the procedures specified in these Bylaws, will be followed. The Medical Executive Committee may defer action; however, any such deferral must be followed up within 70 days, unless the Medical Executive Committee determines there is good cause for further deferral.

### **Section 6.9**

If the Medical Executive Committee recommendation is favorable to the practitioner but the Governing

Board's decision is adverse to the practitioner with respect to appointment and/or clinical privileges and if the adverse decision is grounds for a hearing, the Governing Board will refer its concerns and tentative recommendation to the Medical Executive Committee for reconsideration, including a reasonable period of time for the Medical Executive Committee to reconsider and make a subsequent recommendation. If after such referral back to the Medical Executive Committee, the Governing Board and Medical Executive Committee still do not agree, the dispute will be submitted to the Dispute Resolution Committee. If after consideration by the Ad Hoc Dispute Resolution Committee, the Governing Board's decision remains adverse to the practitioner and the Medical Executive Committee's recommendation remains favorable to the practitioner, the Chief Executive Officer will promptly notify the practitioner of such adverse decision by "mail", as such term is defined in these bylaws, and such adverse decision will be held in abeyance until the practitioner has exercised or has been deemed to have waived his/her rights under these Bylaws. In making their recommendation under this section, the governing board will give great weight to the recommendation of the medical staff and must not act arbitrarily or unreasonably. During the period while the foregoing process is being implemented, if necessary in order to avoid an expiration and lapse in membership and clinical privileges, the member will be appointed by the Governing Board for a short period pending the resolution. The fact that a practitioner may be reappointed pending resolution of conflicting recommendations between the Medical Executive Committee and Governing Board or that an adverse decision is held in abeyance will not be deemed to confer privileges when none existed before.

#### **Section 6.10**

Submission of an application for reappointment signifies that the medical staff member has participated in a sufficient number of patient care contacts at the hospital each year since the last period of reappointment in order to demonstrate current competence. Should the physician have insufficient patient contacts at the hospital in order to demonstrate current competence, detailed documentation must be submitted to support current competence from another facility where the physician is currently practicing or via office records. If the practitioner is unable to verify activity, by virtue of copies of H&P's, discharge summaries, operative reports, consultation reports or other documentation submitted and accepted by the Credentials Committee or Department Chair, within sixty (60) days of the request, such failure will be regarded as a voluntary resignation which will become effective on the date of expiration of his/her current appointment.

#### **Section 6.11**

If a practitioner wishes to reapply following such a voluntary resignation, s/ he must submit a complete initial application and **pay** an additional application fee in order to be considered for appointment. Practitioners will be processed as new applicants and have the burden set forth in these Bylaws of a new applicant. If a practitioner has previously completed proctoring (FPPE), consideration may be given to waiving further proctoring, however, this would require documentation of current clinical competence to support privileges requested.

#### **Section 6.12**

A recommendation to reappoint will not be deemed to be a waiver by the Medical Staff of its right to subsequently take corrective action or any other adverse action in accordance with these Bylaws based upon the qualifications, conduct, or other activity or information which may have existed or occurred prior to such appointment.

### **ARTICLE VII. PEER REVIEW MONITORING**

#### **Section 7.1 Routine Monitoring and Education**

##### **Section 7.1.1 Responsibility:**

It is the responsibility of the Chair of the Clinical Department and Vice Chair, who may work through or with the assistance of a standing Department, Committee, or an Ad Hoc Committee to:

Section 7.1.1.1 Monitor and assess the quality of professional practice in each Department



- Section 7.1.1.2 Promote quality of practice in each department by:
- Section 7.1.1.2.1 Providing education and counseling, and
  - Section 7.1.1.2.2 Issuing letters of admonition, warning, censure, as necessary, and,
  - Section 7.1.1.2.3 Requiring routine monitoring when deemed appropriate

**Section 7.1.2 Procedure**

- 7.1.2.1 Review and Studies: Each Departmental Peer Review Committee will conduct regular patient care reviews and studies of practice within the department in conformity with the hospital's general Performance Improvement Plan (Plan for Provision of Care) that has been approved by the medical staff, Medical Executive Committee and Governing Board. The Department Chair, who may work through committees, as appropriate, may review any matter or practitioner which has been brought to the Chair's or the Department's attention which relates to the professional practice or conduct of individuals with privileges in the department.
- 7.1.2.2 Informal Counseling: In order to assist those with privileges in the Department in conforming their conduct or professional practice to the standards of the Medical Staff, the Department Chair may issue informal comments and/or suggestions either orally or in writing. Such comments or suggestions will be subject to the confidentiality requirements of all medical staff information and may be issued by the Department Chair or Vice Chair with or without prior discussion with the recipient and with or without consultation with the department or a committee. Such comments or suggestions will not constitute a restriction of privileges, will not be considered to be corrective action, and will not give rise to hearing, review or appeal rights. Such actions taken need not be reported to the Medical Executive Committee. Written documentation of the counseling will be placed in the practitioner's permanent credential file.
- 7.1.2.3 Following discussion of identified concern(s) with any individual with privileges in the department, any Department may authorize the Chair to issue a letter of admonition, warning or censure, or to require such member to be subject to routine monitoring for a stipulated period of time. Such action may also be initiated by the Department Chair in concurrence with the Chief of Staff without the authorization of the department. The affected member may make a written response, which will be placed in the member's Credential file. Such action will not constitute a restriction of privileges, will not be considered to be corrective action, and will not give rise to a hearing review or appeal rights. Matters which result in routine monitoring will be reported to the Medical Executive Committee at the next regular meeting. The issuance of a letter of admonition, warning, or censure will not require reporting to the Medical Executive Committee.
- 7.1.2.4 Should an issue relating to a member of the Medical Staff be reviewed by a Department, Division, or Committee of the Medical Staff, the Chair of the Department, Division, or Committee, the member will have the ability to provide information pertaining to the issue if the member is in attendance at the meeting. Once this has been done, the member will be asked to leave the meeting in order to allow for candid discussion and to preserve the confidentiality of the peer review process. Should the Chair deem that the issue as one which would not warrant such exclusion from the meeting, the member may be allowed to remain.

**Section 7.2 Special Attendance Requirements or Conferences:**

Whenever a suspected deviation from standard clinical or professional practice or from acceptable conduct or behavior is identified, the Chair of the applicable Clinical Department or Committee may require the practitioner to attend a meeting, to confer with him/her or with a standing or ad hoc committee considering the matter. The practitioner will be given special notice of the meeting at least five (5) days prior to the conference, including the date, time and place, a statement of the issue involved, and a statement that the practitioner's appearance is mandatory. Failure of the practitioner to appear at any such meeting, unless excused by the Chief of Staff, upon showing good cause, will

result in an automatic suspension of all of the practitioner's clinical privileges. Minutes will be prepared for the meeting which may consist of a memo from the Chair of the meeting that includes the matters discussed at the meeting and the attendees. A suspension under this section will remain in effect until the special attendance requirement is satisfied or the matter is resolved by subsequent action of the Medical Executive Committee and Governing Board. Such resolution will be made in a timely manner.

Should a practitioner be invited to attend a peer review committee meeting to address an issue identified as part of the peer review process, they will be required to attend unless they are deemed to have good cause. They will be given a second chance to attend the following meeting. Notification of which will be via certified mail. If the practitioner fails to attend the meeting as required, notification will be made to the Medical Executive Committee who will notify the practitioner that they must attend the next meeting of the peer review committee or they will be automatically suspended, without hearing rights until such time as they attend a meeting as required. Should their suspension reach 90 consecutive days, the practitioner would be voluntarily resigned without hearing rights.

## **ARTICLE VIII. CORRECTIVE ACTION**

### **Section 8.1. Corrective Action**

Section 8.1.1 Any person or group may provide information to the hospital or medical staff about the conduct, performance, or competence of any individual practitioner who is a member and/or has clinical privileges. A request for an investigation or corrective action may be requested by any member of the Medical Staff, the Governing Board or the Chief Executive Officer when reliable information indicates a member or practitioner with privileges may have exhibited care, acts, demeanor, or conduct reasonably likely to be:

- 8.1.1.1 Detrimental to patient safety or to the delivery of quality patient care within the hospital;
- 8.1.1.2 Unethical;
- 8.1.1.3 Contrary to the Medical Staff Bylaws, Rules and Regulations, Standards or Policies and Procedures; or Hospital Bylaws, Rules, Regulations or Policies that have been approved by the Medical Executive Committee, or,
- 8.1.1.4 Below applicable Medical Staff professional standards, and/or;
- 8.1.1.5 Disruptive behavior, discrimination or harassment;

Requests for corrective action may be communicated orally or in writing, will be made to the Medical Executive Committee, and will be supported by reference to the specific activities or conduct which constitutes the grounds for the request. Based upon information reported to the Medical Executive Committee, or upon its own motion, the Medical Executive Committee may institute an investigation. The Medical Executive Committee may accept reported information as a request for an investigation and/or corrective action.

Section 8.1.2 If the Medical Executive Committee concludes an investigation is warranted, it will 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, Department Chair, Medical Staff Department, or standing or Ad Hoc Committee of the Medical Staff. The Medical Executive Committee may dispense with some or all of the investigation to the extent it already has been investigated by a Department Chair, Department or Committee. The Medical Executive Committee, at its discretion, may appoint practitioners who are not members of the medical staff as non-admitting members of the medical staff for the sole purpose of assisting with an investigation, serving on a standing or Ad Hoc committee, or acting as a resource to the medical staff.

- Section 8.1.3 The Officer, Department Chair, Department, or Committee designated to perform the investigation, will promptly investigate and make a report of its investigation to the Medical Executive Committee. Prior to making the report, the practitioner against whom corrective action has been requested will have an opportunity to respond to the investigator's concerns. The investigating person or Committee may require that the practitioner attend an interview and respond to questions. At such interview, s/he will be informed of the general nature of the charges against him/her and will be invited to discuss, explain, or refute them. This interview will not constitute a hearing, is preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to a hearing apply. A record of such interview will be made by the Officer, Department Chair, Department, or Committee performing the investigation and included with its report to the Medical Executive Committee. There is no right to have attorneys or other advisors present during an interview.
- Section 8.1.4 The Medical Executive Committee may at any time within its discretion take whatever action may be warranted by the circumstances including summary suspension or the termination or reassignment of responsibility for the investigative process.
- Section 8.1.5 As soon as practicable after conclusion of the investigation, the Medical Executive Committee will consider and take appropriate action on the recommendation of the investigating person(s). If the corrective action could involve a reduction of clinical privileges, or expulsion from the staff, and if there is not an urgency that may be the basis for a summary action, the affected practitioner will be permitted to make an appearance before the Medical Executive Committee prior to its acting on the recommendation. This appearance does not constitute a hearing, will be preliminary in nature, and none of the procedural rules provided in the bylaws with respect to hearings will apply. A record of such appearance will be made by the Medical Executive Committee. There is no right to have attorneys or other advisors present during this appearance.
- Section 8.1.6 Actions which the Medical Executive Committee may recommend may include, without limitation:
- 8.1.6.1 Determining no corrective action should be taken;
  - 8.1.6.2 Deferring action for a reasonable time not to exceed ninety (90) days where circumstances warrant;
  - 8.1.6.3 Issuing a letter of warning, admonition, reprimand, or censure, although nothing herein will be deemed to preclude Medical Staff, Departments or Department, or Committee Chairs, from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which is placed in the member's file;
  - 8.1.6.4 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-admissions, mandatory consultation;
  - 8.1.6.5 Recommending reduction, modification, suspension, or revocation of clinical privileges;
  - 8.1.6.6 Recommending reduction of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;
  - 8.1.6.7 Recommending revocation, probation or limitations on medical staff membership, or;
  - 8.1.6.8 Taking other actions deemed appropriate under the circumstances.

Section 8.1.7 The Chief of Staff will promptly notify the Chief Executive Officer, of all requests for corrective action received by the Medical Executive Committee and will continue to keep the Chief Executive Officer fully informed of all action taken in connection therewith. If the Medical Executive Committee recommends any corrective action which would entitle the practitioner to request a hearing pursuant to the Hearing and Appellate Review Procedure, the Chief of Staff or designee will give the practitioner written notice of its recommendation. Unless the Medical Executive Committee has decided to impose a Summary Suspension or Summary Restriction of the practitioner's privileges as provided and/or under Summary Suspension, the Medical Executive Committee's recommended action will not go into effect until the practitioner has either completed or waived any applicable hearing, review or appeal rights provided in the Hearing and Appellate Review Procedure. Any Medical Executive Committee action, that has become effective will remain in effect until it expires according to its own terms or is modified or terminated.

Section 8.1.8 If the Medical Executive Committee does not recommend any corrective action or if the corrective action does not entitle the practitioner to a hearing, the matter is concluded upon notice to the practitioner.

## **Section 8.2 SUMMARY SUSPENSION**

Section 8.2.1 Whenever the failure to immediately suspend or restrict a practitioner's clinical privileges may result in an imminent danger to the health, safety, or well-being of any individual, any or all of the practitioner's clinical privileges may be summarily suspended or summarily restricted effective immediately upon imposition by:

- (1) Either the Chief of Staff, or designee,
- (2) Chair of the Clinical Department in which the practitioner holds clinical privileges, or any one of their designees, or
- (3) The Chief Executive Officer or designee, following consultation with the Chief of Staff, or designee, or the Chair of the Clinical Department, or designee, in which the practitioner holds clinical privileges.

Section 8.2.2 The person summarily suspending or summarily restricting a practitioner will notify the Chief of Staff or designee and the Chief Executive Officer within twenty-four (24) hours of such summary action.

Such summary suspension or summary restriction will become effective immediately upon imposition and remain in effect for the period stated, and if no period is stated, then until modified or terminated following the process described in these Bylaws. The person or body responsible for imposing the Summary Suspension or Summary Limitation will immediately give oral notice of the suspension or restriction to the practitioner and will, within no more than five (5) days, give written notice of the summary suspension or summary restriction to the practitioner and the Medical Executive Committee. The notice to the practitioner will be deemed to have occurred on the earlier of the dates the practitioner was notified, orally or in writing. The oral notice or written confirmation should inform the practitioner of his/her right to request the Medical Executive Committee to review the suspension under Section 8.2.3 of this Article. The notice of the summary suspension or summary restriction given to the Medical Executive Committee constitutes a request for corrective action. Following such notice, the Medical Executive Committee will complete its corrective action investigation and make its corrective action recommendation and report to the Medical Executive Committee.

A practitioner whose clinical privileges have been summarily suspended or summarily restricted and who has requested an interview within seven (7) days

after s/he was notified of the suspension or summary restriction may be informally interviewed by the Medical Executive Committee within such reasonable time period thereafter as the Medical Executive Committee may be convened, not to exceed fourteen (14) days after the summary suspension was imposed and not to exceed twenty-nine (29) days after the summary restriction was imposed. This interview will be informal and does not constitute a hearing or review as provided in the Hearing and Appellate Review Procedure. The Medical Executive Committee may notify the practitioner that s/he is required to attend a Medical Executive Committee meeting and respond to questions.

Section 8.2.3 The Medical Executive Committee may recommend modification, continuance or termination of the terms of the summary suspension or summary restriction. If the Medical Executive Committee does not terminate the summary suspension after the suspension has been in effect in excess of fourteen (14) days or does not terminate the summary restriction of privileges after it has been in effect for thirty (30) days, the Medical Executive Committee will give the practitioner written notice of his/her right to request a hearing pursuant to the Hearing and Appellate Review Procedure. Unless the Medical Executive Committee terminates the summary action, the summary action will remain in effect until the hearing and appeal are completed. In that case, the Medical Executive Committee will also complete its corrective action investigation and give prompt notice of its recommendation in order to assure that the hearing to review the summary suspension or restriction is combined with any hearing or review to which the practitioner may be entitled because of the Medical Executive Committee's corrective action recommendation.

Section 8.2.4 Immediately upon the imposition of a Summary Suspension, the Chief of Staff or responsible Chair of the Department or designee will have the authority and responsibility to provide for alternative medical coverage for the patients of the suspended practitioner still in the hospital at the time of suspension. The wishes of the patients and their families will be considered in the selection of such alternative practitioner.

### **Section 8.3 AUTOMATIC SUSPENSION, RESIGNATION AND TERMINATION**

Section 8.3.1 Automatic suspension of membership and all privileges will be imposed if one or more of the following occurs:

8.3.1.1 Failure to provide proof that the practitioner maintains a current DEA certificate with a full schedule (with the exception of clinical psychologists, pathologists, and telemedicine and other non-admitting category physicians).

8.3.1.2 Failure to provide proof that the practitioner has malpractice insurance as required by the Bylaws, however, if the practitioner has the required amount of insurance but does not have coverage for all of his/her clinical privileges, only the privileges that are not fully covered will be automatically suspended. To be reinstated, the practitioner must provide proof of continuous coverage for privileges held at the Hospital.

8.3.1.3 Failure to pay medical staff dues in accordance with these Bylaws

8.3.1.4 Failure, without good cause, to appear and satisfy the special meeting attendance requirements set forth in these Bylaws, will result in automatic suspension of all or such portion of his/her clinical privileges as the Medical Executive Committee may direct.

8.3.1.5 Failure to maintain clinical coverage by a physician who holds the same clinical privileges. (revised 11/16/09)

8.3.1.6 Failure to complete medical records in a timely manner, as defined in the Rules and Regulations.

Section 8.3.2 Failure to correct the deficiency which was the basis for one or more of the foregoing automatic suspensions within ninety (90) consecutive days after the

date a suspension became effective will be deemed a voluntary resignation of the practitioner's medical staff membership and clinical privileges, as applicable. Practitioners whose clinical privileges are automatically suspended and/or have resigned their medical staff membership and/or clinical privileges pursuant to the above, will not be entitled to the procedural rights set forth in Article IX.

- Section 8.3.3 The following automatic actions will be imposed upon the following events, with none of the procedural rights set forth in ARTICLE IX.
- 8.3.3.1 Revocation or suspension of a practitioner's **California** license will result in automatic termination of the practitioner's Medical Staff membership and clinical privileges.
  - 8.3.3.2 Expiration of the member's license will result in the automatic suspension of the practitioner's privileges. If the license is not retroactively reinstated within 60 days after its expiration, the practitioner will be deemed to have voluntarily resigned.
  - 8.3.3.3 If the practitioner's professional license is placed on probation, is restricted or limited, then the same terms of probation, restrictions, or limitations will automatically be placed on the practitioner's privileges and the foregoing may be deemed a request for corrective action against such practitioner.
  - 8.3.3.4 If restrictions or terms of probation are placed on a practitioner's right to prescribe, such conditions, terms and restrictions will automatically be placed on the practitioner's right to prescribe and may be deemed a request for corrective action against such practitioner.
  - 8.3.3.5 Conviction, pleading guilty or no contest to a felony or conviction, pleading guilty or no contest to a healthcare related offense will result in automatic termination of the practitioner's Medical Staff membership and clinical privileges as determined by the Medical Executive Committee.
  - 8.3.3.6 Medical record automatic suspensions and deemed resignations for medical records deficiencies will be imposed in accordance with Medical Policies and Procedures.

#### **Section 8.4 Other Investigative and Disciplinary Actions**

Notwithstanding anything in these Bylaws to the contrary, if the Medical Executive Committee in its sole discretion deems it desirable, it may investigate any matter or any Medical Staff member brought to its attention by any source and may take any action it deems appropriate with respect thereto, including but not limited to the possible actions set forth in these Bylaws. Such investigation will not be deemed a hearing and may be substantially as described above in this Article. The Medical Executive Committee will act with reasonable promptness and give notice of any action thus taken or recommended within five (5) business days, to any affected practitioner and the Chief Executive Officer. Such practitioner has the right to request a hearing or Fair Review under the Hearing and Appellate Review Procedures section of these Bylaws, only if the action taken or recommendation falls into one or more of the categories set forth in in that section.

#### **Section 8.5 805.1 Reporting – Adverse Recommendations Prior to Hearing**

805.1 Reporting is part of the California Business and Professions Code and requires the filing of a report with the relevant licensing agency of certain recommended adverse actions before there is a hearing to review the proposed action. The licensing agency will be notified when certain adverse recommendations are made and notified again if the recommendations are upheld.

**8.5.1** Reports are only required if the recommendation is based on one or more of the following:

**8.5.1.1** Incompetence or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public.

**8.5.1.2** The use of, or prescribing for administering to him/herself, any controlled substance, or the use of any dangerous drug, as defined in the Business and Professions Code Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or

injurious to the licentiate, any other person, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.

**8.5.1.3** Repeated acts of clearly excessive prescribing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefore. However, in no event will a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain, consistent with lawful prescribing, be reported for excessive prescribing and prompt review of the applicability of these provisions will be made in any complaint that may implicate these provisions.

**8.5.1.4** Sexual misconduct with one or more patients during a course of treatment or an examination.

**8.5.2** Report must be filed within fifteen (15) days after the reportable recommendation is made. The licentiate must be notified of the right to submit explanatory or exculpatory statements electronically or otherwise.

## **ARTICLE IX. HEARING AND APPELLATE REVIEW PROCEDURE**

### **Section 9.1 HEARING REQUIREMENTS**

The hearing requirements set forth in this Fair Hearing Plan are applicable to physicians, oral surgeons, dentists, psychologists, and podiatrists applying to be members and/or for clinical privileges, or are members of the Medical Staff. Fair Hearing and Appellate Review Procedures for Allied Health Professionals are located in the Allied Health Professional's section of these Bylaws.

### **Section 9.2 INITIATION OF HEARING**

9.2.1 Recommendations or Actions: The following recommendations or actions will, if deemed adverse pursuant to Section 9.2.1 of this Plan, and if based upon Medical Disciplinary Cause or Reason entitle the practitioner affected thereby to a hearing:

9.2.1.1 Denial of initial staff appointment

9.2.1.2 Denial of reappointment

9.2.1.3 Summary suspension of staff membership for more than fourteen (14) days

9.2.1.4 Revocation of staff membership

9.2.1.5 Denial of requested clinical privileges

9.2.1.6 Reduction in clinical privileges for a cumulative total of thirty (30) days or more in any 12-month period

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

9.2.1.8 Revocation of clinical privileges

9.2.1.9 Restrictions imposed on clinical privileges (not including proctoring incidental to provisional staff status, the granting of new privileges and not including routine monitoring) for a cumulative total of thirty (30) days or more in any 12-month period.

9.2.2 When deemed Adverse: A recommendation or action listed in Section 9.2.1 of this Plan will be deemed adverse only when it has been:

9.2.2.1 Recommended by the Medical Executive Committee, or

**9.2.2.2** Taken by the Governing Board contrary to a favorable recommendation by the Medical Executive Committee, following the processes specified in these Bylaws.

The Governing Board will not make a recommendation or impose an action listed in Section 9.2 of this Plan without first submitting the matter to the Medical Staff for a Medical Staff action or recommendation and allowing the Medical Staff a reasonable time to address the matter. If the Governing Board would disagree with the Medical Staff recommendation or action the matter would be submitted to the Ad Hoc Dispute Resolution Committee before the practitioner is notified of the adverse action or

recommendation and offered his/her rights to a hearing or fair review under this Article IX.

- 9.2.3 Notice of Adverse Recommendation: A practitioner against whom an adverse recommendation or action, has been taken will promptly be given notice of such action in accordance with these Bylaws. Such notice will:
- 9.2.3.1 State that an adverse professional review action has been imposed or proposed.
  - 9.2.3.2 State what adverse action has been imposed and the proposed action.
  - 9.2.3.3 State if the action or proposed action must be reported to the Medical Board of California pursuant to Section 805 of the California Business and Professions Code and/or the National Practitioner Data Bank.
  - 9.2.3.4 Include a brief statement of the reasons for the action or recommended action.
  - 9.2.3.5 Advise the practitioner of his/her rights to request a hearing pursuant to the provisions of the Medical Staff Bylaws and the Fair Hearing Plan.
  - 9.2.3.6 Inform the practitioner that s/he has thirty (30) days following the date of receipt of notice within which to request a hearing.
  - 9.2.3.7 State that failure to request a hearing within a specified time period will constitute a waiver of rights to a hearing and to an appellate review on the matter.
  - 9.2.3.8 Inform the practitioner that s/he has the hearing rights described in these Bylaws.
- 9.2.4 Request for a Hearing: A practitioner will have thirty (30) days following his/her receipt of a notice pursuant to 9.2.3 of these Bylaws, to file a written request for a hearing. Such request must be delivered to the Chief Executive Officer either in person with receipted delivery, by receipted delivery service or by certified or registered U.S. mail, return receipt requested.
- 9.2.5 Waiver by Failure to Request a Hearing: A practitioner who fails to request a hearing within the time and in the manner specified in Section 9.2.4 waives any right to such a hearing and to any appellate review to which s/he might otherwise have been entitled. Such a waiver in connection with:
- 9.2.5.1 An adverse recommendation or action by the Governing Board will constitute acceptance of that action or recommendation which will thereupon become effective as the final decision by the Governing Board.
  - 9.2.5.2 An adverse recommendation or action by the Medical Executive Committee will constitute acceptance of that recommendation or action, which will thereupon become and remain effective pending the final decision of the Governing Board. The Governing Board will consider the Medical Executive Committee's recommendation or action at its next regular meeting following the waiver. In its deliberation, the Governing Board will review relevant information submitted by the Medical Executive Committee, may request additional information, and may consider other relevant information received from any source. The Governing Board will give great weight to the Medical Executive Committee's recommendation, and in no event will act in an arbitrary or capricious manner. If the Governing Board's action on the matter is not in accord with the Medical Executive Committee's recommendation, the matter will be submitted to a Joint Conference which consists of an equal number of medical staff members appointment by the Chief of Staff, and Governing Board members appointed by the Chair of the Governing Board. The Joint Conference will meet within thirty (30) days of submission of a matter to it. If the Joint Conference cannot recommend a decision acceptable to both the Medical Executive Committee and the Governing Board, a Dispute Resolution Committee as established in the Medical Staff Rules and Regulations for matters of Medical Staff self governance will be appointed and the processes then followed as set forth in the Rules. The Governing Board then may make a final decision. The Chief Executive Officer will promptly notify the practitioner of action taken pursuant to this section and notify the Chief of Staff and the Medical Executive Committee of each such action. If the Governing Board's final action is not in accord with the Medical Executive



Committee's action, the Medical Executive Committee then will have the right to seek an injunction, writ of mandate, or other appropriate order.

### **Section 9.3 HEARING PREREQUISITES**

9.3.1 Notice of Time and Place for Hearing: Upon receipt of a timely request for hearing, the Chief Executive Officer will deliver such request to the Chief of Staff, and if the Governing Board action prompted the request for the hearing, to the Governing Board. At least 30 days prior to the hearing, the Chief of Staff or his/her designee will send the practitioner notice of the time, place, and date of the hearing in accordance with these Bylaws. The hearing date will be not less than 30 days from the date the notice of the hearing is mailed to the practitioner, nor more than 60 days from the date of receipt of the request for a hearing.

9.3.2 Statement of Issues and Events: The notice of hearing required by these Bylaws must contain a concise statement of the practitioner's alleged acts or omissions, a list by number of the specific or representative patient records in question, if applicable, and/or the other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing.

Amendments to the statement of issues and events may be made at any time prior to the close of the hearing by the medical staff representative at the hearing. Such amendments may delete, modify, or add to the acts, omissions, charts or reasons specified in the original notice. Notice of amendments will be given to the affected practitioner and the Hearing Officer. In the event the amendment to the notice reasonably causes the practitioner to need additional time to prepare and respond, the Hearing Officer may grant a reasonable postponement of the hearing to enable the practitioner to prepare a response or defense to any such amendment that substantially adds to, or modifies the acts which are the basis for the hearing.

9.3.3 Appointment of Hearing Committee or Arbitrator: The hearing will be held before a trier of fact which will be a Hearing Committee composed of not less than 5 individuals. The Chief of Staff will appoint the Hearing Committee with the approval of the Officers of the Medical Staff if the Medical Executive Committee initiated the action and the Chief Executive Officer will appoint the Hearing Committee if the Governing Board initiated the action. The panel will be composed of individuals who will gain no direct financial benefit from the outcome, who have not acted as an accuser, investigator, fact finder, or initial decision maker in the same matter, and will include, where feasible, an individual practicing the same specialty as the practitioner.

9.3.4 Appointment of Hearing Officer: A Hearing Officer will be appointed to preside at the evidentiary hearing. The Hearing Officer will be appointed by the Chief Executive Officer if the Medical Executive Committee initiated the action and by the Chief of Staff if the Governing Board initiated the action. A Hearing Officer may or may not be an attorney at law, but must be experienced in conducting hearings. The Hearing Officer will act as the presiding officer of the hearing. The individual selected will gain no direct financial benefit from the outcome, will not act as a prosecuting officer or advocate, and will not be entitled to vote.

9.3.5 Questioning Panel Members: Both sides will have the right to question panel members and the Hearing Officer regarding their qualifications and/or impartiality. The Hearing Officer determines the manner in which questioning will be conducted to not unduly delay the process or harass the panel members.

9.3.6 Challenges: Both sides have the right to challenge the impartiality of any panel member or Hearing Officer. Such challenges will be ruled upon by the Hearing Officer whose decision will be final.

9.3.7 Inspecting documentary Information: Each party will have the right to inspect and copy, at its own expense, documentary information relevant to the charges which the other party has in its possession or control as soon as practicable after a receipt of a request therefore, but at least thirty (30) days prior to the hearing if reasonably possible. The right does not extend to confidential information referring solely to other practitioners

rather than to the practitioner under review. Any dispute regarding requests for access to information will be submitted, in writing, to the Hearing Officer, who will consider and rule upon the request and who may impose any safeguards deemed necessary in the interests and fairness or for the protection of the peer review process. When ruling on the request and determining the relevancy of the information being sought, the Hearing Officer will consider:

- 9.3.7.1 Whether the information may be introduced to support or defend the charges;
  - 9.3.7.2 The exculpatory or inculpatory nature of the information sought, if any;
  - 9.3.7.3 The burden imposed on the party in possession of the information, if access is granted, and
  - 9.3.7.4 Any previous request for access to information submitted or resisted by the parties to the same proceeding.
- 9.3.8 Documents and Witnesses to be produced at Hearing: At the request of either side, the parties will exchange lists of witnesses expected to testify and copies of all documents expected to be introduced at the hearing. This exchange will take place at least 10 days prior to commencement of the hearing. The witness list may be amended when additional witnesses are identified.
- 9.3.9 Continuances: A continuance may be granted based upon a showing of good cause which may include, but not be limited to:
- 9.3.9.1 The failure of either party, following approval of the request by the Hearing Officer, to provide access to requested information at least 30 days prior to the hearing.
  - 9.3.9.2 The failure of either party to provide a requested list of witnesses or copies of all documents expected to be introduced at the hearing at least 10 days prior to the hearing.
  - 9.3.9.3 The mutual agreement of the parties.
- 9.3.10 Prehearing Procedure: It will be the duty of the practitioner and the body whose decision prompted the hearing to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural irregularity or any objection to the Hearing Panel or to the Hearing Officer, as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be expeditiously made. Objection to any such pre-hearing decisions will be raised at the Judicial Hearing, and when so raised will be preserved for consideration at any Appellate Review Hearing which thereafter might be requested.

## **Section 9.4 HEARING PROCEDURE**

- 9.4.1 Personal Presence: The personal presence of the practitioner who requested the hearing will be required. Personal presence in and of itself does not fulfill the criteria for proceeding. If a hearing panel has been appointed, the hearing panel will confer with the hearing officer and decide if the practitioner failed without good cause to appear and proceed and should be deemed to have waived his/her rights to a hearing and accepted the adverse recommendation. If the hearing panel has not been appointed, (i) the hearing officer will question the appointed hearing panel members to confirm that each member is qualified to serve, which is defined as will not gain a direct financial benefit from the outcome and has not acted as an accuser, investigator, fact finder or initial decision-maker in the same matter, and (ii) the members who the hearing officer determines are qualified to serve will confer with the hearing officer and decide if the practitioner failed without good cause to appear and proceed and should be deemed to have waived is/her rights to a hearing and accepted the adverse recommendation.
- 9.4.2 Presiding Officer: The Hearing Officer will act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/she will be entitled to determine the order of procedure during the hearing and make all rulings on matters of procedure and the admissibility of evidence.

- 9.4.3 Representation: The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on conduct or professional competency. Accordingly, neither the petitioner, the Medical Executive Committee nor the Governing Board will be represented by legal counsel before the Hearing Committee. The practitioner who requested the hearing is entitled to be accompanied and represented at the hearing by a licensed practitioner who is not an attorney-at-law and who preferably is a member of the Hospital's Medical Staff. The Medical Executive Committee or the Governing Board, depending on whose recommendation or action prompted the hearing, will appoint individual(s) to present the facts in support of the adverse recommendation or action, and to examine witnesses. A representative may also be a witness. The foregoing will not be deemed to deprive the practitioner, the Medical Executive Committee, or the Governing Board of the right to legal counsel in connection with preparation for a hearing or appellate review.
- 9.4.4 Rights of Parties: During the hearing, each of these parties will have the right to:
- 9.4.4.1 Be provided with all information made available to the Hearing Panel.
  - 9.4.4.2 Call, examine, and cross-examine witnesses.
  - 9.4.4.3 Present and rebut any evidence determined by the Hearing Officer to be relevant.
  - 9.4.4.4 Submit a written statement at the close of the hearing.

If the practitioner who requested the hearing does not testify in his/her own behalf, s/he may be called and examined by the Medical Staff's representative an/or the Hearing Committee as if under cross-examination. The Hearing Committee may interrogate the witnesses.

- 9.4.5 Procedure and Evidence: The hearing need not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs will be admitted, regardless of the admissibility of such evidence in a court of law. Each party, prior to or during the hearing, will be entitled to submit motions concerning any issue of law or fact. The moving party will provide a copy of the motion to the other party who will have five (5) working days to submit a written response to the Hearing Officer and the moving party. Such motions and response will become part of the hearing record. The Hearing Officer may set guidelines for the introduction of evidenced and testimony, and set time limits for each party's presentations and cross-examination, in order to conduct and conclude the hearing in a reasonable period of time, given the circumstances. The body whose decision prompted the hearing may object to the introduction of evidence that was not provided by the practitioner during an appointment, reappointment or privilege application or corrective action despite requests for such action. The information will be barred from the hearing by the Hearing Officer unless the practitioner can prove s/he previously acted diligently and could not have submitted the information.

Latitude may be exercised in accommodating the schedule of witnesses, Hearing Committee members, parties and representatives and allowing modification of required notices, allowing recesses or extensions of time upon a reasonable showing of need, and allowing changes in the order of the proceedings and the presentation of evidence. The decision of the Hearing Officer regarding such matters will be final, subject to later reconsideration for good cause only.

- 9.4.6 Official Notice: In reaching a decision, the Hearing Committee may take official notice, either before or after submitting the matter for the decision, of any generally accepted matter, including but not limited to technical or scientific matter relating to the issues under consideration. Parties present at the hearing will be informed of the matter to be noticed and be given the opportunity to refute the official noticed matter by evidence or by written or oral presentation of authority; the matter of such refutation to be determined by the Hearing Committee. The Committee will also be entitled to consider all other information that can be considered, pursuant to the Medical Staff Bylaws, in connection with applications for appointment or reappointment to the Medical Staff and for clinical privileges.

9.4.7 Burden of Proof

9.4.7.1 Duty of Producing Evidence: The Medical Executive Committee or Governing Board if the hearing is to review a Governing Board action or recommendation has the initial duty to present evidence which supports the charge or recommended action.

9.4.7.1.2 Initial Applicants: When a hearing relates to initial request for appointment or for initial or additional privileges, the practitioner who requests the hearing will have the burden of proving his/her qualifications, by a preponderance of the evidence, by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning his/her current qualifications for staff privileges or membership.

9.4.7.1.3 Current Staff Members: In all other cases, the Medical Executive Committee or Governing Board will bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that the action or recommendation is reasonable and warranted.

9.4.8 Record of Hearing

A court reporter will be used to make a record of the hearing. Each party is entitled to obtain a copy of the record thereof upon the payment of a reasonable cost of preparation fee.

9.4.9 Postponement

Requests for postponement of a hearing after it already has commenced will be granted by the Hearing Officer only upon showing of good cause and only if the request therefore is made as soon as it is reasonable practical. Requests for a continuance, prior to commencement of the hearing, are governed by Section 9.3.

9.4.10 Presence of Hearing Committee Members and Vote

A majority of the Hearing Committee must be present throughout the hearing and deliberations. If a committee member is absent from any part of an extended proceeding because of an unusual circumstance, the Hearing Officer may permit the member to participate in the deliberations or the decision if the committee member has read the entire transcript of the portion of the hearing from which he or she was absent or viewed a video of the portion he or she was absent. The final decision of the Hearing Committee must be approved by a majority of the members who participated in the deliberations and decision.

9.4.11 Recesses and Adjournment

The Hearing Committee may recess the hearing and reconvene without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of the presentation of oral and written evidence, the hearing will be closed. The Hearing Committee will thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of its deliberations, the hearing will be declared finally adjourned. If requested by the Hearing Committee, the Hearing Officer may be present during the deliberations, may be a legal advisor to the Hearing Committee, and may assist in the drafting of the Committee's written report and recommendation required pursuant to these Bylaws and applicable law. However, the Hearing Officer will not be entitled to vote.

9.4.12 Exclusion

No person may disrupt any hearing. Any person in attendance who disrupts a hearing after being warned by the Hearing Officer to cease such disruption on penalty of exclusion, will, at the discretion of the Hearing Officer, leave the hearing. If such excluded person is a witness, s/he will have the right to submit to the Hearing Committee, not later than ten (10) days after such exclusion, a written affidavit of his/her testimony or other evidence, with copies thereof to the other party.

9.4.13 Attendance

Except as otherwise provided in these Bylaws and subject to reasonable restriction by the Hearing Officer, the following individuals are permitted to attend the entire hearing: the Hearing Committee, the Hearing Officer, the court reporter, the practitioner, a representative of the body which initiated the adverse recommendation or action, one key consultant for each party, the Chief Executive Officer or his/her designee, and the Medical Staff Director or Assistant.

**Section 9.5 HEARING COMMITTEE REPORT AND FURTHER ACTION**

9.5.1 Hearing Committee Report

As soon as reasonably possible after final adjournment of the hearing, the Hearing Committee will make a written report of its findings and recommendation in the matter. The written report will include the Committee's findings of facts and conclusions articulating the connection between the evidence produced at the hearing and the decision reached. The Hearing Officer will assist the Hearing Committee with the drafting of the written report. The report will be forwarded, together with the hearing record and all other documentation considered by it, to the Chief Executive Officer.

9.5.2 Notice: The Chief Executive Officer will promptly send a copy of the Hearing Committee's written report to the practitioner, to the Chief of Staff, to the Medical Executive Committee and to the Governing Board.

**Section 9.6 INITIATION AND PREREQUISITES OF APPELLATE REVIEW**

9.6.1 Request for Appellate Review

The practitioner, or the Medical Executive Committee or the Governing Board, depending on which body initiated the adverse recommendation or decision, will have thirty (30) days following its receipt of the Hearing Committee written report sent pursuant to Section 9.5.2 to file a written request for an appellate review. The written request for an appeal will include identification of the grounds for appeal and a clear and concise statement of facts in support of the appeal. The grounds for appeal from the hearing may be:

- 9.6.1.1 Substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice; and/or
- 9.6.1.2 The decision was not supported by the evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 9.7.4.

Such request will be delivered to the Chief Executive Officer either in person by receipted delivery or by certified or registered US mail return receipt requested.

9.6.2 Waiver by Failure to Request Appellate Review

A party which fails to request an appellate review within the time and in the manner specified in Section 9.6.1 above waives any right to such review and accepts the Hearing Committee's report. If an appeal is not requested by either party, the Governing Board will affirm the Hearing Committee's report.

9.6.3 Notice of Time and Place for Appellate Review

Upon receipt of a timely request for Appellate Review, the Chief Executive Office will deliver such request to the Governing Board. As soon as practicable, the Chair of the Governing Board will schedule and arrange for an Appellate Review which will be not less than 60 days, no more than 90 days from the date of receipt of the appellate review request. At least thirty (30) days prior to the appellate review, the Chief Executive Officer will send each of the parties special notice of the time, place and date of the review. The notice will advise each party of its right to appear and respond at the appellate review and of its right to be represented by an attorney or any other representative of its choice. The time for appellate review may be extended by the appellate review body for good cause, and if the request, is made as soon as it is reasonably practical.

9.6.4 Appellate Review Body

The Chair of the Governing Board will determine whether the Appellate Review will be conducted by the Governing Board as a whole or by an Appellate Review Board of 3 or more members of the Governing Board, appointed by the Chair of the Governing Board. These individuals should be representative of a member of the Medical Staff, a lay member of the Governing Board and one other independent member. If three (3) members are not qualified to serve, less than three Governing Board members may act as the Appellate Board or the Governing Board may appoint individuals to serve on the Appellate Review Board who are not members of the Governing Board. Knowledge of the matter involved will not preclude any member from serving as a member of the appeal board so long as that person did not participate in the matter at a previous level (e.g., as an accuser, investigator, fact-finder or initial decision maker). For purposes of this section, participating in an initial decision to recommend an investigation will not be deemed to constitute participation in a prior hearing on the same matter. The appeal board may select an attorney to advise the Governing Board regarding its duties and to assist the Governing Board in drafting its final decision. If a Committee is appointed, one of its members will be designated as Chair. If the action was taken by the Governing Board the members of the Governing Board will not act as the Appellate Review Body.

## **Section 9.7 APPELLATE REVIEW PROCEDURE**

### **9.7.1 Nature of Proceedings:**

The proceedings by the review body will be in the nature of an appellate review based upon the record of the hearing before the Hearing Committee and that Committee's report. The Governing Board will give great weight to the decision of the Hearing Committee, and will not act in an arbitrary or capricious manner. The Governing Board, however, will exercise its independent judgment in determining whether a fair hearing was afforded, whether the decision was reasonable based upon the evidence considered by the Hearing Committee or such additional evidence as may be permitted pursuant to Section 9.7.4. Each party will have the right to submit a written brief in support of its position. The party requesting the appeal will deliver a copy of its statement to the other party and the Governing Board at least twenty (20) days before the Appellate Review. A written statement in reply may be submitted, and if submitted, a copy thereof will be provided to the other party at least five (5) days prior to the scheduled date of the appellate review.

### **9.7.2 Presiding Officer**

The Chair of the Appellate Review Board will be Presiding Officer, unless the Chair of the Governing Board has appointed a Hearing Officer. The Presiding Officer will determine the order of procedure during the review, make all required rulings, and maintain decorum. If a Hearing Officer is appointed, the Hearing Officer may act as an advisor, participate in the deliberations, and assist in the preparation of the decision, but can not vote.

### **9.7.3 Oral Statement**

Any party or representative appearing before the Appellate Review Board to present an oral statement will be required to answer questions put to him/her by any member of the Appellate Review Board.

### **9.7.4 Consideration of New or Additional Matters**

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record may be introduced at the appellate review only at the discretion of the Appellate Review Board, and only following a determination by the Appellate Review Board that the party requesting consideration of such new or additional matter or evidence can demonstrate it previously acted diligently but could not have submitted such matter or evidence at the evidentiary hearing. A request to submit additional evidence will be submitted to the Chair of the Appellate Review not less than fourteen (14) days prior to the Appellate Review. A written reapply may be submitted, and if submitted, it will be not less than two (2) days before the hearing. The Presiding Officer will give notice of his/her decision on such matter to all parties as soon as reasonably possible.

- 9.7.5 Powers:  
The Appellate Review Board will have all the powers granted to the Hearing Committee, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.
- 9.7.6 Presence of Members and Vote:  
A majority of the Appellate Review Board must be present throughout the review and deliberations. If a member of the Review Board is absent from any part of the proceedings, s/he will not be permitted to participate in the deliberations of the decision.
- 9.7.7 Recesses and Adjournment  
The Appellate Review Board may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or to obtain new or additional evidence or a consultation. Upon the conclusion of oral statements, the appellate review will be closed. The Appellate Review Board will thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusions of those deliberations, the appellate review will be declared finally adjourned.
- 9.7.8 Action Taken  
The Appellate Review Board may recommend that the Governing Board affirm, modify or reverse the recommendation of the Hearing committee or, at its discretion, may refer the matter back to the Hearing Committee for further review and recommendation to be returned to it within 60 days and in accordance with its instruction. Within 30 days after receipt of such recommendations after referral, the Appellate Review Board will make its recommendation to the Governing Board.
- Conclusion  
The Appellate Review will not be deemed to be concluded until all of the procedural steps provided herein have been completed or waived.

**Section 9.8 FINAL DECISION OF THE GOVERNING BOARD**

Absent unusual circumstances, within thirty (30) days after the conclusion of the deliberations, the Governing Board will render its final decision in the matter in writing, will include a statement of the Governing Board's basis for its decision, and will include the text of the report which will be made to the National Practitioner Data Bank, if any, and send notice thereof to the practitioner, to the Chief of Staff, and to the Medical Executive Committee. The Governing Board's action on the matter will be effective and final.

**Section 9.9 NATIONAL PRACTITIONER DATA BANK REPORTING**

- 9.9.1 Adverse Actions  
The authorized representative will report an adverse action to the National Practitioner Data Bank in accordance with the Rules and Regulations. The authorized representative will report any and all revisions of an adverse action including, but not limited to, any expiration of the final action consistent with the terms of that final action.
- 9.9.2 Dispute Process  
A member who was the subject of an adverse action report or the Chief of Staff may request an informal meeting to dispute the report filed. The report dispute meeting does not constitute a hearing and will be limited to the issue of whether the report filed is consistent with the final action issued. The meeting will be attended by the subject of the report, the Chief of Staff, the Chair of the subject's department, and the Chief Executive Officer, or their respective designees.

**Section 9.10 GENERAL PRIVISIONS**

- 9.10.1 Number of Hearings and Reviews  
Notwithstanding any other provision of the Medical Staff Bylaws or this Plan, no practitioner will be entitled to more than one evidentiary hearing **or fair review** and appellate review with respect to an adverse recommendation or action.
- 9.10.2 Releases

By requesting a hearing or appellate review under this Fair Hearing Plan, a practitioner agrees to be bound by the provisions regarding immunity from liability in all matters relating thereto.

9.10.3 Waiver

If at any time after receipt of notice of an adverse recommendation, action or result, a practitioner fails to make a required request or appearance or fails to comply with the procedures in this Article ~~IX~~, or fails to timely proceed with the matter, s/he will be deemed to have consented to such adverse recommendation, action, or result and to have voluntarily waived all rights which s/he might otherwise have been entitled to under the Medical Staff Bylaws then in effect or under this Article ~~IX~~ with respect to the matter involved.

9.10.4 Notice

Any and all notices required hereunder will be delivered personally to the addressee with receipted delivery, sent by receipted delivery, or by prepaid registered or US certified mail, return receipt requested. The notice will be deemed received upon its actual delivery if personally delivered or delivered by receipted delivery. Notices that are refused by the practitioner or office personnel will be deemed received when delivered, and mail will be deemed received at the time it is delivered if the practitioner or office personnel refuse to accept and/or sign for the delivery.

9.10.5 Substantial Compliance

Technical non-prejudicial or insubstantial deviations from the procedures set forth in these Bylaws will not be grounds for invalidating the actions taken.

9.10.6 Exhaustion of Remedies

If an adverse action is recommended or imposed that is grounds for a hearing or grounds for a fair review as described in this Article, the practitioner agrees to exhaust the remedies afforded by these Bylaws before resorting to legal action.

9.10.7 Challenges to Rules

The Hearing Committees have no authority to adopt or modify Bylaws, Rules or Policies and/or to decide questions about the merits or substantive validity of Bylaws, Rules or Policies. If the only issue in a case is whether a Bylaw, Rule, or Policy is lawful or meritorious, the practitioner is not entitled to a hearing or review under this Article. In such cases, the practitioner must submit his challenges first to the Medical Executive Committee, then notify the Governing Board of the dispute if it is not resolved by the Medical Executive Committee. Only thereafter may he or she seek judicial intervention.

**Section 9.11 EXCEPTIONS TO HEARING RIGHTS**

9.11.1 Termination of Temporary Privileges

No practitioner is entitled to the hearing, review or appeal rights provided in these Bylaws by virtue of the expiration, non-renewal or termination of temporary clinical privileges, unless such action is expressly stated to be for a medical disciplinary cause.

9.11.2 Closed Staff or Exclusive Use Departments, Hospital Contract Physicians

9.11.2.1 Closed Staff or Exclusive Use Departments: The procedures in this Article do not apply to a practitioner whose application for medical staff membership and clinical privileges was denied or whose privileges were terminated or limited because the privileges s/he seeks or held are subject to a closed staff or exclusive use policy.

9.11.2.2 Practitioners who serve as hospital contract physicians are not entitled to procedures in this Article to review the termination or expiration of their contracts. Termination of such contracts will not affect such practitioners' medical staff membership or privileges, although the right of access to hospital equipment, resources, and personnel reasonably necessary to exercise those privileges may be restricted or denied if and when the Hospital enters into an agreement which grants another practitioner or medical group the exclusive right to provide some or all of the services which encompass the practitioners' clinical privileges. Notwithstanding the foregoing, the hearing rights of this Article will apply to the extent that an action is taken which must be reported under Business and Professions Code Section 805 and to the extent that medical staff membership status or clinical privileges which are



independent of the practitioner's contract and not subject to an exclusive contract are removed or suspended.

9.11.3 Allied Health Professionals

Allied Health Professionals are not entitled to the rights set forth in this Article.

9.11.4 Denial of Applications for failure to meet Minimum Qualifications

A practitioner is not entitled to a hearing or appellate review if his or her membership application or privileges request is not processed or is denied because of his or her failure to timely submit documents or information required by the Medical Staff during the course of the credentialing process or failure to meet the criteria to apply for membership and privileges.

9.11.5 Automatic Suspensions and Resignations

Subject to the terms of Article VIII, Section 8.3; Practitioners whose clinical privileges or membership are subject to an automatic action for any of the reasons specified in Article VIII, 8.3 are not entitled to any hearing or appellate review rights.

9.11.6 Hospital Policy Decision

The hearing and appeal rights of these Bylaws are not applicable if the hospital makes a policy decision (e.g. physical plant changes, closing a department) that adversely affects the staff membership or clinical privileges of any member or applicant.

9.11.7 Failure to Meet Minimum Activity Requirements

Practitioners are not entitled to the hearing and appellate review rights if their membership or privileges are denied, restricted, or terminated, or if their medical staff categories are changed or not changed because of a failure to meet the minimum activity requirements set forth in the Medical Staff Bylaws or Rules. In such cases, the only review will be provided by the Medical Executive Committee through a subcommittee consisting of at least three Medical Executive Committee members who are appointed by the Chief of Staff. The Medical Executive Committee will give the practitioner notice of the reasons for the intended denial or change in membership, privileges, and/or category. If the practitioner disputes the reasons which are the basis for the intended denial or change in membership, privileges and/or category, the practitioner must notify the Medical Executive Committee, in writing, of the dispute and the information, documents or other evidence upon which the practitioner bases the dispute, within thirty (30) days after the practitioner's receipt of the foregoing notice from the Medical Executive Committee. If the practitioner requests an interview, the subcommittee will schedule an interview with the practitioner to occur no less than thirty (30) days and no more than one hundred (100) days after the practitioner requested the interview and provided the information, documents or other evidence upon which the practitioner bases the dispute. At this interview, the practitioner may discuss the evidence submitted in support of why the action should not be taken. The subcommittee will render a written decision within forty-five (45) days after the interview. A copy of the decision will be sent to the practitioner, the Medical Executive Committee, and the Governing Board. The subcommittee's decision will be final unless it is reversed or modified by the Medical Executive Committee within forty-five (45) days after the decision was rendered or by the Governing board within ninety (90) days after the decision was rendered; provided, however, if the Governing Board's action on the matter is not in accord with the Medical Executive Committee's recommendation, the matter will be submitted to a Joint Conference which consists of an equal number of medical staff members appointed by the Chief of Staff and Governing Board members appointed by the Chair of the Governing Board. The Joint Conference will meet within thirty (30) days of submission of a matter to it. If the Joint Conference cannot recommend a decision acceptable to both the Medical Executive Committee and the Governing Board, an Ad Hoc Dispute Resolution Committee, as established in the Medical Staff Rules for matters of Medical Staff governance will be appointed and the processes then followed as set forth in the Rules. The Governing Board then may make a final decision. The Chief Executive Officer will promptly notify the practitioner of action taken pursuant to this Section and will notify the Chief of Staff and the Medical Executive Committee of each such action. If the Governing Board's final action is not in accord with the Medical Executive Committee's

action, the Medical Executive Committee will have the right to seek an injunction, writ of mandate or other appropriate order.

**Section 9.12 FAIR REVIEW OF CERTAIN ADVERSE RECOMMENDATIONS OR ACTION**

9.12.1 Types of Actions subject to a Fair Review Process

Subject to Section 9.11 that limits the rights to hearings and air reviews, a Fair Review, as described in Section 9.12.2 will be offered to the affected practitioner If any of the following recommendations or actions is made by the Medical Executive Committee or Governing Board in accordance with Article IX:

12.1.1 Any of the actions or recommendations in Section 9.2.1 but not for Medical Disciplinary Cause or Reason (MDCR).

12.1.2 A summary suspension of membership or clinical privileges for MDCR that is in effect for fourteen (14) days or less.

12.1.3 A reduction of clinical privileges or restriction imposed on clinical privileges for MDCR that is in effect for twenty-nine (29) days or less in a twelve month period, provided, however, that the foregoing will not be grounds for a Fair Review if it was either:

12.1.3.1 An automatic action as described in Article VIII, Section 8.3

12.1.3.2 An action as described in Article IX, Section 9.11 or,

12.1.3.3 An action that these Bylaws state is not grounds for a hearing or appeal.

9.12.2 Fair Review Process

The conduct of a fair review will be the same as for hearings except that:

9.12.2.1 There is no right to discovery,

9.12.2.2 The hearing will be before an arbitrator to be designated by the Chief Executive Officer with pre-procedural rights of voir dire to confirm the proposed arbitrator is qualified and not biased,

9.12.2.3 The parties must exchange documents and witness lists at least five (5) working days prior to the hearing, and testimony of witnesses and copies of evidence not timely exchanged may be barred,

9.12.2.4 The body whose decision prompted the hearing has the initial burden of producing evidence to support its action or recommendation, with the burden then shifting to the affected practitioner to produce evidence and demonstrate that the decision was unreasonable.

9.12.2.5 Neither party has the right to be represented by an attorney at the fair review, and

9.12.2.6 Neither party has the right to personal attendance, oral argument or representation by an attorney at the Governing Board appeal.

9.13 Informal Interviews

Nothing in these Bylaws will be deemed to prevent any committee, or person contemplating any action or recommendation that is grounds for a hearing or for a Fair Review from, at its sole discretion, inviting the affected practitioner to participate in an informal discussion of the contemplated action or recommendation. Such discussion will not be deemed to constitute a hearing under this Article.

**ARTICLE X. OFFICERS**

**Section 10.1 OFFICERS OF THE MEDICAL STAFF**

The Officers of the Medical Staff will be:

- Chief of Staff
- Vice Chief of Staff
- Secretary/Treasurer
- Immediate Past Chief of Staff (no election)

## **Section 10.2 QUALIFICATIONS OF OFFICERS**

Officers of the Medical Staff include the Chief of Staff, Vice Chief of Staff, Secretary/Treasurer, and Past Chief of Staff. They must be members of the Active Medical Staff at the time of nomination and election and must remain members in good standing during their term of office. Officers must be board certified in their specialty or remain qualified to take their boards. Officers must be approved by the MEC and Active Medical Staff prior to taking office. Officers may not simultaneously be an officer of the Medical Staff, Chief of Service or member of the Governing Board at another hospital. Failure to maintain such status will immediately create a vacancy in the office involved.

## **Section 10.3 ELECTION OF OFFICERS**

Only members of the active Medical Staff are eligible to vote or be nominated or elected.

- 10.3.1 Officers whose terms expire during the current Medical Staff year will be elected through mail balloting.
- 10.3.2 The membership of the Nominating Committee is delineated in the Medical Staff Rules and Regulations and Policies and Procedures. The Committee will offer one or more nominations for each office. The Nominating committee will report their recommendations to the Medical Executive Committee for ratification. Nominees will then be contacted to ensure that they are willing to serve. Notice of nominees will be mailed to the active Medical Staff via certified mail.
- 10.3.3 Additional nominations may also be made in writing, signed by at least thirty-five (35) members of the active Medical Staff and delivered to the Chief of Staff at the Medical Staff Office. The Medical Staff will be notified of such additional nominations by virtue of their inclusion of such individuals on the ballot. The ballot will be sent to the Active Staff and may be sent via mail or email based upon the recommendation of the Medical Executive Committee.
- 10.3.4 A candidate must receive a majority vote of those ballots returned. Where three or more candidates are nominated and no candidate received a majority vote, the top two candidates will participate in a run-off election. The candidate receiving a majority of the ballots returned will be deemed to have been elected. In case of a tie vote for any position, the majority vote of the Medical Executive Committee will decide the election, by secret ballot, at a special meeting called for that purpose or at the next meeting of the Medical Executive Committee, whichever can be scheduled first.

## **Section 10.4 TERM OF OFFICE**

All Officers of the Medical Executive Committee will serve a **two**-year term which cannot be consecutively repeated. Officers will take office on the first day of the staff year which begins July 1<sup>st</sup>.

## **Section 10.5 VACANCIES IN OFFICE**

- ~~10.5.1~~ Vacancies in office during the Medical Staff year, will be referred to the Nominating Committee in order to seek nominations for the open position with the balloting process, as described in these bylaws, to then be followed.
- 10.5.2 Any Officer of the Medical Staff may be removed from office for valid cause, including, but not limited to, gross neglect or malfeasance of office, or serious acts of moral turpitude. Removal of a Medical Staff Officer may be initiated by the Medical Executive Committee or may be initiated by a petition signed by at least one-third (1/3) of the members of the active Medical Staff. Removal will require a two-thirds (2/3) vote of the active Medical Staff at a special meeting called for that purpose or by mail ballot. A ballot will be sent to each active Medical Staff member at least twenty-one (21) days prior to the date of the special meeting date.
- 10.5.3 Any suspension or revocation of professional license by the Medical Board of California will result in immediate removal of any Officer.

## **Section 10.6 DUTIES OF OFFICERS**

### **10.6.1 CHIEF OF STAFF**

The Chief of Staff will serve as the Chief Officer of the Medical Staff. The duties required of the Chief of Staff will include, but not be limited to:

- 10.6.1.1 Enforcing the Medical Staff Bylaws and Rules and Regulations, implementing sanctions where indicating, and promoting compliance with procedural safeguards where correction action has been requested or initiated.
- 10.6.1.2 Serving as Chair of the Medical Executive Committee and calling, presiding at, and being responsible for the agenda of all meetings thereof.
- 10.6.1.3 Serving as an Ex-Officio member of all other staff committees, without vote, unless the Chief of Staff membership in a particular committee is required in these Bylaws (e.g. clinical department which he/she holds privileges)
- 10.6.1.4 Interacting with administration in all matters of mutual concern within the hospital;
- 10.6.1.5 Appoint Committee chairpersons to all standing, special, and multi-disciplinary Medical Staff committees except the Medical Executive Committee, Nominating Committee, Credentials Committee, Interdisciplinary Practice Committee, Cancer Committee, IRB Committee, etc, The Committee Chair will select and appoint the committee members.
- 10.6.1.6 Represent the views, policies, needs, and grievances for the Medical Staff to the Governing Board and to the Chief Executive;
- 10.6.1.7 Receive and interpret policies of the Governing Board to the Medical Staff and report to the Governing Board on the performance and maintenance of quality with respect to the medical staff's delegated responsibility to provide medical care;
- 10.6.1.8 Be responsible for the oversight of the educational activities of the Medical Staff, participate in educational opportunities, and;
- 10.6.1.9 Be the spokesperson for the Medical Staff in its external professional and public relations.
- 10.6.1.10 The Chief of Staff will not serve as the Chair of any Medical Staff Committee other than the Medical Executive Committee unless specifically approved by the Medical Executive Committee under special circumstances.

#### **10.6.2 VICE CHIEF OF STAFF**

In the absence of the Chief of Staff, s/he will assume all of the duties and have the authority of the Chief of Staff. S/he will be a voting member of the Medical Executive Committee. S/he will automatically succeed the Chief of Staff when the latter fails to serve for any reason. S/he will serve as the Chairperson for the Pharmacy & Therapeutics Committee. The Vice Chief of Staff will also participate in educational opportunities in order to support the Medical Staff.

#### **10.6.3 IMMEDIATE PAST CHIEF OF STAFF**

The duties of the Immediate Past Chief of Staff are principally advisory in nature. S/he will serve as the Chairperson for the Nominating Committee, Bylaws Committee, Credentials Committee, Interdisciplinary Practice Committee, and Multi-Disciplinary Peer Review Committee. S/he will be a voting member of the Medical Executive Committee. The Immediate Past Chief of Staff will also participate in educational opportunities in order to continue his/her support of the Medical Staff.

#### **10.6.4 SECRETARY/TREASURER**

S/he will be a voting member of the Medical Executive Committee. The treasurer will keep an accurate accounting of the Medical Staff funds and be responsible for reporting to the Medical Executive Committee on the status of the funds. S/he will also be responsible for developing the Medical Staff budget for approval by the Medical Executive Committee and submission to the active Medical Staff for informational purposes. S/he will serve as the Chairperson for the Performance Improvement Committee. The Secretary/Treasurer will also participate in educational opportunities in order to support the medical staff.

## ARTICLE XI. DEPARTMENTS/DIVISIONS

### Section 11.1 ORGANIZATION OF DEPARTMENT

The medical staff is organized into departments with divisions. Each department will have a Chairperson with overall responsibility for supervision and satisfactory discharge of assigned functions.

### Section 11.2 DEPARTMENTS

Medical Staff Departments are defined as:

- 11.2.1 Department of Medicine (including, but not limited to, Emergency Medicine, Hospitalists, Radiology, Family Practice and all other medical sub-specialties)
- 11.2.2 Department of OB/GYN (including all sub-specialties of Obstetrics and Gynecology, other than GYN Oncology)
- 11.2.3 Department of Pediatrics (including, but not limited to, Neonatology, Pediatric Intensive Care, Pediatric Hospitalists, and all pediatric sub-specialties)
- 11.2.4 Department of Surgery (including, but not limited to, Anesthesiology, Pathology, GYN Oncology **effective** 9/19/11, and all surgical sub-specialties).

### Section 11.3 QUALIFICATIONS, SELECTION, AND TENURE OF DEPARTMENT CHIEFS

#### 11.3.1 QUALIFICATIONS

Each Department or Division Chief must be a member of the Active Medical Staff, **and** be board certified by an appropriate specialty board. ~~and must not be receiving compensation from Providence, i.e., Medical Directors or physicians receiving administrative duty compensation will be excluded. Emergency Call Panel coverage compensation is excluded from this restriction.~~ **Department and Division Chiefs must be approved by the Medical Executive Committee.**

11.3.2 S/he must meet the qualifications and perform the functions specified for the position.

#### 11.3.3 VICE CHIEF

11.3.3.1 After the Department Chief is elected, s/he will select a Vice-Chief of the Department. The Vice Chief must be approved by the Medical Executive Committee. ~~and may not be an individual who receives compensation from Providence, i.e., Medical Directors or physicians receiving administrative duty compensation will be excluded. Emergency Call Panel Coverage compensation is excluded from this restriction.~~ During any absence of the Department Chief, the Vice Chief will represent the Department at the Medical Executive Committee meeting and be eligible to vote on behalf of the department they represent.

11.3.3.2 The Vice Chief will chair the Departmental Peer and Chart Review Committee.

#### 11.3.4 ELECTION AND REMOVAL FROM OFFICE

##### 11.3.4.1 Election Process for Department Chiefs

11.3.4.1.1 Each Chief will be elected by the Active Medical Staff of the Department in the manner herein described for a two-year term. Two-year terms in even year elections for the Chiefs of the Departments of Medicine and Pediatrics. Two year terms commence in odd year elections for the Chiefs of the Departments of OB/GYN and Surgery.

11.3.4.1.2 A letter will be sent to each Active Staff member of the Department asking if the member would like to serve as the Department Chief. This process will begin in January of the election year. ~~The members would be notified that physicians who are receiving compensation from Providence, i.e., Medical Directors or physicians receiving administrative duty compensation would be excluded from placing their name in nomination. Physicians receiving Emergency Call Panel coverage compensation would not be excluded from placing their name in nomination.~~ Should the physician wish to place his/her name in

nomination, the request must be received by the Medical Staff within seven (7) days of the date the letter was received.

**11.3.4.1.3** Within seven (7) days after the deadline for return of the nomination letters, the ballots will be submitted, by the Medical Staff Office, to the Active Medical Staff of the Department. Such ballots are to be returned to the Medical Staff Office within seven (7) days of the date the ballots were received. Proxy votes are not valid.

**11.3.4.1.4** In the event that no candidate receives a majority of votes, the two candidates with the greatest number of votes will have a run-off election. Such ballots will be mailed immediately and are to be returned to the Medical Staff Office within seven (7) days of receipt.

**11.3.4.1.5** In the event of a tie vote between the two candidates, a selection will be made by a vote of the Medical Executive Committee. The elected Chief will take office, July 1<sup>st</sup> of the year in which the election is called.

**11.3.4.1.6** In the event that the Medical Executive Committee must decide between two candidates for which there was a tie vote, the retiring Chief of the Department will continue to serve in that capacity after July 1<sup>st</sup> until the Medical Executive Committee makes its final decision.

**11.3.4.1.7** The Director of the Medical Staff Office or designee will notify the Medical Executive Committee of its election results as promptly as possible after such election, but no later than June 30<sup>th</sup>.

**11.3.4.1.8** The selection of a Vice Chief of a Clinical Department must be approved by the Medical Executive Committee subsequent to identification by the Chief of a Clinical Department.

**11.3.4.1.9** The elected Chief of the Clinical Department and the Vice Chief of the Clinical Department are required to attend a Medical Executive Committee sanctioned educational conference prior to **or shortly after** taking office. Should the newly elected Chief or Vice Chief not complete the required training **in a timely manner** ~~prior to July 1<sup>st</sup>, which would be the beginning of the Medical Staff year~~, the past Chief of the Clinical Department would continue on until the required training has been completed.

**11.3.5** Any Chief of a Clinical Department may be removed from office for valid cause, including but not limited to, gross negligence or malfeasance of office, or serious acts of moral turpitude. The removal from office of a clinical department Chief may be initiated by the Medical Executive Committee or will be initiated by a petition signed by at least one-third (1/3) of the active medical staff of the department. Removal requires a two-thirds (2/3) vote of the active Medical Staff of the Department at a special meeting called for that purpose or by mail ballot. A ballot will be sent to each member of the active Medical Staff of the Department at least 21 days prior to the date of the special meeting date. No such removal will be effective unless and until it has been ratified by the Medical Executive Committee. Removal is final and none of the provisions of Hearing Rights apply.

#### 11.3.6 VACANCY IN OFFICE

If there is a vacancy in the Office of the Chief of the Clinical Department, the Vice Chief will serve out the remaining term and it will not be necessary to fill this resulting vacancy. Should this physician be unable or unwilling to assume this responsibility, the nomination process will be undertaken as prescribed in this section. As soon as possible after taking over, a Department Chief will choose a Vice Chair Chief.

#### 11.3.7 FUNCTIONS OF DEPARTMENT CHIEFS

Each Clinical Department Chair will have, at least but not limited to the following duties and authority and such other duties as may from time-to-time reasonably be requested by the Chief of Staff or Medical Executive Committee.

- 11.3.7.1 Be accountable for all professional, clinical, and administrative activities within his/her department
- 11.3.7.2 Be a voting member of the Medical Executive Committee, giving guidance on the overall medical policies of the Hospital and making specific recommendations and suggestions regarding his/her own Department in order to assure quality patient care including but not limited to the needed off-site patient care services not provided by the Hospital and the assessment of these services.
- 11.3.7.3 Be responsible for assisting in the development, implementation, and enforcement of the Hospital rules that have been approved by the Medical Staff and of the Medical Staff Bylaws, Rules and Regulations and Policies and Procedures within his/her Department in order to integrate with the primary functions of the organization, guiding and supporting the overall provision of services.
- 11.3.7.4 Be responsible for implementation within his/her Clinical Department of actions taken by the Medical Executive Committee and assisting in the coordination and integration of interdepartmental and intradepartmental services, e.g. Peer and Chart Review responsibilities.
- 11.3.7.5 Transmit to the Medical Executive Committee his/her Department's recommendations concerning the staff classification, the appointment, reappointment, and delineation of clinical privileges for all practitioner's to his/her Department. This will include the recommending of criteria for clinical privileges relevant to the care provided in the Department.
- 11.3.7.6 Be responsible for orientation, teaching, education (of the Medical Staff and themselves), continuous quality improvement, and research programs including surveillance of the professional performance of all individuals in the Department who have delineated clinical privileges.
- 11.3.7.7 Participate in every phase of administration of his/her Department through cooperation with the nursing services and hospital administration in matters affecting patient care, including personnel, supplies, space planning, special regulations, pre-printed orders, and techniques; and assure coordination and integration of interdepartmental and intradepartmental services both for inpatient and off-site services needed for patient care and treatment.
- 11.3.7.8 Assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her Department as may be required by the Medical Executive Committee, the Chief Executive Officer, or the Governing Board.
- 11.3.7.9 Be responsible to develop and implement monitoring and evaluation activities to evaluate the appropriateness and quality of clinical services provided for the purpose of identification and resolution of problems and identification of opportunities to improve care.
- 11.3.7.10 Be responsible for recommending criteria for clinical privileges to his/her Department.
- 11.3.7.11 Be responsible for assuring the determination of qualifications and competence of department or service personnel who are not licensed independent practitioners who provide patient care services.
- 11.3.7.12 Recommend sufficient number of qualified and competent persons to provide care, treatment, and services as required, e.g. staffing for Emergency Department or other clinical areas.

#### 11.3.8 ASSIGNMENT TO DEPARTMENTS

The Medical Executive Committee will, after consideration of the recommendations of the Chief of the appropriate clinical department(s), recommend department assignments for all Medical Staff members in accordance with their qualifications. Each member of the Medical Staff will be assigned membership to one department.

### Section 11.4 DIVISIONS

Any group of physicians may organize themselves into a division within a department. Any division, if organized, will not be required to hold any number of regularly scheduled meetings, nor will attendance be required unless the division Chief calls a special meeting to discuss a particular issue. A division may develop rules which specify the method of selecting its Chief and its purposes and responsibilities. Special meetings must be preceded by at least two weeks prior notification for all of those expected to attend.

Divisions must be formally sanctioned by the Medical Executive Committee to perform peer review and credentialing duties. The divisions will then be required to meet at least quarterly and maintain minutes and attendance records for their meetings. They will also be required to report to their respective Department and ultimately to the Medical Executive Committee.

Divisions may also perform any of the following activities on behalf of the overseeing clinical department(s); however, responsibility and accountability for performance of department function will remain at the department level.

- 11.4.1 Continuing education;
- 11.4.2 Grand Rounds;
- 11.4.3 Discussion of policy;
- 11.4.4 Discussion of equipment needs;
- 11.4.5 Development of recommendations for Division Director to discuss at the Departmental meetings for possible recommendation to the Medical Executive Committee;
- 11.4.6 Participation in the development of criteria for clinical privileges;
- 11.4.7 Discuss a specific issue at the special request of a Department Chief

When performing the above noted activities, minutes will be taken and retained and filed with the Medical Staff Office. Presentation will be made to the Department meeting and subsequently to the Medical Executive Committee.

#### 11.4.8 ELECTION AND REMOVAL OF DIVISION CHIEFS

- 11.4.8.1 Each Chief will be elected by the active Medical Staff of the Division, in the manner herein described, for a two-year term.
- 11.4.8.2 A letter will be sent to each active member of the Division asking if the member would like to service as the Division Chief. This letter will advise each member to complete and return the letter to the Medical Staff Office within seven (7) days of the date the letter was received in order to request that his/her name be added to the ballot. Included with this letter will be a copy of the duties and responsibilities of the Division Chief.
- 11.4.8.3 Within seven (7) days after the deadline for return of the nomination letters, the ballots will be submitted, by the Medical Staff Office, to the active Medical Staff of the Division. Such ballots are to be returned to the Medical Staff within seven (7) days of the date the ballots were mailed. Proxy votes are not valid.
- 11.4.8.4 In the event that no candidate receives a majority of votes, the two candidates with the greatest number of votes will have a run-off election, such ballots to be mailed immediately and returned to the Medical Staff Office within seven (7) days of mailing.
- 11.4.8.5 In the event of a tie vote between two candidates, a selection will be made by a vote of the Medical Executive Committee, which takes office July 1<sup>st</sup> of the year in which the election is called.



11.4.8.6 In the event that the Medical Executive Committee must decide between two candidates for which there was a tie vote, the retiring Chief of the Division will continue to serve in that capacity after July 1<sup>st</sup> until the Medical Executive Committee makes its final decision.

11.4.8.7 Each division will notify the Medical Executive Committee of its election result as promptly as possible after such election, but no later than June 30<sup>th</sup>.

#### **11.5 Vacancies In Office**

Should a vacancy in the position of Division Chief occur, the Vice Chief will assume the position as Chief for the remainder of the term. Should this physician be unable or unwilling to assume this responsibility, the nomination process will be undertaken as prescribed in this section. As soon as possible after taking over, a Division Chief will choose a Vice Chief.

## **ARTICLE XII. COMMITTEES**

### **Section 12.1 MEDICAL EXECUTIVE COMMITTEE**

Section 12.1.1 Composition: The Medical Executive Committee will include the Chief of Staff, Vice-Chief of Staff, Immediate Past Chief of Staff, Secretary/Treasurer, Chief of each Clinical Department, Vice Chiefs of each Clinical Department (non-voting unless attending as designee for Department Chiefs), a representative from the adult hospitalist group (non-voting member), and a representative of each of the following specialty, division, or groups of specialists who is elected to a two-year term by the active members of the specialty. The divisions, specialties, or groups of specialists to be included, with voting rights are:

- Anesthesiology
- Emergency Medicine
- Pathology
- Radiology
- Cardiology

Additional representatives of divisions, specialties, or groups of specialists may apply for a seat on the Medical Executive Committee, with or without voting rights. Addition of these individuals would be via a Medical Staff Bylaws Amendment process as specified by these Bylaws. The voting members of the Medical Executive Committee must be physicians on the active Medical Staff.

The Chief Executive Officer and Chief Medical Officer will be an ex-officio member without vote. The Chief of Staff will be the chairperson of the Medical Executive Committee.

The administrative representatives, (including, but not limited to, the Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer, Chief Operating Officer, Chief Financial Officer, Director of Business Development, Assistant Administrator, present at a meeting may be excused any time during a meeting that the Chief of Staff deems it appropriate in order to allow for the discussion of confidential Medical Staff issues.

12.1.2 Duties: The duties of the Medical Executive Committee include but are not limited to:

12.1.2.1 To represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

12.1.2.2 To coordinate the activities and general policies of the various Departments

12.1.2.3 To receive and act upon Departmental and Committee reports;

- 12.1.2.4 To implement policies of the Medical Staff not otherwise the responsibility of the Departments;
- 12.1.2.5 To provide liaison between the Medical Staff and the Chief Executive Officer;
- 12.1.2.6 To recommend action to the Chief Executive Officer on medico-administrative matters;
- 12.1.2.7 To make recommendations on hospital management matters and policies, e.g. long-range planning, to the Governing Board;
- 12.1.2.8 To ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the hospital;
- 12.1.2.9 To fulfill the Medical Staff organization's accountability to the Governing Board for the medical care of patients in the hospital;
- 12.1.2.10 To review the report of the Credentials Committee on all applicants and to make recommendations for staff membership, assignments to departments, and delineation of clinical privileges;
- 12.1.2.11 To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance for all members with clinical privileges, but not limited to overseeing and participating in, the Medical Staff's performance improvement activities, peer review, corrective action, and fair hearing procedures;
- 12.1.2.12 To act on behalf of the Medical Staff in the intervals between general Medical Staff meetings of the organized medical staff, within the scope of its responsibilities as defined by the Medical Staff Bylaws/Rules and Regulations and Policies.;
- 12.1.2.13 To review and approve the designation of the hospital's authorized representative for National Practitioner Data Bank purposes;
- 12.1.2.14 To interpret the Medical Staff's Bylaws, Rules and Regulations and policies if the application or implementation in a particular situation is disputed or there are requests for clarification.
- 12.1.2.15 To conduct such other functions as are necessary for the effective operation of the Medical Staff.
- 12.1.2.16 To participate in educational endeavors in order to act on behalf of the Medical Staff in accordance with The Joint Commission and CMS Standards and Medical Staff and Hospital Bylaws/Rules and Regulations.
- 12.1.2.17 To participate, as requested by administration, in accreditation visits from accrediting bodies.

Section 12.1.3 Meetings: the Medical Executive Committee will meet at least quarterly, but as often as necessary to fulfill its responsibility. A permanent record of the proceedings and actions will be maintained. Special meetings of the Medical Executive Committee may be called at any time by the Chief of Staff.

Section 12.1.4 Election and Removal of Medical Executive Committee members: Individuals who are members of the Medical Executive Committee, with the exception of Officers or Department Chiefs may be removed from the Committee upon a two-thirds majority vote of the voting members present and voting at a Medical Executive Committee meetings, to be voted as a secret ballot. If a member other than an Officer or Department Chief is removed or there are other reasons why there is a vacancy in such a position, it will not be necessary to fill the vacancy. A Medical Executive Committee member is elected to the Committee by virtue of being an elected officer, department or division Chief. Accordingly Officers are elected as provided in these Bylaws

**Section 12.1.5 Delegation and Removal of Authority**

By adopting these bylaws, the Medical Staff has delegated to the Medical Executive Committee the authority to perform on behalf of the Medical Staff all of the functions described in these Bylaws. Such authority may be removed pursuant to the conflict management process set forth in these Bylaws.

## **Section 12.2 MEDICAL STAFF FUNCTION**

Provision will be made in these Bylaws, Medical Staff Rules and Regulations, and Policies and Procedures, or by resolution of the Medical Executive Committee, approved by the Governing Board, either through assignment to the Department, to Medical Staff Committees, to Medical Staff Officers designees, or to Interdisciplinary Medical Staff Committees, for the effective performance of the Medical Staff functions specified in this section and described in the Rules and Regulations of the Medical Staff and of such other staff functions as the Medical Executive Committee or the Governing Board will reasonably require. These are to:

- 12.2.1 Monitor and evaluate care provided in and develop clinical policy, the foregoing to include but not be limited to, special care areas, such as intensive or coronary care units; patient care support services, such as respiratory therapy, physical medicine and anesthesia; and emergency, outpatient, home care, and other ambulatory care services;
- 12.2.2 Monitor quality, appropriateness and improvement activities, including, but not limited to: invasive procedures, blood usage, pharmacy and therapeutics, including drug usage review and surveillance over drug utilization policies and practices, tissue review, medical records including clinical pertinence, patient safety, nosocomial infections and the hospital's Infection Control Program, and other reviews as necessary;
- 12.2.3 Participate in utilization review activities
- 12.2.4 Conduct or coordinate credentials investigations for staff membership and granting of clinical privileges and specified services;
- 12.2.5 Provide continuing medical education opportunities responsive to quality assessment/improvement activities, new state-of-the-art developments and other perceived needs, and supervise the hospital's professional library services;
- 12.2.6 Participate in the planning of response to:
  - 12.2.6.1 Fire and other disasters
  - 12.2.6.2 Hospital growth and development, and
  - 12.2.6.3 The provision of services required to meet the needs of the community;
- 12.2.7. Direct all Medical Staff organizational activities, including:
  - 12.2.7.1. Medical Staff Bylaws and Rules and Regulations, and Policies and Procedures review and revision of the foregoing.
  - 12.2.7.2. Medical Staff Officers and Committee nominations,
  - 12.2.7.3. Liaison with the Governing Board and Administration, and
  - 12.2.7.4. Review and maintenance of hospital accreditation;
- 12.2.8 Monitor the care provided by members of the Medical Staff, the care provided by nursing and other patient care activities that potentially affect patient care.
- 12.2.9 Assisting Medical Staff members who may be impaired by chemical dependency, physical illness, and/or mental illness to obtain necessary rehabilitative services, and;
- 12.2.10 Maintain confidentiality of peer review information, which grants immunity from liability and includes a release of liability.

## **ARTICLE XIII. MEDICAL STAFF MEETINGS**

### **Section 13.1 SPECIAL MEETINGS – GENERAL**

- 13.1.1 The Chief of Staff may call a special meeting of the Medical Staff at any time. The Chief will call a special meeting within 20 days after receipt of a written request for such a meeting, signed by not less than one-fourth of the active Medical Staff, or upon a resolution by the Medical Executive Committee. Such a request or resolution must state the purpose of the meeting. The Chief of Staff will designate the time and place of any special meeting.
- 13.1.2 A written or printed notice stating the time, place, and purpose(s) of any special meeting of the Medical Staff will be conspicuously posted and sent to each member of the Medical Staff at least seven (7) days before the date of such meeting. The attendance of a member of the Medical Staff at a meeting will constitute a waiver of notice of such meeting. No business will be transacted at any special meeting, except that stated in the notice of such meeting.
- 13.1.3 Robert's Rules of parliamentary Procedure will be used to formalize the business of a meeting.

**Section 13.2 REGULAR MEETINGS**

Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments will meet at least quarterly or more frequently at the discretion of the Department or Division Chief.

**Section 13.3 SPECIAL MEETINGS - DEPARTMENT OR COMMITTEE**

A special meeting of any committee or department may be called by or at the request of the Chief, thereof, or by the Chief of Staff.

**Section 13.4 QUORUM**

The quorum requirement for the following meetings are:

- 13.4.1. Medical Staff Meetings: Not less than two (2) active Staff Members.
- 13.4.2. Medical Executive Committee: Those members of the Committee so designated with voting rights present and voting, but not less than seven (7).

**Section 13.5 ATTENDANCE REQUIREMENTS**

- 13.5.1 Members of the Medical Staff are encouraged to attend meetings of their clinical department. Departmental and Committee general meeting requirements are delineated in the Medical Staff Rules and Regulations.
- 13.5.2 Medical Executive Committee meetings: Members of the Medical Executive Committee are **REQUIRED** to attend at least seventy-five (75%) of the meetings held.

**Section 13.6 CONFLICT OF INTEREST**

At the discretion of the Chair of the meeting or a majority of those members in attendance, an individual who has a direct personal or financial interest in the outcome of a decision or whose care, conduct or qualifications is a subject under discussion at the meeting, may be required to leave the meeting while the members complete their discussion and vote on the matter. If the Chair is the subject of the matter, the Vice-Chair will act in the Chair's behalf in determining whether the Chair should be excused and then chairing the meeting during the Chair's absence. When an issue arises which requires a vote, the Chair will make sure that there is no one participating whom may have a conflict of interest.

**Section 13.7 PARTICIPATION BY THE CHIEF EXECUTIVE OFFICER**

Subject to Article 12. Section I, The Chief Executive Officer or one (1) designee and the Chief Medical Officer may attend any Committee, Department, or Division meetings of the Medical Staff. the Chief Executive Officer or designee and the Chief Medical Officer may be excused at any time during a meeting that the Chair of the Committee deems it appropriate in order to allow for the discussion of confidential Medical Staff issues.

**Section 13.8 NOTICE OF MEETINGS**

A written notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution will be delivered or sent to each member of the Committee, Department, or Division not less than three (3) days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting will constitute a waiver of notice of such meeting.

**Section 13.9 ACTION OF COMMITTEE/DEPARTMENT/DIVISION**

The action of a majority of its members present at a meeting at which a quorum is present will be the action of a Committee, Department, or Division.

**Section 13.10 RIGHTS OF EX-OFFICIO MEMBERS**

Except as otherwise provided in these Bylaws, when the Chief Executive Officer attends a meeting, and when the Chief of Staff attends any Department, Division, or Committee meeting other than the Medical Executive Committee and the Department in which s/he is a member, those individuals will have all rights and privileges of regular members thereof, except that they can not vote or be counted in determining the existence of a quorum.

**Section 13.11 MINUTES**

Minutes of each regular and special meeting of a Committee, Division, or Department will be prepared and include a record of the attendance of members and the vote taken on each matter. The minutes will be approved by the presiding officer and members and recommendations submitted to the Medical Executive Committee. Minutes of each Committee, Division, and Department meeting will be maintained in a permanent Medical Staff file.

**ARTICLE XIV. CATEGORIES OF THE MEDICAL STAFF AND CLINICAL PRIVILEGES**

**Section 14.1 ACTIVE MEDICAL STAFF**

14.1.1 Appointees to this Category

14.1.1.1 Must meet patient care contact requirements as defined in departmental rules and regulations (also documented on delineation of privileges). Documentation must provide evidence of current clinical competence in privileges requested.

14.1.1.2 Must meet the minimum meeting attendance requirements as established in the Medical Staff Rules and Regulations for each department in order to maintain active Medical Staff membership.

14.1.1.3 Must actively participate in Proctoring/FPPE of new appointments to the medical/ahp staff or for any physician granted new privileges, when requested.

14.1.1.4 May vote on proposed amendments to the Medical Staff Bylaws, Rules and Regulations, policies, and vote on all matters presented at departmental, committee, and special meetings of the Medical Staff.

14.1.1.5 May hold office,

14.1.1.6 May sit on Departmental/Division/Committee meetings

14.1.1.7 May be Chief or Chairperson of any Department/Division or Committee

## **Section 14.2 COURTESY MEDICAL STAFF**

### 14.2.1 Appointees to this Category:

- 14.2.1.1 Are involved in fewer patient contacts than required for Active Medical Staff Status commensurate with clinical privileges granted. This may also include physicians who request limited privileges which allows them to follow patients under the care of another physician with full admitting privileges. These physicians may round on patients, document in the medical record (may not change the orders of the primary physician), may dictate histories and physicals and order out-patient testing and procedures. For patients who may be undergoing out-patient procedures, the ordering physician must provide the name of a physician with admitting privileges to care for the patient should they require admission as an inpatient.
- 14.2.1.2 Must be able to document current competence by submission of documentation of records of patients (excluding patient name, and other patient identifying information) treated at the practitioner's office or other **accredited** facility, in order to document current competence in privileges requested, and,
- 14.2.1.3 May participate in Performance Improvement and other monitoring activities, in monitoring initial appointees during their provisional period,
- 14.2.1.4 May attend meetings of the Medical Staff and Department to which s/he is appointed, committee meetings, and any continuing medical education programs but may not vote.
- 14.2.1.5 May not vote on amendments to Bylaws, Rules & Regulations, or on matters presented at departmental, committee, or special meetings of the medical staff.

## **Section 14.3 PROVISIONAL STAFF**

### 14.3.1 Appointees to this Category:

- 14.3.1.1 Must complete the proctoring requirements of their assigned Department as defined in the Medical Staff Rules and Regulations. Monitoring will require observation of care provided during the initial period of membership in order to recommend the practitioner to Active or Courtesy staff membership.
- 14.3.1.2 Appointees will be Provisional for no more than 18 months. Failure to complete proctoring within this time frame will result in voluntary resignation of Medical Staff membership and clinical privileges without hearing or fair review rights. Physicians may request a one-time, six (6) month extension of their proctoring period prior to 12 months of membership, with documentation of good cause, which would require approval by the Chief of the Clinical Department who will present his/her recommendation to the Medical Executive Committee and who will either recommend approval or disapproval to the Governing Board. Practitioners may only reapply one (1) additional time after resignation for non-completion of proctoring. Practitioners then must wait for two (2) years after the date of being voluntarily resigned in order to reapply to the Medical Staff. The Medical Executive Committee may waive proctoring and provisional status on a case-by-case basis, however, FPPE will be required of a minimum of one case prior to a change in status.
- 14.3.1.3 Appointees may exercise privileges granted with appropriate oversight
- 14.3.1.4 May attend meetings for the clinical Department in which they are a member.
- 14.3.1.5 May attend Medical Staff educational programs

- 14.3.1.6 May not vote
- 14.3.1.7 May not hold office

**Section 14.4 NON-ADMITTING MEDICAL STAFF**

14.4.1 Appointees to this Category:

- 14.4.1.1 May be professionals who have been granted the privilege to dictate histories and physicals and refer patients to the hospital. They may also have “social visit” privileges which allow them to round on patients but not to document or view the patient medical record. Physicians in this category will not have admitting privileges or in-patient care privileges, or,
- 14.4.1.2 May provide an important resource for the Medical Staff performance improvement activities. Such individuals will be qualified to perform functions for which they are granted privileges (i.e. special monitoring and evaluation, education/preceptorship/proctor for new procedures, etc)
- 14.4.1.3 May participate as a Consultant on Peer Review matters in those cases where a Peer Review Committee or Department deems it necessary to obtain a review of a practitioner’s practice by an outside consultant who is not a member of the medical staff, the outside consultant may be granted non-admitting privileges for the limited purpose of conducting the review, reporting to the Peer Review Committee/Department, and for testifying at a hearing or appeal with regard to that review.
- 14.4.1.4 May participate in a Hearing or Fair Review. In the rare situation where there are no qualified members of the Medical Staff to act as a presenter or member of a Medical Review Committee, Non-Admitting privileges may be granted to a qualified individual for the limited purpose of participating as a presenter or a member of the Medical Review Committee.
- 14.4.1.5 May participate as Teleradiology physician, granted privileges only to provide teleradiology service or consultative services on a timely basis within their area of competence.
- 14.4.1.6 May attend meetings of the Medical Staff and Department to which s/he is appointed.
- 14.4.1.7 May not vote
- 14.4.1.8 May not hold office

With the exception of the Teleradiology physicians who are fully credentialed as are all other members of the Medical Staff , other Non-admitting physicians may be appointed by the Chief of Staff, or designee, to fulfill the foregoing functions, without completing the appointment process and may be excused from such qualifications as are not applicable to the functions to be performed, provided, however, the individual will submit and have verified, at least the following:

- A current curriculum vitae
- An abbreviated Application
- An AMA
- Query of the National Practitioner Data Bank
- Criminal Background Check
- Verification of current and valid licensure

**Section 14.5 TEMPORARY PRIVILEGES**

- 14.5.1 Prior to temporary privileges being granted, a practitioner must demonstrate that s/he has appropriate professional qualifications, including verification of an

unrestricted, current and valid California license, a current and unrestricted DEA registration, if applicable, training and experience which verifies current competence, hospital affiliation and privileges, professional liability insurance coverage in the amount required by the Governing Board. The National Practitioner Data Bank and Criminal Background Check must be queried prior to the granting of Temporary Privileges. By applying for Temporary Privileges, all practitioners agree to be bound by the Medical Staff Bylaws, Rules and Regulations, Departmental Rules and Regulations and all applicable Hospital and Medical Staff Policies.

14.5.2 Authority to grant Temporary Privileges/Conditions:

The Chair of a Division or designee (if applicable) in addition to the Chief of the Clinical Department or designee and the Chief of Staff or designee, may grant Temporary Privileges under the circumstances noted below. Temporary Privileges will be granted for a specific period of time, not to exceed 30 days. After that period of time, the practitioner may request an extension of Temporary Privileges for another specific period of time, as deemed appropriate by the Department, but not to exceed 30 days and not to exceed a cumulative total of 120 days. Special requirements of supervision and consultation may be imposed upon the granting of Temporary Privileges. No practitioner has the right to Temporary Privileges.

14.5.3 Temporary Privileges may be granted for the care of a specific patient or patients. Temporary privileges may be granted to a practitioner whose services are required for the care of a specific patient or patients when the required expertise is not available within the Medical Staff Membership.

14.5.4 Physicians who qualify for processing pursuant to the Temporary Privileges Credentialing portion of the Medical Staff Rules and Regulations, have been recommended for their requested clinical privileges by both the Credentials Committee or Credentials Committee Chair and the Chief of the Clinical Department or designee, and the Medical Executive Committee and **are** awaiting approval by the Governing Board are eligible for Temporary Privileges. These privileges may be granted by the Chief Executive Officer after approval by the Credentials Committee or Credentials Chair, the Chief of the Clinical Department or designee, and upon the recommendation of the Chief of Staff or his/her designee and recommendation for approval by the Medical Executive Committee. Temporary privileges granted to a practitioner pursuant to this section may not be granted for a cumulative total of more than 120 days.

14.5.5 Denial, Termination, or Restriction of Temporary Privileges

14.5.5.1 Temporary privileges, unless acted upon pursuant to other provisions of these Bylaws, will terminate automatically at the end of the specific period for which they were granted, without the hearing and appeal rights under these Bylaws. The Chief Executive with concurrence of the Chief of Staff or Department Chair or their designees may terminate or restrict Temporary Privileges at any time with or without cause. Termination or restriction may also be made by the Chief of Staff or Department Chair or their designee without need for the concurrence of the Chief Executive. No practitioner is entitled to the hearing and appeal rights set forth in these Bylaws for denial, non-renewal, restriction or termination of temporary privileges, unless such action must be reported pursuant to California Business and Professions Code, Section 805. In the event a practitioner's temporary privileges are terminated or restricted, the practitioner's patients then in the hospital will be assigned to another practitioner by the Department Chair responsible for supervision or by the Chief of Staff. The wishes of the patient or the patient's family will be considered, when feasible, in choosing a substitute practitioner.

14.5.6 Emergency Temporary Privileges



In the case of an emergency, if no member of the medical staff is available to render care, any practitioner, to the degree permitted by licensure and regardless of Department or staff status or lack of it, will be permitted and assisted to do everything possible to save the life of a patient, using every facility of the hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or s/he does not desire to request privileges, the Chief of Staff or designee, in consultation with the Chief of Service, will assign the patient to an appropriate member of the Medical Staff. For the purpose of this section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger or in which any delay in administering treatment would add to that danger.

## **Section 14.6 DISASTER PRIVILEGES**

- 14.6.1 Disaster privileges may be granted to a practitioner only if the Disaster Plan has been activated and the existing credentialed practitioners are unable to meet the immediate patient needs. Primary source verification of licensure will begin as soon as the immediate situation is under control, and completed within 72 hours from the time the practitioner presents to the hospital. Should there be extraordinary circumstances that prohibit primary source verification within 72 hours, it then will be completed as soon as possible. Primary source verification is not required if the practitioner did not provide care, treatment or services under the disaster privileges.
- 14.6.2 The Chief of Staff or his/her designee may grant Disaster privileges on the recommendation of the Chief of the applicable Clinical Department or his/her designee, if available or the Chair of the Division or his/her designee. Once the disaster has passed, the full temporary privilege form will be completed with back-up documentation to be the same as that required for any other Temporary privilege request.
- 14.6.3 Care provided by a physician granted Disaster Privileges will be retrospectively reviewed as soon as possible after the disaster is under control. Individuals granted disaster privileges will be provided name badges that identify them as having been granted disaster privileges.
- 14.6.4** Disaster privileges may be granted upon submission of a valid government issued photo identification, issued by a state or federal agency (e.g. drivers license or passport) and at least one of the following:
- A current picture hospital ID card that clearly identifies professional designation
  - A current license to practice medicine
  - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups.
  - Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).
  - Identification from current hospital Medical Staff, or Medical Staff member(s) who possess personal knowledge regarding the individual's ability to act as a licensed independent practitioner during a disaster.
  - Primary source verification of the license

## **Section 14.7 LOCUM TENENS STAFF**

- 14.7.1 Appointees to this Category

14.7.1.1 Appointment to the Locum Tenens Staff Category includes only physicians who provide week-end/vacation coverage for members of the Medical Staff, and are not members of an established medical group within the community, and:

14.7.1.2 Appointees may be in an approved Fellowship training program or covering for a contract service group (e.g. Anesthesiology, Radiology, Pathology, Emergency Medicine, Neonatology, Hospitalists).

14.7.1.3 May be granted privileges which allows them to cover for another member of the Medical Staff. These physicians must have training and hold privileges which are consistent with those held by the physician they are covering.

14.7.1.4 Must complete proctoring requirements within eighteen months of membership as a Locum Tenens provider. A portion of the proctoring may be submitted from another accredited facility by way of proctoring reports or activity listings. If a physician is still in a fellowship program, case listings may also be considered.

14.7.1.4 Must be able to document current competence by submission of documentation of records of patients (excluding patient identifiers) treated at PTMC or another accredited facility in order to be reappointed to the Medical Staff for coverage purposes.

14.7.2 May not admit their own patients to the hospital.

14.7.3 May attend Medical Educational Conferences

14.7.4 Will be required to pay an initial application fee as determined by the Medical Executive Committee and will pay a fee equal to the application fee annually thereafter.

14.7.5 May not cover for more than the number of days allowed by their malpractice coverage or for a maximum of 120 days per year.

## **Section 14.8 LEAVE OF ABSENCE**

14.8.1 Members of the Medical Staff may apply for a Leave of Absence not to exceed one year. Request for a leave of absence must be in writing and include the reason for the Leave of Absence.

14.8.2 By requesting a Leave of Absence, the member understands and agrees that s/he will be treated as an initial applicant for the purpose of evaluating his/her qualifications for appointment and will bear the burden of proof to demonstrate to the satisfaction of the Medical Executive Committee and Governing Board that s/he is qualified for initial appointment.

14.8.3 Physicians on a Leave of Absence will not be required to pay dues during the period in which they are on leave. Dues will be assessed upon return from the Leave of Absence on a pro-rated basis. Members of the Medical Staff who are on a Leave of Absence are excluded from meeting attendance requirements during an approved leave.

### **14.8.4 TERMINATION OF LEAVE**

14.8.4.1 At least sixty (60) days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff member may request an application for reappointment to the Medical Staff. No application fee will be assessed. Medical Staff members requesting reappointment following a leave for medical reasons must provide documentation of medical clearance. The Credentials Committee or Medical Executive Committee may require that the applicant submit to an independent medical examination as part of the application process. An appointment may be subject to an observation requirement. Such routine observation will not be considered disciplinary action and will not entitle the practitioner to a hearing and appeal rights under these Bylaws.

14.8.4.2 If the application is not deemed to be complete at the time of termination of the leave of absence, an application fee will be assessed and the application process continued.

14.8.5 Requests for leave of absence to fulfill military service obligations will be granted upon notice and review by the Medical Executive Committee. Reactivation of membership and

clinical privileges previously held will be granted, but may be granted subject to monitoring and/or proctoring as determined by the Medical Executive Committee. Such required proctoring and/or monitoring will not to be deemed disciplinary action or cause for a hearing or fair review.

## **Section 14.10 TELEMEDICINE CLINICAL PRIVILEGES**

### **14.10.1 MEMBERSHIP NOT REQUIRED**

Notwithstanding any other provision of the Bylaws, Rules and Regulations, and/or Policies, a Practitioner may be granted Telemedicine Clinical Privileges without also becoming a Member of the Medical Staff ("Telemedicine-Only Practitioners"). All Telemedicine-Only Practitioners:

- a) Shall agree to abide by the Bylaws, Rules and Regulations, and/or Policies to the extent they pertain to the exercise of any Telemedicine Clinical Privileges, regardless of their non-Member status; and
- b) Shall be entitled only to consult on patients at the Hospital, and to exercise only the Telemedicine Clinical privileges granted them.
- c) May not attend meetings
- d) May not vote
- e) May not hold office

### **14.10.2 INITIAL TELEMEDICINE CLINICAL PRIVILEGES**

**Each application for initial Telemedicine Clinical Privileges may be processed in one of the following manners:**

- a) The applicant may obtain Medical Staff membership and Clinical Privileges at the Hospital in full compliance with the Bylaws, Rules and Regulations, and Policies;
- b) The Credentials Committee, Medical Executive Committee and Governing Body may rely solely upon information provided by any other hospital(s) at which the applicant is a member of the medical staff and has clinical privileges, or any telemedicine entity providing telemedicine services with which the applicant is affiliated, in accordance with a written agreement with such hospital or telemedicine entity, in order to make a credentialing decision based upon this Hospital's standards; or
- c) The Credentials Committee, Medical Executive Committee and Governing Body may rely fully on the membership and clinical privileging decisions made by any other hospital(s) in which the Practitioner is a member of the medical staff and has clinical privileges, as long as such hospital(s) is/are accredited by The Joint Commission, or any telemedicine entity providing telemedicine services with which the applicant is affiliated, in accordance with a written agreement with such hospital or telemedicine entity.

### **14.10.3 RECREDENTIALING OF TELEMEDICINE CLINICAL PRIVILEGES**

Each application for renewed Telemedicine Clinical Privileges shall be based upon the Practitioner's performance at the Hospital, and upon information from any hospital(s) where the Practitioner is a member of the medical staff and has clinical privileges, as well as from any telemedicine entity with which the Practitioner is affiliated.

### **14.10.4 TERMINATION OF TELEMEDICINE CLINICAL PRIVILEGES**

- a) Privileges granted to Telemedicine-Only Practitioners may be revoked or limited at any time, for any reason, by the Governing Body on the recommendation of the Medical Executive Committee.
- b) Telemedicine Clinical Privileges granted in full reliance on the membership and clinical privileging decisions of another hospital shall terminate automatically in the event that: (1) the Practitioner's medical staff membership and/or clinical privileges at such hospital are revoked, suspended, limited or voluntarily relinquished; (2) the Practitioner's license to practice medicine in this State is revoked, expired, suspended, or restricted; or (3) such hospital no longer has a valid written agreement with this Hospital.
- c) Telemedicine Clinical Privileges granted in full reliance on the credentialing and clinical privileging decisions of a telemedicine entity providing telemedicine services in accordance with a written agreement with the Hospital shall terminate automatically in the event that: (1) the Practitioner's affiliation with and/or clinical privileges at the

telemedicine entity are revoked, suspended, limited or voluntarily relinquished; (2) the Practitioner's license to practice medicine in this State is revoked, expired, suspended, or restricted; or (3) the telemedicine entity no longer has a valid written agreement with the Hospital.

#### **14.10.5 NO PROCEDURAL RIGHTS**

Practitioners who are not granted Telemedicine Clinical Privileges at the Hospital, or whose Telemedicine Clinical Privileges are revoked, suspended or limited in any manner, shall not be entitled to any procedural rights under the Bylaws.

#### **14.11 MODIFICATION**

Anytime within the two (2) year appointment cycle, and upon recommendation of the Credentials Committee, or pursuant to a members request, the Medical Executive Committee may recommend a change in Medical Staff Category.

#### **14.12 EMERITUS STAFF**

14.2.1 Emeritus Staff Status is awarded to physicians who have participated in medical staff activities, i.e. Department Chair, Division Chair, Committee Chair, Medical Staff Leadership, etc. Physicians requesting this status must complete a formal request which is reviewed and recommended for approval by the Credentials Committee, Department in which the physician practiced and the Medical Executive Committee. No Dues are required to be paid by these physicians and they are entitled to attend Medical Staff Continuing Medical Education Programs. They are not entitled to serve on Medical Staff Committees.

14.2.2 May not attend medical staff meetings other than educational meetings

14.2.3 May not vote or hold office

#### **14.13 EDUCATIONAL STAFF**

14.13.1 Educational Staff Status is provided to physicians in the community who either were not members of the Medical Staff of Providence Tarzana Medical Center and wish to attend our Continuing Medical Education Programs or physicians who wish to attend these programs but do not meet the requirements for Emeritus Status. Annual dues are determined by the Medical Executive Committee. The Membership does not allow physicians access to the Medical Staff Dining Room.

14.3.2 May not attend medical staff meetings other than educational meetings

14.3.3 May not vote or hold office

### **ARTICLE XV. ALLIED HEALTH PROFESSIONALS**

#### **Section 15.1. Categories of Allied Health Professional Staff**

The Governing Board will determine, based upon comments by the Medical Executive Committee and affected departments, and other information as it has before it, those categories of Allied Health Professionals that should be eligible to exercise privileges in the hospital. If it is determined that a licensure category does not represent a needed service, the clinical privileges will not be permitted for professionals in that licensure category.

#### **Section 15.2 Limitations and Restrictions to Appointment**

Allied Health Practitioners will not be eligible for appointment to or membership on the Medical Staff. Patients may only be admitted to the Hospital by a member of the Medical Staff who has admitting privileges. The general qualifications to be required of members of each category of Allied Health Professionals will be recommended by the Chair of the Interdisciplinary Practice Committee in conjunction with the clinical Department concerned. The Chairperson of the Committee on Interdisciplinary Practice will submit a list of such qualifications to the Medical Executive Committee for approval, which then will be subject to the approval of the Governing Board.

### **Section 15.3 Appointment to Allied Health Professional Staff**

15.3.1 Applications for privileges and renewal thereof will be processed and information verified by the Medical Staff Office. All completed and verified credentials first will be reviewed by the Interdisciplinary Practice Committee and then considered and recommended by the applicable Committee, Division, and/or Department of the Medical Staff.

15.3.2 Allied Health Professionals are health care providers who:

15.3.2.1 Hold a current, valid, and unrestricted license, certificate, or other legal credential as required by this State which authorizes the Allied Health Professional to provide patient care services;

15.3.2.2 Are in a category of Allied Health Professionals designated by the Governing Board to carry out privileges under defined degree of supervision and monitoring.

15.3.2.3 Meet the qualifications in these Bylaws, Rules and Regulations, and applicable Policies;

15.3.2.4 Allied Health Professionals are not entitled to Medical Staff membership or prerogatives;

15.3.2.5 Allied Health Professionals are not entitled to hearing or appeal rights as specified in the Medical Staff Bylaws.

15.3.2.6 These Bylaws do not construe Allied Health Professionals as a separate or self-governing entity.

15.3.2.7 Must consent to a criminal background check

15.3.2.8 Must possess a current and valid DEA or Furnishing License in order to write medication orders

**15.3.2.9** Must possess a current and valid CPR or ACLS certification. PALS and NRP are also required based upon privileges

15.3.3 Qualifications

15.3.3.1 To be eligible for, and to maintain clinical privileges and membership as an Allied Health Professional, at a minimum, the Allied Health Practitioner must meet each of the following requirements in addition to any requirements recommended by the Medical Executive Committee and required by the Governing Board.

15.3.3.1.1 Document his/her background, relevant training, education, experience, demonstrated current competency, judgment, character, and physical and mental health status (subject to reasonable accommodation if and to the extent required by law), with sufficient adequacy to demonstrate that patient care services will be provided by the Allied Health Professional level of quality and efficiency established by the Medical Staff and Governing Board.

15.3.3.1.2 Submit an application for clinical privileges on the form prescribed by the Medical Staff and Governing Board, providing all requested information and documentation;

15.3.3.1.3 Provide a written confirmation of the existence and extent of required supervision by a physician member of the medical staff as recommended by the Medical staff and approved by the Governing Board;

15.3.3.1.4 Document his/her strict adherence to the Ethics of this Medical Staff and Allied Health Professional's respective profession; his/her ability and agreement to work cooperatively with others in the hospital setting; and his/her willingness to commit to and regularly assist the Medical Staff in fulfilling its obligations related to patient care within the area of the Allied Health Professional's competence and credentials; and

15.3.3.1.5 Maintain professional liability insurance in amounts, of a type, and with a carrier as required by the Medical Executive Committee and Governing Board.

15.3.4 Provisional Period

15.3.4.1 All Allied Health Professionals will undergo a Provisional period for a minimum of one year from the time of reappointment, during which time the following should occur: A minimum of six (6) proctoring reports are required for review by the

appropriate clinical department to satisfactorily indicate completion of the proctoring program and provisional period for Allied Health Professionals.

15.3.4.2 Following are specific proctoring requirements for dependent and independent Allied Health Professionals:

- 15.3.4.2.1 **DEPENDENT PRACTITIONERS:** (e.g. but not limited to: RNFA, Nurse Practitioner, RN, Scrub Tech) Dependent practitioners are required to undergo evaluation by way of proctoring. The sponsoring physician(s) will be required to complete the proctoring on cases in which they participated. The evaluation must be submitted to the appropriate Medical Staff Department for evaluation.
- 15.3.4.2.2 **INDEPENDENT PRACTITIONERS:** (e.g. but not limited to: Optometrists, Acupuncturists) The Independent Practitioner is required to submit a list of six (6) cases for evaluation and monitoring by the appropriate clinical department.
- 15.3.4.2.3 Proctoring of specific types of procedures or activities may be initiated at any time when it is deemed necessary by the sponsoring physician and/or the clinical department. Any clinical department may require more than six (6) proctored cases for a specific applicant at its discretion.
- 15.3.4.2.4 Failure to submit the necessary documentation for monitoring and evaluation purposes at the end of the provisional period is deemed a voluntary resignation from the Allied Health professional Staff without hearing or grievance rights.
- 15.3.4.2.5 Allied Health Practitioners will be evaluated annually with reappointment at least every two years.

#### **Section 15.4 Processing for Reappointment**

All Allied Health Professionals will be required to submit a reappointment packet at least every two (2) years. The reappointment packet will include, at least, but not limited to the following:

- 15.4.1 Completed reapplication form, signed and dated.
- 15.4.2 Evidence of continuing education, as required by licensure/certification
- 15.4.3 History of Malpractice cases during the last two years
- 15.4.4 Letter of Sponsorship for dependent Allied Health Professionals, attesting to competency
- 15.4.5 Current California Licensure or Training Certification
- 15.4.6 Malpractice Policy Certification/Claims History
- 15.4.7 Hospital Reference Letter(s) (if applicable)
- 15.4.8 Updated delineation of privileges
- 15.4.9 Letter of verification of current competence from sponsor for dependent Allied Health Professionals
- 15.4.10 Acknowledgement of current competence from the Director of Medical/Surgical Service under which the independent Allied Health Professional is practicing.
- 15.4.11 Peer recommendation letter
- 15.4.12 Consent for Criminal Background Check
- 15.4.13 Once all of the aforementioned information has been obtained, the reappointment packet will be submitted to the Interdisciplinary Practice Committee and appropriate clinical department for review. The applicant would then be presented to the Medical Executive Committee and Governing Board for approval of reappointment. The reappointment process will be the same as that for a member of the Medical Staff.

#### **Section 15.5 Assignment**

Allied Health Professionals will be individually assigned to an appropriate clinical department. The Allied Health Professional's will carry out their professional activities under the supervision of the Committee of Interdisciplinary Practice and the Chair of the

Clinical Department or the appropriate Attending Staff Member assigned this responsibility, and subject to Departmental Rules and Regulations.

### **Section 15.6 Duties and Responsibilities**

- 15.6.1 Allied Health Professionals may participate directly in patient management as consistent with the practice privileges granted to the Allied Health Professionals and within the Allied Health Professional's licensure or certification.
- 15.6.2 An Allied Health Professional's duties and responsibilities may be extended to include service on Medical Staff, Department, and Committees, attendance at the meetings of the Department to which s/he is assigned, as permitted by the Department's Rules and Regulations, and attendance at continuing medical educational programs in his/her field of practice.
- 15.6.3 An Allied Health Professional may participate as appropriate in patient care audit and other quality review evaluation and monitoring activities required of the Allied Health Professional, supervising initial appointee's of his/her same occupation or profession or of a lesser included occupation or profession, and in discharging such other functions as may be required from time to time.
- 15.6.4 At all times, and Allied Health Professional will meet those responsibilities specified in the Medical Staff Rules and Regulations, and if not so specified, meet the responsibilities specified in the Medical Staff Bylaws, as are generally applicable to the more limited practice of the Allied Health Professional.
- 15.6.5 Although ultimate responsibility for patient care will always rest with the member of the Medical Staff, an Allied Health Professional will retain appropriate responsibility within his/her area of professional competence for the care and supervision of the patient in the hospital for whom s/he provides service(s).
- 15.6.6 Allied Health Professionals are permitted to write orders to the extent established by the Departmental Policies and Procedures and within the scope of their licensure/certification, and applicable statutes, and as granted by their clinical privileges. All orders must be authenticated by a member of the Medical Staff within 24 hours.
- 15.6.7 The scope of an Allied Health Professional's duties will be specifically listed in the delineation of privileges for each category. Any new duties requested would require appropriate documentation of training and experience as well as coverage under the scope of licensure for that category and Malpractice coverage.
- 15.6.8 Maintain the confidentiality of all peer review related matters and waive any right under State law to voluntarily disclose such matters.

### **Section 15.7 Termination of Privileges**

- 15.7.1 Nothing herein will create any vested rights in any Allied Health Professional to receive or maintain any privilege in the hospital. The provisions of the Medical Staff Bylaws specifically relating to Corrective Action and Hearing, and Appellate Review Procedure, including but not limited to the Fair Review process, will not apply to an Allied Health Professional applying for privileges or one to whom such privileges already have been granted. An Allied Health Professional's clinical privileges will terminate automatically or be automatically suspended at the sole discretion of the Chief Executive Officer, Chief of Staff, or Chair of the Department upon occurrence of any of the following:
  - 15.7.1.1 Suspension, restriction, termination, voluntary relinquishment, expiration, or the imposition of terms of probation (whether voluntary or involuntary) on the Medical Staff Membership or Privileges of any supervising practitioner.
  - 15.7.1.2 Termination of the supervisory/sponsoring relationship between the Allied Health Professional and the Supervising practitioner;
  - 15.7.1.3 Suspension, revocation, expiration, voluntary or involuntary relinquishment or restriction, termination, or imposition of terms of

- probation by the applicable licensing or certifying agency of the Allied Health Professional's license, certificate or other legal credential which authorizes the Allied Health Professional to provide health care services;
- 15.7.1.4 Failure of the Allied Health Professional to perform properly assigned duties including but not limited to medical record completion;
  - 15.7.1.5 Conduct by the Allied Health Professional which interferes with or is detrimental to the provision of quality of patient care;
  - 15.7.1.6 Failure of the Allied Health Professional to maintain professional liability insurance as required;
  - 15.7.1.7 Failure of the Supervising physician to maintain professional liability insurance as required;
  - 15.7.1.8 Failure of the Supervising physician to maintain Medical Staff Membership and clinical privileges in good standing;
  - 15.7.1.9 Termination of the Sponsoring Practitioner's professional services contract, if any, with the hospital; and/or
  - 15.7.1.10 The Supervising Practitioner takes a Leave of Absence or is otherwise unavailable to provide the required supervision and has not made appropriate arrangements for another practitioner to be the Allied Health Professional's Supervising Practitioner.

## **Section 15.8 Grievance Process**

- 15.8.1 Within fifteen (15) days following any action that would constitute grounds for a Hearing or Fair Review under these Medical Staff Bylaws, an Allied Health Professional will have the right to file written grievance with the Medical Executive Committee. Upon receipt of such a grievance, the Medical Executive Committee will conduct a review that affords the Allied Health Professional an opportunity for an interview concerning the grievance. The interview will not constitute a "hearing" or "fair review" as established in the Medical Staff Bylaws, and need not be conducted according to the procedural rules applicable to those proceedings. At least one week before the interview, the Allied Health Professional will be generally informed of the cause for the action. The Allied Health Professional may present relevant information at the interview. An allied Health Professional's failure to present information or documents that are relevant will be deemed a waiver to subsequently present such information or documents in any challenge to or appeal of the Medical Executive Committee's decision, unless it can be demonstrated that such information or documents could not have been provided during the interview. A record of the interview will be made and a decision on the action taken will be made by the Medical Executive Committee. The Chief of Staff will notify the Allied Health Professional of the Medical Executive Committee's decision. If the Allied Health Professional disagrees with the Medical Executive Committee's decision, the Allied Health Professional has the right to request that the Governing Board review the Medical Executive Committee's decision. Such request must be submitted to the Chief Executive Officer within fifteen (15) days following the Allied Health Professional's receipt of the Medical Executive Committee's decision, and include all information and documentation which the Allied Health Professional believes support the Allied Health Professional's position. Upon receipt of such request, the Governing Board has the option to:
  - 15.8.1.1 Either grant an interview to afford the Allied Health Professional an opportunity to present his/her objections following such procedures as the Governing Board may establish,
  - 15.8.1.2 To reject the request and affirm the decision of the Medical Executive Committee,
  - 15.8.1.3 Or to refer the matter back to the Medical Executive Committee for further consideration. If the Governing Board has questions or concerns regarding the Medical Executive Committee's



recommendation, the Governing Board may refer the matter back to the Medical Executive Committee for further review. If the Medical Executive Committee and Governing Board still disagree, the matter will be submitted to the Ad Hoc Dispute Resolution Committee as established in the Medical Staff Rules and Regulations for matters of Medical Staff Self-Governance. Each Allied Health Professional is obligated to exhaust the process described in this Section before challenging the actions resorting to legal action.

## **ARTICLE XVI. PRACTITIONER RIGHTS**

- 16.1 In addition to the rights set forth in these Bylaws:
- 16.1.1 Each physician on the Medical staff has the right to an audience with the Medical Executive Committee. In the event a practitioner is unable to resolve a difficult issue with his/her respective Department Chair, that physician may, upon presentation of a written notice, meet with the Medical Executive Committee to discuss the issue.
  - 16.1.2 Any section/subspecialty group may request a department meeting when a majority of the members/sub-specialists believe that the department has not acted appropriately.

## **ARTICLE XVII. REVIEW, REVISION, ADOPTION, AND AMENDMENT OF THE BYLAWS, RULES AND REGULATIONS AND POLICIES**

The Medical Staff Bylaws, Rules and Regulations, and the Bylaws of the Governing Board and hospital policies are compatible with each other and are compliant with law and regulation. Once approved by the Medical Staff and Governing Board, the Bylaws and Rules and Regulations of the Medical Staff are binding on the Hospital Governing Board and Medical Staff.(MS.01.01.01, EP4)

### **Section 17.1 Medical Staff Responsibility**

The Medical Staff will have the responsibility to formulate, adopt and recommend to the Governing Board, all Medical Staff Bylaws, and any Amendments thereto, which will be effective when approved by the Governing Board. Such responsibility will be exercised in good faith and in a reasonable, responsible, and timely manner. This applies as well to the review, adoption, and amendment of the Rules and Regulations, Policies, and Protocols developed by the Medical Executive Committee to implement various sections of these Bylaws.

### **Section 17.2 Methods of Adoption and Amendment**

**Section 17.2.1** These Bylaws may be adopted or amended by the Medical Executive Committee. A Medical Executive Committee Bylaw proposal will be submitted to a vote of the Active Medical Staff and will require approval by fifty-one (51%) of the Active Staff.

**Section 17.2.2** These bylaws may be adopted or amended by the Organized Medical Staff To do so they must first submit a petition bearing the signature of a minimum of fifty-one (51%) percent of the Active Medical Staff to the Medical Executive Committee for review;

#### **17.2.2.1 Executive Committee Review**

**17.2.2.1.1** The Medical Executive Committee will review a petition received within sixty (60) days of its receipt.

**17.2.2.1.2** Within thirty (30) days after the Medical Executive Committee meeting, that considers such petition, the Medical Executive Committee will either: (1) send it to a vote requiring approval by a minimum of

sixty-seven (67%) of the Active Medical Staff (with or without the Medical Executive Committee's comments) or, (2) ask the backers of the petition for clarification or revision on such points that the Medical Executive Committee feels need to be addressed.

**17.2.2.2 Meeting to resolve conflicts**

**17.2.2.2.1** If the backers of the petition were asked to comment or clarify, as stated above, they will have thirty (30) days to submit a written request for a meeting with the Medical Executive Committee. The Medical Executive Committee will schedule a meeting for this purpose within sixty (60) days after receipt of the meeting request. All medical staff members who signed the petition will be notified of the meeting and invited to attend.

**17.2.2.3 Second Petition**

After meeting with the Medical Executive Committee to address the Medical Executive Committee's concerns, the petitioners will have thirty (30) days to submit a second petition, signed by at least fifty-one percent (51%) of the active medical staff, to the Medical Executive Committee. This second petition may either be modified as suggested or remain as originally proposed.

**17.2.2.4 Action on Proposed Amendment**

The second proposal will be reviewed at the next regular Medical Executive Committee meeting. Within thirty (30) days, the Medical Executive Committee will either, (a) submit it to the Governing Board for approval, or (b) send it (with or without Medical Executive Committee comments) for a vote, which will require at least sixty-seven (67%) of the Active Medical Staff. If so approved, it will be advanced to the Governing Board for approval.

**17.2.3** Any ballot sent to the Active Medical Staff will indicate which portions of the Bylaws are affected or deleted, including a copy of the proposed Bylaws or Amendment(s) and contain provisions which permit the Active Medical Staff member to approve or disapprove the proposal. All ballots are to be returned within fifteen (15) days, and will be counted by a delegated Officer of the Medical Staff or their designee, who will certify the vote, and if approved by the Governing Board, become effective immediately thereafter. The Medical Staff will be informed of any Amendments to the Bylaws.

**17.2.4** No Bylaws or Amendments thereto will become effective unless and until approved by the Governing Board, with such approval not to be unreasonably withheld. In the event the Governing Board does not take any action to review, process, reject, approve or otherwise respond to the proposed Bylaws within ninety (90) days after the Bylaws have been approved by the Medical Staff and received by the Governing Board, the bylaws will be deemed approved by the Governing Board. If the approval is withheld, the Governing Board will state, in writing, its reasons for the denial and forward its reasons to the Chief of Staff, the Medical Executive Committee and the Bylaws Committee. (MS.01.01.01)

### **Section 17.3 Rules and Regulations**

The Medical Executive Committee will recommend to the Governing Board, all Medical Staff Rules and Regulations which include General Rules and Regulations, Departmental Rules and Regulations, proctoring requirements, and further define the general policies contained in these Bylaws. Upon adoption by the Governing Board, these Rules and Regulations will be incorporated by reference and become part of these Medical Staff Bylaw, with or without the requirement of a Medical Staff vote. If there is a conflict between the Bylaws and the foregoing Rules and Regulations, the Bylaws will prevail.

**17.3.1** The organized medical staff can propose rules and regulations adoption, amendments, or policies in a manner identical to that prescribed in Section 17.2 above.

#### **17.3.2 Notice of Amendments to Rules and Regulations and Policies**

##### **17.3.2.1 Notice of Proposed Amendment to Rules and Regulations or Policies**

The Medical Executive Committee will notify the members of the Active Medical Staff of the proposed amendments to a general rule and regulation, giving members at least thirty (30) days to submit comments regarding the proposed amendment. Notice may be provided by mail, e-mail, fax, posting in the doctor's dining area and/or posting on the medical staff intranet, as directed by the Medical Executive Committee.

**17.3.2.2** After the period for submitting comments has expired, the Medical Executive Committee will review any comments received and vote whether to revise the proposed amendment. The Medical Executive Committee may approve revisions to the amendment to address the issues raised and is not required to submit the revised amendment to the staff for comment. Notwithstanding the foregoing, the Medical Executive Committee may decide to submit the revised amendment for comments.

**17.3.2.3** If the Medical Executive Committee receives comments that object to the proposed rule but decides to approve the rule without further revisions to address the comments, a summary of the comments that were received will be provided to the Governing Board by the Medical Executive Committee when the Medical Executive Committee submits the rules to the Governing Board for approval.

**17.4** Notwithstanding the above, if an urgent amendment to the rules and regulations is necessary to comply with law or regulation, the Medical Executive Committee and Governing Board may provisionally approve an amendment without prior notification to the medical staff. If an urgent amendment is adopted without prior notice to the medical staff, as described in 17.3, the medical staff will be notified of the amendment after its approved and given thirty (30) days to submit comments. After reviewing any comments received, the Medical Executive Committee may approve revisions to the amendment to address the issues raised and is not required to submit the revised amendments to the staff for comment. Notwithstanding the foregoing, the Medical Executive Committee may decide it wishes to submit the revised amendment for comments.

### **17.5 Technical corrections**

The medical executive committee will have authority to adopt non-substantive changes to the bylaws, rules and regulations, and policies such as reorganization or renumbering, and technical corrections needed due to errors in punctuation, spelling, grammar or syntax, and/or inaccurate or missing cross-references. Such changes will not affect the interpretation or intent of the sections being changed. The Medical Executive Committee may take action to implement such non-substantive changes by motion, in the same manner as any other motion before the Medical Executive Committee. After approval by the Medical Executive Committee, such technical corrections will be communicated promptly, in writing, to the Governing Board. Such corrections are subject to approval by the Governing Board, which approval will not be withheld unreasonably. Following approval by the Governing Board, technical corrections will be communicated to the medical staff within a time that is reasonable under the circumstances (which may be when the Medical staff is notified of the next substantive change to the bylaws, rule and regulations, or policies affected).

## **ARTICLE XVIII. MEDICAL STAFF SELF GOVERNANCE**

### **Section 18.1**

All policies, procedures, protocols, criteria, standards, or guidelines related to Medical Staff self-governance activities will be set forth in the Bylaws, Rules and Regulations of the Medical Staff or other documents which will be deemed to be a part of the Bylaws and Rules and Regulations, upon approval by the Medical Staff and Governing Board. Such self-governance activities include, but are not limited to, standards and criteria for Medical Staff membership, standards and criteria for clinical privileges, procedures for enforcement of such standards and criteria, quality improvement, utilization management, and review and analysis of patient medical records. The Chief Executive Officer will immediately inform the Chief of Staff or designee for review by the Medical Staff of:

- Any unusual occurrences that have affected or pose a significant risk of affecting the quality of patient care or patient safety, and
- Any reports to the Department of Health Services of an “adverse event” as defined in California health and Safety Code Section 1279.1 as it may be amended from time to time. Except in emergency situations which the Hospital must immediately act to prevent imminent danger, the Hospital will consult with the Medical Executive Committee before deciding to add or delete Hospital services or departments.
- The Governing Board will uphold the Medical Executive Committee’s determination regarding related quality of care issues unless the Governing Board makes specific written findings that the Medical Executive Committee’s determination is arbitrary, capricious or is illegal. Notwithstanding any other term or condition of these Bylaws or Rules and Regulations, the Medical Staff does not waive and will at all times retain its rights of self-governance as specified in California Business and Professions Code Section 2282.5 as the foregoing may be amended by the legislature or interpreted by the courts from time to time.

### **Section 18.2 CONFLICT MANAGEMENT-CONFLICT RESOLUTION**

#### **COMMITTEE**

### **18.2.1 PETITIONS FOR APPOINTMENT OF MEDICAL STAFF CONFLICTS RESOLUTION COMMITTEE**

If members of the medical staff object to specific actions taken by the Medical Executive Committee, other than decisions about individual practitioners taken pursuant to the bylaws, rules and regulations, or policies, the members may submit a petition to the Medical Executive Committee. The petition must be signed by at least sixty-seven percent (67%) of the Active Medical Staff, describe the actions that are objected to, demand the Medical Executive Committee appoint a Conflict Resolution Committee to discuss the matters identified in the petition and nominate at least three (3) members of the active medical staff who have agreed to be members of the Conflict Resolution Committee.

### **18.2.2 APPOINTMENT OF CONFLICTS RESOLUTION COMMITTEE**

Within sixty (60) days after receipt of the petition described in 18.2.1, the Medical Executive Committee will appoint a Conflicts Resolution Committee to address the issues identified in the petition. The Conflicts Resolution Committee voting members will include an equal number of members of the Medical Executive Committee and members who were nominated in the Petition, and a non-voting chair. The Conflicts Resolution Committee will discuss and attempt to resolve the conflict that was described in the petition. The Conflicts Resolution Committee Chair will report the results of the committee's efforts back to the Medical Executive Committee not more than sixty (60) days after the Conflicts Resolution Committee was appointed. Unless a majority of the Conflicts Resolution Committee's voting members request continuation of the Conflicts Resolution Committee's deliberations and the request is approved by the Medical Executive committee, the Conflicts Resolution Committee will dissolve thirty (30) days after its Chair reported the results of the committee's efforts to the Medical Executive Committee.

### **Section 18.3**

Subject to section 3.2.6.2, these bylaws and the membership and privileges granted in accordance with these bylaws, will be binding upon any successor in interest in the Hospital, notwithstanding the foregoing, if the Hospital's general acute care license is being consolidated with another hospital's general acute care license and the medical staff must be combined, the medical staffs will work together to develop new bylaws which will govern the combined medical staffs and be subject to Governing Board approval of the Hospital or its successor in interest. Until such time as the new bylaws are approved by the combined medical staffs, the existing bylaws of each hospital will remain in effect.

## **ARTICLE XIX. INDEMNIFICATION**

### **Section 19.1 Scope of Indemnification**

The Hospital will indemnify, defend and hold harmless the Medical Staff, its members and representatives from and against losses and expenses (including attorneys fees, judgments, settlements and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities, including but not limited to:

19.1.1. As a member, witness for or representative of the medical staff, a department, service, committee or hearing panel;

19.1.2. As a member, witness for or representative of the Hospital Governing Body or any Hospital task force, group or committee: and

19.1.3. As a person providing information to the Medical Staff, Hospital or Governing Body, or a committee, group, officer, representative, or employee of the Medical Staff, Hospital or Governing Body for the purpose of aiding in the evaluation of the qualifications, fitness or character of a medical staff member, AHP, or an applicant.

The Medical Staff or individual may seek indemnification for such losses and expenses under this Bylaws provision, statutory and case law, and any available insurance or otherwise and in any sequence the member or Medical Staff determines. Payment of any losses or expenses by the Medical Staff or individual is not a condition precedent to the Hospital's indemnification. Although the Hospital will consult with the Medical Staff and individual, if requested, regarding the qualifications and selection of the counsel and will assure that the attorney(s) selected are qualified and experienced in the type of matters that are the subject of the action, the Hospital will have the right to select and manage the defense.

### **Section 19.2 Exception to Indemnification.**

Notwithstanding Section 19.1:

19.1.1. The Hospital will not be obligated to indemnify, defend and hold harmless those individuals and/or the Medical Staff who a judge or jury determines acted in bad faith and with malice or motivation of personal gain or if the Medical Staff or individuals fail to notify the Hospital of a summons, lawsuit or other legal or equitable action in a reasonable timely manner so that the Hospital has an opportunity to timely respond in order to provide a defense.

19.1.2. If the Hospital alleges that the Medical Staff or individuals acted in bad faith and with malice or motivation of personal gain, then from and after the time the Hospital alleges such bad faith, malice or inappropriate motivation, the Medical Staff or individuals who are the subject of such allegations will have the right to be represented at the Hospital's expense by counsel separate from the Hospital, but will repay the Hospital for any and all losses and expenses (including attorneys' fees, judgments, settlements and other costs) advanced by Hospital in providing such separate defense only if a judge or jury determines the Medical Staff acted in bad faith and with malice or motivation of personal gain.

## DEFINITIONS

1. The term “administrative reason” when used in reference to the reasons why a person no longer is a member of the medical staff, means a resignation as a result of medical records delinquency, failure to timely pay dues, failure to timely return an application for reappointment, failure to appear and satisfy special attendance requirements, or failure to maintain a complete Drug Enforcement Administration certificate.
2. The term “Allied Health Professional or Allied Health Practitioner” or “AHP” is defined as an individual, not a member of the Medical Staff, who is trained in some aspect of the evaluation or treatment of human illness and who is allowed to perform specified services to patients at the hospital as delineated in their clinical privileges and in accordance with the Bylaws and Rules and Regulations of the Medical Staff.
3. The term “Appellate Review Body” means the group designated pursuant to the Fair Hearing Plan to hear a request for appellate review.
4. The term “authorized representative” means the individual designated by the hospital and approved by the Medical Executive Committee to provide and request information from the National Practitioner Data Bank.
5. The term “Chief Executive Officer” or CEO is defined as the individual appointed by the Governing Board to act on its behalf in the overall management of the hospital. The term “Chief Executive Officer” includes a duly appointed acting administrator serving as designee when the Chief Executive Officer is away from the Hospital. The Medical Staff may rely upon all actions of the CEO as being the actions of the Governing Board taken pursuant to a proper delegation of authority from the Governing Board.
6. The term “clinical pertinence” refers to the processes or outcomes of care associated with the delivery of clinical services allowing for intra- and inter-organizational comparisons to be used to continuously improve patient health outcomes, focusing on the appropriateness of clinical decision making and implementation of these decisions. Clinical pertinence monitoring is condition specific, procedure specific, and addresses important functions of patient care including medication use, infection control, patient assessment, utilization, etc.
7. The term “clinical privilege or “privilege” is defined as the permission granted to a Medical Staff member or Allied Health Professional to render specific patient services.
8. The term “discrimination or harassment” includes, without limitation, sexual harassment and discrimination or harassment against any individual on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender, age, or sexual orientation.
9. The term “disruptive behavior” includes any aberrant behavior which may reasonably appear to compromise quality of care, patient safety or the delivery of care, either directly, or indirectly, because it disrupts the ability of other individuals to provide care or services.

Examples of disruptive behavior includes without limitation, (1) verbal abuse of any individual, (2) verbal abuse which is directed at large but is perceived by a member of a group to be offensive, (3) delaying the progress of surgery or other procedures to reprimand nurses or staff, (4) throwing instruments or other equipment, (5) making bad faith, false accusations of unprofessional behavior against any individual, or (6) any other aberrant behavior which may reasonably appear to compromise quality of care, patient safety or the delivery of care, either directly or indirectly, because it disrupts the ability of other individuals to provide care or services.

10. The term “ex officio” means service as a member of a body by virtue of an office or position held and unless otherwise expressly stated, means without voting rights.
11. The term “fair review” means the process provided to review certain actions and recommended actions as described in these Bylaws. Any statement in the Bylaws that an action or recommended action is not grounds for a hearing also means that the action or recommended action is not grounds for a fair review.
12. The term “Governing Board” or Board as defined as the Board of Directors responsible for conducting the affairs of Providence Health System – Southern California, San Fernando Valley & Santa Clarita Valley Service Areas which for purposes of these bylaws and except as the context otherwise requires will be deemed to act through the authorized actions of the Southern California San Fernando and Santa Clarita Valleys Community Ministry Board, the officers of the corporation and through the Chief Executive of the Hospital. The term “Governing Board” is referred to as the San Fernando Valley Service Area Board.
13. The term “Hearing Committee” means the group designated pursuant to the Fair Hearing Plan to hear a request for an evidentiary hearing.
14. The term “Hospital” means the two general acute care facilities which comprise Encino-Tarzana Regional Medical Center and all locations where the two facilities are licensed to provide outpatient services.
15. The term “Impaired Practitioner” refers to any individual who exhibits a physical or mental condition which potentially impacts his or her medical/clinical judgment or professional conduct and which has or could be expected to adversely affect patient care.
16. The term “in good standing” relates to a, (1) Medical Staff Member who at the time issues is raised has no pending medical staff recommendation or action that is cause for requesting a Medical Staff hearing and no disciplinary action in effect for which the member was entitled to request a Medical Staff hearing, and (2) a former member who was not subject to any of the foregoing at the time the individual ceased being a member and who did not have outstanding delinquent medical records which resulted in records being closed without being completed.
17. The term “investigation” means a process instigated by the Medical Executive Committee to determine whether a concern or complaint is cause for discipline, and does not include the reviews or usual activities of other Committees or Departments of the Medical Staff.
18. The term “mail” will include any of the following methods of delivery:
  - A. U.S. Mail Service
  - B. U.S. Mail – Certified Return Receipt Requested
  - C. Hand Delivery via Courier Service with signed receipt
  - D. Private and/or Network Courier Service
  - E. Private and/or Network Courier Service – Return Receipt Requested
  - F. Hand delivery



Mail will be sent to the addressee at the last address as it appears in the records of the Medical Staff Office. It will be deemed received on the date it was hand delivered if sent as described in C, D, E, or F above and will be deemed received seventy-two hours after it was deposited in the United States mail if it was delivered as described in A or B above. Mail will be deemed delivered whether accepted by the doctor or the office personnel. Refusal by the doctor or office personnel to accept the document will be considered equivalent to delivery and receipt.

19. The term “Medical Disciplinary Cause or Reason or MDCR” means that aspect of a practitioner’s competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
20. The term “Medical Staff” is defined as that group of health care professionals who have been granted Medical Staff membership by the Governing Board.
21. The term “Medical Staff Year” means the period from July 1<sup>st</sup> to June 30<sup>th</sup>.
22. The term “member” is defined as any professional appointed to, and maintaining membership in, any category of the medical staff in accordance with these Bylaws.
23. The term “parties” means the practitioner who requests the Hearing or Appellate Review and the body or bodies whose adverse recommendations or action a hearing or appellate review request is predicated.
24. The “patient” is defined as any person undergoing diagnostic evaluation or receiving medical treatment under the auspices of the hospital.
25. The term “patient contacts” will be defined as inpatient admissions, surgical/operative and other invasive procedures, consultations, including telemedicine, emergency consultations, pathologic and radiologic consultations, and surgical assisting.
26. The term “physician” includes the following licentiates who are eligible for Medical Staff Membership: Doctor of Medicine, Doctor of Osteopathy , or Doctor of Podiatry degree holding a license to practice in the State of California.
27. The term “practitioners” will include the following licentiates who are eligible for Medical Staff membership: Doctor of Medicine, Doctor of Osteopathy degree, Dentists, Podiatrists, and clinical Psychologists holding a license to practice in the State of California.
28. The term “routine monitoring” or “monitoring” as it applies to an individual refers to review of a member’s practice for which the member’s only obligation is to provide reasonable notice of admissions, procedures, or other patient contacts, with information regarding the patient and proposed care. All members of the Medical Staff, regardless of status, will be subject to potential routine monitoring. Routine monitoring is not a restriction of privileges or membership and is not cause for a medical staff hearing or appeal.
29. The term “telemedicine” refers to the use of electronic communication or other communication technologies to provide or support clinical care at a distance. The diagnosis and treatment of a patient may be performed via a telemedicine link.
30. The term “telemedicine practitioner” refers to any licensed and appropriately credentialed practitioner who prescribes, renders diagnosis, or otherwise provides clinical treatment to a patient. The practitioner must have applied for and been granted telemedicine privileges.

ADOPTED BY THE MEDICAL STAFF, SUBJECT TO THE GOVERNING BOARD APPROVAL

**Submitted by: Zahi Nassoura, M.D.**  
**Immediate Past Chief of Staff/Chair-Bylaws Committee**

**Approved by: Jeffrey Work, M.D.**  
**Chief of Staff**

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**Approved by the Governing Board: Date:**

Reviewed and revised 11/16/09  
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Revised 9/19/2011  
Revised 1/23/2012  
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**PROVIDENCE TARZANA MEDICAL CENTER  
MEDICAL STAFF BYLAWS  
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