



# **BYLAWS**

**Medical Staff**

**Providence St. Joseph Hospital**

**Eureka, California**

*August 24, 2023*

**PROVIDENCE ST. JOSEPH HOSPITAL**  
**MEDICAL STAFF BYLAWS**  
**August 24, 2023**

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# BYLAWS OF THE MEDICAL STAFF OF PROVIDENCE ST. JOSEPH HOSPITAL

## PREAMBLE

These Bylaws are adopted to provide for the organization of the Medical Staff of Providence St. Joseph Hospital, to provide a framework for self-governance in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Body, and relations with applicants, members of the Medical Staff, and others who exercise clinical privileges.

## DEFINITIONS

1. **“AUTHORIZED REPRESENTATIVE” or “HOSPITAL’S AUTHORIZED REPRESENTATIVE”** means the individual designated by the hospital and approved by the Medical Executive Committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these Bylaws.
2. **“GOVERNING BODY”** means the means the governing body of the hospital who is ultimately responsible for safety and quality and derives from its legal responsibility and operational authority for hospital performance.
3. **“CHIEF EXECUTIVE”** means the administrator appointed by the Governing Body to act on its behalf in the overall management of the Hospital.
4. **“CHIEF OF STAFF”** means the chief officer of the Medical Staff elected by members of the Medical Staff.
5. **“CLINICAL PRIVILEGES” or “PRIVILEGES”** means the permission granted to licensed independent practitioners to independently provide patient care services. All privileges are limited as appropriate by licensure and legal restrictions on scope of practice.
6. **“CORRECTIVE ACTION”** means an action taken by the Medical Executive Committee as a result of corrective action investigation, including, but not limited to, actions which create a right to a hearing pursuant to the terms of these Bylaws.
7. **“CORRECTIVE ACTION INVESTIGATION”** means a process specifically initiated by the Medical Executive Committee to determine the validity, if any, of a concern or complaint raised against a member of the Medical Staff or an independent practitioner, and does not include activity by the Medical Staff Physician Support Committee.
8. **“DEPENDENT PRACTITIONER”** means an appropriately licensed or certified health care practitioner whose licensure or certification does not permit, and/or the hospital does not authorize the independent exercise of clinical privileges. Dependent practitioners may only provide patient care services as defined in practitioner specific practice prerogatives.
9. **“EX OFFICIO”** means by virtue of an office or position held. Ex Officio members on committees have no voting rights unless otherwise specified in these Bylaws.
10. **“FEDERAL HEALTH CARE PROGRAM”** means any plan or program that provides health benefits whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health program (with the exception of the Federal Employees Health Benefits Program). The most significant Federal health care programs are Medicare, Medicaid, Blue Cross Federal Employees Program (FEP)/Tricare/CHAMPUS and veterans’ programs.
11. **“HOSPITAL”** means Providence St. Joseph Hospital of Eureka, California.



12. **"INELIGIBLE PERSON"** means any person who:
  - a. is currently excluded, suspended, debarred, or ineligible to participate in any Federal health care program, or
  - b. has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in a Federal health care program after a period of exclusion, suspension, debarment, or ineligibility.
13. **"LIMITED LICENSED PRACTITIONER"** means a non-Medical Staff member whose licensure or certification permits, and the hospital authorizes, the independent provision of patient care services without direction or supervision and within the scope of individually delineated clinical privileges.
14. **"MEDICAL STAFF"** means the organization of those medical physicians, osteopathic physicians, dentists and podiatrists who have been granted recognition as members of the Medical Staff pursuant to the terms of these Bylaws.
15. **"MEDICAL STAFF YEAR"** means the period from January 1 through December 31.
16. **"MEMBER"** unless otherwise expressly limited, means any medical physician, osteopathic physician, dentist or podiatrist holding a current license to practice within the scope of his or her licensure who is a member of the Medical Staff.
17. **"MONTHLY"**, when referring to meetings, means at least ten (10) times per year.
18. **"PHYSICIAN"** means an individual with an M.D. or D.O. degree or the equivalent degree (i.e., foreign) as recognized by the Medical Board of California (MBC) or the California Board of Osteopathic Medical Examiners (CBOME) who is licensed by either the MBC or the CBOME to practice medicine.
19. **"PRACTITIONER"** means those individuals who are members of the Medical Staff of Providence St. Joseph Hospital, Eureka, California.

## **ARTICLE I NAME**

The name of the organization shall be the “**MEDICAL STAFF OF PROVIDENCE ST. JOSEPH HOSPITAL**”.

## **ARTICLE II MEDICAL STAFF MEMBERSHIP**

### **2.1 NATURE OF MEMBERSHIP**

No physician, dentist, or podiatrist shall admit patients to the Hospital unless he or she is a member of the Medical Staff. Appointment to the Medical Staff shall permit the exercise of only those specifically delineated clinical privileges which are granted in accordance with these Bylaws.

### **2.2 QUALIFICATIONS FOR MEMBERSHIP**

#### **2.2-1 General Qualifications**

Only those physicians, dentists, and podiatrists who:

- a. document their (1) current licensure, (2) adequate experience, education and training to exercise the privileges which they seek, (3) current professional competence in the exercise of the privileges which they seek, (4) good judgment and (5) current adequate physical and mental health status relative to the privileges requested, so as to demonstrate to the satisfaction of the Medical Staff and the Governing Body that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;
  - b. except for Affiliate and Emeritus Staff categories, meet the criteria for membership in at least one department of the Medical Staff and hold clinical privileges in at least one department of the Medical Staff although exceptions to this requirement may be made by the Medical Executive Committee for good cause;
  - c. are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care, (3) to keep as confidential, as required by law, all information or records received through the physician-patient relationship, (4) to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff, and (5) to be willing to keep confidential and discuss only within established Medical Staff Committees the proceedings of such Medical Staff activities related to Quality Assurance and Peer Review activities;
  - d. maintain in force professional liability insurance covering the exercise of all requested privileges, with limits of not less than \$1 million per occurrence and \$3 million in the aggregate. Professional liability insurance must be held with an insurance carrier approved by the State Insurance Commissioner, to conduct business in the State of California, or the practitioner may demonstrate membership in a physician's cooperative qualified to conduct business within the State of California with the same minimum amounts of coverage as determined by the Medical Executive Committee;
1. each member of the Medical Staff or applicant there to, shall certify in writing at the time of application, and provide ongoing documentation as required by the Medical Executive Committee, that he or she possess professional liability insurance. Such certification shall include the name of the carrier, the period of coverage, assurance that the coverage can be reduced or canceled only after notification to the Hospital and, if requested by the Medical Executive Committee, a certified or photostat of the face sheet of his or her policy evidencing such coverage, or the entire policy if requested;

2. each member or applicant shall promptly report in writing to the Medical Executive Committee, any actual or proposed reductions, restrictions, cancellation or termination of the required professional liability coverage, or change in insurance carrier; and
  3. in the event of a failure to maintain such professional liability insurance as required above, a practitioner's clinical privileges shall be automatically suspended and shall remain suspended until the practitioner shall provide to the Medical Executive Committee evidence of coverage or insurance as required herein. Failure to provide such coverage within ninety (90) days after the date of suspension, shall be deemed to be a voluntary withdrawal from the Medical Staff.
- e. Are eligible to participate in Federal programs. The practitioner may not currently be an ineligible person and shall not become an ineligible person during any term of membership.

## **2.2-2 Particular Qualifications**

- a. Physicians. An applicant for physician membership on the Medical Staff, except for the Emeritus Staff, must hold an M.D. or D.O. degree or their equivalent and a valid and unsuspended certificate to practice medicine issued by the Medical Board of California or the California Board of Osteopathic Medical Examiners. For the purpose of this section "or their equivalent" shall mean any degree (i.e., foreign) recognized by the Medical Board of California or the California Board of Osteopathic Medical Examiners.
- b. Dentist. An applicant for dental membership on the Medical Staff, except for the Emeritus Staff, must hold a D.D.S. or equivalent degree and a valid and unsuspended certificate to practice dentistry issued by the California Board of Dental Examiners.
- c. Podiatrist. An applicant for podiatric membership on the Medical Staff, except for the Emeritus Staff, must hold a D.P.M. degree and a valid and unsuspended certificate to practice podiatry issued by the California Board of Podiatric Medicine.

## **2.3 EFFECT OF OTHER AFFILIATIONS**

No person shall be entitled to membership in the Medical Staff or to exercise any clinical privilege merely because that person holds a certain degree, is licensed to practice in California or any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at any health care facility.

## **2.4 NONDISCRIMINATION**

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of age, sex, race, creed, color, handicap unrelated to the ability to fulfill patient care and required staff obligations, national origin or on the basis of any criteria unrelated to the delivery of quality patient care in the hospital, to professional qualifications, to the hospital's purposes, needs, and capabilities or to community need.

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

Except for the Emeritus Staff members, the ongoing responsibilities of each member of the Medical Staff include:

- a. providing patients with the quality of care meeting the professional standards of the Medical Staff of this hospital;
- b. abiding by the Medical Staff Bylaws, Rules and Regulations and Medical Staff policies;

- c. discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments;
- d. preparing and completing in a timely fashion, medical records for all the patients to whom the member provides care in the hospital;
  - 1. A medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and hospital policy.
  - 2. An updated examination of the patient, including any changes in the patient's condition, be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and hospital policy.
- e. abiding by the lawful ethical principles of professional and specialty associations, as applicable;
- f. participating in any Medical Staff approved educational programs for medical students, interns, resident physicians and resident dentists, although members who choose not to participate in professional graduate education programs shall not be subject to denial or limitation of privileges for that reason alone;
- g. working cooperatively with members, nurses, hospital administration and others so as not to adversely affect patient care;
- h. making appropriate arrangements for coverage for his or her patients as determined by the Medical Staff;
- i. refusing to engage in improper inducements for patient referral;
- j. participating in continuing education programs as determined by the Medical Staff;
- k. discharging such other staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Committee;
- l. providing information and otherwise contributing to credentialing quality assurance and peer review activities;
- m. responding in a timely manner to all notices or requests made by a peer review body of the Medical Staff. Such requests may include requests for information, clarification of information or a request for personal appearance by the practitioner at a specific peer review meeting;
- n. abiding by the lawful, ethical principles of the American Medical Association or the member's professional association; and
- o. faithfully and consistently meeting the terms of any agreement to participate in Emergency Department specialty coverage.

Each non-Medical Staff member who exercises any clinical privilege shall also be obligated to meet each of these responsibilities and other provisions of Article II.

## **2.6 BEHAVIOR**

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

- a. to work with and relate to other staff members, members of other health disciplines, hospital management and employees, visitors and the community in general in a cooperative, professional, non-disruptive manner that is essential for maintaining a hospital environment appropriate to quality and efficient patient care; and,
- b. to discharge the basic obligations of Medical Staff membership and to participate equitably in the discharge of staff obligations appropriate to staff membership category.
- c. failure of a member to demonstrate behavior as described in Section 2.6(a) and (b) may result in corrective action by the Medical Staff which may include, but is not limited to, disciplinary action as described in Article VII.

## **2.7 HARASSMENT PROHIBITED**

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

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

## **2.8 ALLIED HEALTH PROFESSIONALS**

The Medical Staff shall have general responsibility for monitoring the quality of care provided in the Hospital by Allied Health Practitioners (to include Nurse Practitioner, Physician Assistant, Certified Nurse Midwife, Registered Dental Assistant) who are not eligible for Medical Staff membership, but who are permitted to treat patients at the Hospital by virtue of allied health professional status.

The Medical Staff shall fulfill its responsibilities under this Section by performing the following functions with respect to allied health professional categories under its jurisdiction:

- a. establishing standards of practice for the category;
- b. credentialing allied health professionals from the category who apply for appointment or reappointment to allied health professional status; and
- c. undertaking peer review of allied health professionals in the category.

The Medical Staff shall establish appropriate standards and procedures for carrying out its functions.

**ARTICLE III  
CATEGORIES OF THE MEDICAL STAFF**

**3.1 CATEGORIES**

The categories of the Medical Staff and all credentialed providers shall include the following: Active, Courtesy, Administrative, Consulting, Provisional, Affiliate, Emeritus, Telemedicine, and Temporary. At the time of appointment and each reappointment, the member's staff category shall be determined.

**3.2 ACTIVE STAFF**

**3.2-1 Qualifications**

The Active Staff shall consist of members who:

- a. meet the general qualifications for membership set forth in Section 2.2;
- b. have offices or residences which, in the opinion of the Medical Executive Committee, are located closely enough to the hospital to provide appropriate continuity of quality care;
- c. are involved in at least eight (8) patient care activities per two (2) year period except for dentists, dermatologists and psychiatrists who must be involved in five (5) patient care activities in a two (2) year period. These may consist of admissions, assisting at surgeries, consultations, and/or other patient care procedures; and
- d. have satisfactorily completed their designated term in the Provisional Staff category appointment.

**3.2-2 Prerogatives**

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

- a. applying for admitting and attending privileges and exercising other clinical privileges which are granted to the member pursuant to Article V;
- b. attending and voting on matters within the scope of the member's licensure and privilege which are presented at general and special meetings of the Medical Staff or any meeting of any department or committee of which he or she is a member;
- c. holding any staff or department office for which the member is qualified; and
- d. serving as a voting member on any committee to which he or she is duly appointed or elected by the Medical Staff or duly authorized representative thereof. Voting shall be only on issues within the member's scope of licensure.

**3.2-3 Relinquishment of Active Staff Status**

The failure of an Active Staff member to meet the requirements of Section 3.2-1(a-c) shall be deemed a voluntary relinquishment of active staff status and the member shall automatically be transferred to the appropriate staff category, if any, for which the member is eligible. In the event that the member is not eligible for any other category, his or her Medical Staff membership shall automatically terminate. No such transfer or termination shall be subject to the provisions of Article VII.

### **3.3 COURTESY STAFF**

#### **3.3-1 Qualifications**

The Courtesy Staff shall consist of members who:

- a. meet the general qualifications for membership set forth in Section 3.2-1(a) and (b);
- b. are involved in at least two (2) but not more than eight (8) direct patient care activities including admissions, assisting in surgeries, consultations, or other patient care procedures per two (2) years;
- c. are members in good standing of the active Medical Staff of another accredited hospital, although exceptions to this requirement may be made by the Medical Executive Committee; and
- d. have satisfactorily concluded Provisional Staff status at this hospital as set forth in Section 3.6.

#### **3.3-2 Prerogatives**

Except as otherwise provided, the prerogatives of a Courtesy Staff member shall be:

- a. applying for admitting and attending privileges and exercising those clinical privileges which are granted pursuant to Article V, within the limitation of Section 3.3-1(b) and
- b. attending in a nonvoting capacity, general and special meetings of the Medical Staff and open committee meetings and educational programs of any department or of which he or she is a member. Courtesy Staff members shall have no right to vote at such meetings except within committees when the right to vote is specified at the time of appointment and shall not be eligible to hold any Medical Staff or department office.

#### **3.3-3 Relinquishment of Courtesy Staff Status**

The failure of a Courtesy Staff member to meet the requirements of Section 3.3-1 (a-c) shall be deemed a voluntarily relinquishment of Courtesy Staff status and the member shall automatically be transferred to the appropriate staff category, if any, for which the member is eligible. In the event the member is not eligible for any other category, his or her Medical Staff membership shall automatically terminate. No such transfer or termination shall be subject to the provisions of Article VII.

### **3.4 ADMINISTRATIVE STAFF**

#### **3.4-1 Qualifications**

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

The Administrative Staff shall consist of members who:

- a. are charged with assisting the Medical Staff in carrying out medical-administrative functions, including but not limited to, quality assessment, peer review, performance improvement, and utilization review;
- b. document their current licensure, adequate experience, education and training, current professional competence, good judgment, and current physical and mental health status, so

as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent to exercise their duties;

- c. are determined to adhere to the ethics of their respective professions, to be able to work cooperatively with others so as not to adversely affect their judgment in carrying out the quality assessment and improvement functions, and to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff.

#### **3.4-2 Prerogatives**

The Administrative Staff shall be entitled to:

- a. Attend meetings of the Medical Staff department, sections, and committees, but shall have no right to vote at such meetings, except to the extent the right to vote is specified at the time of appointment.
- b. Administrative Staff members shall not be eligible to hold office in the Medical Staff organization, admit patients, or exercise clinical privileges.

### **3.5 CONSULTING STAFF**

#### **3.5-1 Qualifications**

Any member of the Medical Staff in good standing may consult in his or her area of expertise; however the Consulting Medical Staff shall consist of such practitioners who:

- a. are not otherwise members of the Medical Staff and meet the general qualifications set forth in Section 2.2;
- b. are involved in at least three (3) patient care activities per two-year period, as defined in Section 3.2-11;
- c. are members of the active Medical Staff at another accredited hospital, although exceptions to this requirement may be made by the Medical Executive Committee for good cause;
- d. have satisfactorily completed appointment in the Provisional category; and
- e. are willing and able to come to the hospital on schedule or promptly respond when called to render clinical services within their area of competence.

#### **3.5-2 Prerogatives**

The Consulting Medical Staff member:

- a. shall neither admit nor provide primary care to patients as an attending practitioner but may otherwise exercise such clinical privileges as are granted pursuant to Article V; and
- b. may attend, in a nonvoting capacity, general and special meetings of the Medical Staff and open committee meetings and educational programs of any department of which he or she is a member. Consulting Staff members shall not be eligible to hold any Medical Staff or department office.

#### **3.5-3 Relinquishment of Courtesy Staff Status**

Consulting Staff members who do not meet the requirements of Section 3.5-1(b) shall be deemed to have voluntarily relinquished Consulting Staff status and shall be automatically transferred to the appropriate staff category, if any, for which the member is eligible. In the event the member is not eligible for any other category, his or her Medical Staff membership shall automatically terminate. No such transfer or termination shall be subject to the provisions of Article VII.



## **3.6 PROVISIONAL STAFF**

### **3.6-1 Qualifications**

The Provisional Staff shall consist of members who:

- a. meet the general Medical Staff membership qualifications set forth in Section 2.2;
- b. meet the requirements set forth in either Section 3.2-1(b), Section 3.3-1(c) or Section 3.5-1(c) and I; and
- c. meet the requirements of Section 3.2-1(b) if they are applying for Active or Courtesy Staff.

### **3.6-2 Prerogatives**

The Provisional Staff member shall be entitled to:

- a. exercise such clinical privileges as are granted pursuant to Article V; and
- b. attend, in a nonvoting capacity, general and special meetings of the Medical Staff, committee meetings and educational programs of any department of which he or she is a member.  
Provisional Staff members shall not be eligible to hold any Medical Staff department office, but may serve upon committees.

### **3.6-3 Observation of Provisional Staff Member**

Each Provisional Staff member shall undergo a period of observation, evaluation and proctoring by designated monitors as described in Section 5.3. The observation shall be to evaluate the member's (1) proficiency in the exercise of clinical privileges initially granted and (2) overall eligibility for continued staff membership and advancement within staff categories. Observation, evaluation and proctoring of provisional staff members shall follow a format as may be established in the General Medical Staff Rules and Regulations and/or Medical Staff policies. Such observation must include concurrent observation and proctoring, however, retrospective chart review may also be utilized. Appropriate observation and proctoring records shall be maintained and results of the observation and proctoring shall be communicated by the department chairperson to the Medical Executive Committee.

### **3.6-4 Conclusion of Provisional Staff Status**

With the exception of practitioners applying for Affiliate Staff category, all new members of the Medical Staff will initially be appointed to the Provisional Staff and shall remain in the Provisional Staff category for a period of one (1) year but no longer unless the Provisional status is extended for an additional period of up to one (1) year by the Medical Executive Committee for good cause. Recommendations for advancement from provisional status shall be made by the department chairperson to the Medical Executive Committee. Proctoring requirements may be removed by action of the Medical Executive Committee.

### **3.6-5 Action at Conclusion of Provisional Staff Status**

- a. If the Provisional Staff member has satisfactorily demonstrated his or her ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued Medical Staff membership, the member shall be eligible for placement in the Active, Consulting, or Courtesy staff, as appropriate, upon recommendation of the Medical Executive Committee.
- b. Advancement from Provisional to another Medical Staff category does not exclude the possibility of continued proctoring requirements related to specific clinical privileges.

Recommendations related to specific continued proctoring requirements shall be made by the department chairperson to the Medical Executive Committee.

- c. Failure to satisfactorily conclude Provisional Staff status because of failure to complete proctoring requirements shall be governed by the provisions of Section 5.3-2.

### **3.7 EMERITUS STAFF**

#### **3.7-1 Qualifications**

The Emeritus Staff shall consist of physicians, dentists, and podiatrists who have been members of the Medical Staff for no less than ten (10) years and attained age sixty (60), do not actively practice at the hospital, and were members in good standing of the Active Staff and continue to adhere to appropriate professional and ethical standards.

#### **3.7-2 Prerogatives**

The Emeritus Staff members are not eligible to admit patients to the hospital or to exercise clinical privileges in the hospital, or to vote or hold office, but they may serve upon committees with or without vote at the discretion of the Medical Executive Committee. They may attend general and special Medical Staff meetings, open committee meetings and educational programs. Emeritus Staff members may change categories of membership only through the application and credentialing process as established in these Bylaws.

### **3.8 AFFILIATE STAFF**

#### **3.8-1 Qualifications**

The Affiliate Staff shall consist of members who:

- a. meet the general Medical Staff membership qualifications set forth in Section 2.2,
- b. desire Medical Staff membership without holding clinical privileges to treat patients, for the purposes of referring and observing the care rendered to his/her patients by other Medical Staff members with clinical privileges.

#### **3.8-2 Prerogatives**

The Affiliate Medical Staff member:

- a. shall neither admit nor provide primary or consulting care to patients as an attending or consulting practitioner;
- b. shall not hold or exercise clinical privileges to care for patients;
- c. may attend, in a nonvoting capacity, open committee meetings and educational programs of any department to which he/she is a member. Affiliate Staff members shall not be eligible to hold any Medical Staff or department office.

### **3.9 TELEMEDICINE STAFF**

#### **3.9-1 Qualifications**

The Telemedicine Staff shall consist of physicians who:

- a. Meet the qualifications for credentialing as noted in section 2 of these Bylaws
- b. Provide only telemedicine services to patients at the Hospital.

### **3.9-2 Prerogatives**

The Telemedicine Staff:

- a. May provide telemedicine services to patients at the hospital;
- b. Will be credentialed to hold telemedicine privileges only and will not be credentialed for Medical Staff Membership
- c. May not admit patients to the Hospital, exercise any privilege other than through Telemedicine, hold office in the Medical Staff, or have any voting rights under these Bylaws, unless specifically granted by the Medical Staff on an individual basis
- d. May attend meetings of the Medical Staff, the assigned Department and committees to which the Telemedicine Staff provider may be duly assigned, but shall not have the right to vote; and
- e. Must cooperate in the professional practice evaluation and performance improvement processes, including, but not limited to, FPPE and OPPE.

### **3.10 LIMITATION OF PREROGATIVES**

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these Bylaws, or by the Medical Staff Rules and Regulations.

### **3.11 GENERAL EXCEPTIONS TO PREROGATIVES**

Regardless of the category of membership, members shall only exercise those privileges, and shall only have the right to vote on those matters, within the scope of their licensure. In the event of a dispute over voting rights, the issue shall be determined by the chairperson of the meeting, subject to final decision by the Medical Executive Committee.

### **3.12 MODIFICATION OF MEMBERSHIP CATEGORY**

On its own, or upon direction of the Governing Body as set forth in Section 6.1-6, the Medical Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of the Bylaws.

## **ARTICLE IV APPOINTMENT AND REAPPOINTMENT**

### **4.1 GENERAL PROVISIONS AND APPLICATION OF ARTICLE**

No person shall exercise clinical privileges in the hospital unless and until that person applies for and receives appointment to the Medical Staff or is otherwise granted privileges as set forth in these Bylaws. By applying to the Medical Staff for appointment or reappointment, applying for clinical privileges (or, in the case of members of the Emeritus Staff, by accepting an appointment to the category), the applicant acknowledges responsibility to review these Bylaws, Rules and Regulations, and Medical Staff policies and agrees that throughout any period of membership he or she will comply with the responsibilities of Medical Staff membership and with the Bylaws, Rules and Regulations, and policies of the Medical Staff as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws. For the purpose of this Article, the term “member” shall include “applicant” and “limited licensed practitioner” as applicable under the circumstances, unless otherwise stated.

### **4.2 BURDEN OF PRODUCING INFORMATION**

In connection with all applications for appointment, reappointment, advancement or transfer, the applicant shall have the burden of producing sufficient information to permit an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, to resolve any reasonable doubts about these matters, and to satisfy any request for such information. This burden may include submission to a medical examination, which may include blood or other chemical analysis and/or a psychological examination as deemed appropriate by the Medical Executive Committee and Governing Body. Any such examination shall be at the applicant's expense and shall be performed by a physician approved by the Medical Executive Committee. The applicant's failure to produce required information shall render the application incomplete and it shall not be acted upon. This same burden of producing information rests with any practitioner required to produce information as part of an authorized Medical Staff peer review activity. Failure of a practitioner to produce required information related to an authorized Medical Staff peer review, quality assurance or credentialing activity in a timely manner shall result in automatic suspension of all clinical privileges until such time as the required information has been provided.

### **4.3 APPOINTMENT AUTHORITY**

Appointments, denials and revocations of appointments to the Medical Staff shall be made as set forth in these Bylaws, but only after there has been a recommendation from the Medical Staff, or as set forth in Section 6.1.6.

### **4.4 DURATION OF APPOINTMENT AND REAPPOINTMENT**

Except as otherwise provided in these Bylaws, initial appointments and reappointments to the Medical Staff and/or renewal of clinical privileges shall be for a period of up to two (2) years.

### **4.5 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT**

#### **4.5-1 Medical Staff Application for Initial Appointment and Reappointment**

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

- a. postgraduate training, including the name of each institution, degrees granted, programs completed, dates attended and names of practitioners responsible for the applicant's performance;
- b. specialty or subspecialty board certification, recertification and eligibility;
- c. the applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA registration, certification of CPR training, where appropriate and as specified in Medical Staff policy and continuing medical education information related to the clinical privileges to be exercised by the applicant;
- d. the membership staff category and clinical privileges sought by the applicant;
- e. health impairments, if any, affecting the applicant's ability in terms of skill, attitude or judgment to perform professional and Medical Staff duties fully and including information regarding the ability to perform all procedures and other privileges requested with or without reasonable accommodations, according to accepted standards of professional performance without posing a direct threat to patients;
- f. peer references from individuals familiar with the applicant's professional competence and ethical character: one peer reference must be from an individual in the same professional discipline;
- g. the practitioner's professional liability insurance coverage for the clinical privileges sought to be exercised;
- h. the existence and circumstances of any professional liability complaint, claim or other cause of action that has been lodged against the practitioner, and the status or outcome of each such matter, including all final judgments and/or settlements involving the practitioner;
- i. the existence and circumstances of any past or pending professional disciplinary action or investigation involving the practitioner including the status or outcome of each such matter;
- j. any voluntary or involuntary denial or termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of any clinical privilege at any other hospital or health care facility;
- k. any prior or pending government agency or third party proceeding or litigation challenging or sanctioning the practitioner's admission, treatment, discharge, billing, collection, or utilization practices, including but not limited to Medicare and Medicaid fraud and abuse proceedings, convictions, and or settlements; and
- l. any prior or pending challenge to any licensure or registration, or the voluntary or involuntary relinquishment of any such licensure or registration and the status or outcome of each such matter.
- m. information as to any current or pending sanctions affecting participation in any Federal health care program or any action which might cause the practitioner to become an ineligible person, as well as any sanctions from a professional review organization;
- n. information as to whether the applicant has ever been subject to criminal conviction or whether any such action is pending.

Each Medical Staff application shall be in writing submitted on the prescribed form with all provisions completed, or accompanied by an explanation of why answers are unavailable, and signed by the applicant. Any significant misrepresentation or omission of information on the application of initial appointment or reappointment shall be grounds for immediate denial, termination, revocation and/or suspension of the applicant's Medical Staff membership and/or clinical privileges. Each Medical Staff application shall be a confidential peer review document of

the Medical Staff. Each completed Medical Staff application shall be delivered to the Medical Staff Office for action in accordance with these Bylaws.

#### **4.5-2 Effect of Medical Staff Application**

By submitting a Medical Staff application, each applicant:

- a. signifies his or her willingness to appear for interviews in regard to the application;
- b. authorizes consultation with others who may have information bearing on his or her competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;
- c. consents to inspection of any and/or all records and documents that may be material to an evaluation of his or her qualifications, technical skills and ability to exercise the clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;
- d. consents to any requested medical or psychological examination and the inspection of the records of any such examination including blood, urine or other biological testing or other physiological testing;
- e. releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant;
- f. releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;
- g. consents to the disclosure to other hospitals, medical associations, licensing boards, and other similar organizations any information regarding his or her professional or ethical standing that the hospital or Medical Staff may have, and releases the Medical Staff and hospital from liability for so doing to the fullest extent permitted by law;
- h. if a requirement then exists for Medical Staff dues, acknowledges responsibility for timely payment;
- i. pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral and fee splitting;
- j. pledges to provide continuous care for his or her patients, seek consultation whenever necessary, and refrain from delegating patient care responsibility to non-qualified or inadequately supervised practitioners;
- k. consents to the release of records and documents related to the applicant's skills as documented in quality assessment and improvement and/or peer review records;
- l. agrees to fully cooperate with all Medical Staff peer review and/or Quality Assurance processes including providing all information as requested and appearing for interviews if requested;
- m. agrees to notify the Medical Staff immediately regarding any change in professional licensure or certification, or any change in privileges, staff category or staff status, at any health care facility; and
- n. pledges to be bound by the Medical Staff Bylaws, Rules and Regulations, and policies.

#### **4.5-3 Delegated and/or Proxy Credentialing**

- a. The Medical Staff may, at its discretion:
  1. Notwithstanding other credentialing provision in the Medical Staff Bylaws, including the formal application process and the CCVO application used to request Medical Staff membership and clinical privileges.
  2. Execute delegated credentialing contracts or credentialing-by-proxy contracts with accredited organizations to use their applications and primary source verifications
  3. Delegated and/or Proxy Credentialing may be utilized for Telemedicine services credentialing.
  4. Delegated and/or Proxy Credentialing may be utilized for specialists coming from an MEC-approved university medical center in order to provide services to our community.
- b. Regardless of whether the Medical Staff executes agreements for the acceptance of applications from other organizations, the Medical Staff may require an individual to apply by submitting the application developed by the Medical Staff and approved by the Governing Body.
- c. The Medical Staff's receipt of an application, whether directly from an applicant, from the CCVO, or from an organization pursuant to a contract, does not obligate the Medical Staff to process the application if the applicant does not meet the minimum qualifications for membership and/or clinical privileges.

#### **4.5-4 Department Action**

After receipt of the Medical Staff application, the appropriate department chairperson shall review the application and supporting documentation, and may conduct a personal interview with the applicant at his or her discretion. The chairperson of the department shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges granted, the individual's clinical and/or technical skill as indicated by the results of Quality Assurance activities, participation in relevant continuing education, and shall submit to the Credentials Committee recommendations as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached.

#### **4.5-5 Credentials Committee Action**

The Credentials Committee shall review the application, evaluate and verify the supporting documentation and other relevant information. The Credentials Committee may elect to interview the applicant and seek additional information. As soon as practicable, the Credentials Committee shall transmit to the Medical Executive Committee a written report and its recommendation as to appointment and, if appointment is recommended, as to membership category, clinical privileges to be granted, and any special conditions to be attached to the appointment.

#### **4.5-6 Medical Executive Committee Action**

At its next regular meeting following recommendation by the Department Chairperson and the Credentials Committee, or as soon thereafter as is practicable, the Medical Executive Committee shall consider the recommendation and any other relevant information. The Medical Executive Committee may defer action on the application, request additional information, return the matter to the Medical Staff department for further investigation, elect to interview the applicant, or make a recommendation regarding the appointment. The Medical Executive Committee shall forward to the Governing Body a report and recommendation as to Medical Staff appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any conditions to be attached to the appointment, including but not limited to consultation, monitoring and/or proctoring requirements.

#### **4.5-7 Effect of Medical Executive Committee Action**

- a. When the Medical Executive Committee recommends appointment and the granting of all requested privileges, the recommendation shall be promptly forwarded, together with any necessary supporting documentation, to the Governing Body.
- b. When the Medical Executive Committee recommends denial of appointment for reasons related to the applicant's professional competence or conduct, the Governing Body and the applicant shall be promptly informed by written notice and the applicant shall be entitled to the procedural rights provided in Article VII.
- c. When the Medical Executive Committee recommends appointment, but recommends denial of a requested privilege based on the applicant's professional competence or conduct, the Governing Body and the applicant shall be promptly informed by written notice and the applicant shall be entitled to the procedural rights provided in Article VII with respect to the portion of the recommendation which is unfavorable. The remainder of the recommendation shall be transmitted to the Governing Body for action.
- d. When the Medical Executive Committee recommends denial of appointment or denial of a requested privilege for reasons other than the applicant's professional competence or conduct, the Governing Body and the applicant shall be promptly informed by written notice.

#### **4.5-8 Action on the Application**

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

- a. If the Medical Executive Committee recommends appointment and the granting of all requested privileges, the Governing Body shall affirm the recommendation of the Medical Executive Committee, if the Medical Executive Committee's decision is supported by substantial evidence.
  1. If the Governing Body concurs in that recommendation, the decision of the Board shall be deemed final action.
  2. If the tentative final action of the Governing Body is unfavorable, based upon the professional competence or conduct of the applicant, the Chief Executive, acting on behalf of the Governing Body, shall give the applicant written notice of the tentative adverse recommendation and the applicant shall be entitled to an opportunity for a hearing comparable to that described in Article VII of these Bylaws. If the applicant waives his or her procedural rights, the decision of the Governing Body shall be deemed final action.
- b. If the Medical Executive Committee recommends denial of appointment or denial of any requested privilege and the applicant waives his or her procedural rights, the recommendations of the Medical Executive Committee shall be forwarded to the Governing Body for final action. The Governing Body shall affirm the recommendation of the Medical Executive Committee if the Medical Executive Committee's decision is supported by substantial evidence.
- c. If the applicant requests a hearing following an adverse Medical Executive Committee recommendation or an adverse Governing Body tentative final action, the Governing Body shall take final action only after the applicant has exhausted or waived his or her procedural rights as established by Article VII.



#### **4.5-9 Notice of Final Decision**

- a. Notice of the final decision shall be given to the Chief Executive, the Chief of Staff, the Medical Executive Committee, and the chairperson of each department concerned. The applicant shall be notified by mail.
- b. A decision and notice to appoint or reappoint shall include, if applicable (1) the staff category to which the applicant is appointed; (2) the department to which he or she is assigned; (3) the clinical privileges granted; and (4) any conditions attached to the appointment.

#### **4.5-10 Reapplication after Adverse Appointment Decision**

An applicant who has received a final adverse decision regarding appointment based on professional competence or conduct shall not be eligible to reapply to the Medical Staff for a period of one (1) year. Any such reapplication shall be processed as an initial application, and the applicant shall have the burden to submit information as set forth in Section 4.2, including such information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

#### **4.5-11 Timely Processing of Application**

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

- a. evaluation, review and verification of application and all supporting documentation by the Medical Staff Office: thirty (30) days after receipt of a completed application and all necessary supporting documentation
- b. review and recommendation by the department chairperson: thirty (30) days after receipt of all necessary documentation from the Medical Staff office.
- c. review and recommendation by Credentials Committee: thirty (30) days after receipt of all necessary documentation from the department chairperson.
- d. review and recommendation by the Medical Executive Committee: thirty (30) days after receipt of all necessary documentation from the Credentials Committee.
- e. final action: one hundred and twenty (120) days after receipt of all necessary documentation by the Medical Staff Office or upon conclusion of all hearings.

#### **4.5-12 Expedited Review**

- a. A Department Chair may recommend expedited granting of appointment to the Medical Staff and clinical privileges, except when an application is incomplete. The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process.
  1. There is a current challenge or a previously successful challenge to licensure or registration;
  2. The applicant has received an involuntary termination of medical staff membership at another healthcare organization;
  3. The applicant has received an involuntary limitation, reduction, denial or loss of clinical privileges at another healthcare organization;

4. The Department Chair, on behalf of the hospital, determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant; or
  5. There are other facts or circumstances that, in the estimation of the Department Chair, call into question the appropriateness of expedited approval.
- b. Following the favorable evaluation of the Department Chair, the Chair of the Credentials Committee, acting on behalf of the Credentials Committee, is empowered to review the application and make a recommendation. If the recommendation is favorable, the application will be forwarded to the Medical Executive Committee. The action will be reported to the Credentials Committee at its next regularly scheduled meeting.
  - c. The application will be forwarded to a duly authorized subcommittee of the Medical Executive Committee. The subcommittee must include at least two voting members of the Medical Executive Committee. The action will be reported to the committee at its next regularly scheduled meeting. If the Medical Executive Committee's recommendation is adverse or has limitations, the application is ineligible for expedited consideration by the Community Ministry Board.
  - d. If the recommendation is favorable, the application will be forwarded to a duly authorized subcommittee of the Community Ministry Board for expedited action. The subcommittee must include at least two voting members of the Community Ministry Board. The action will be reported to the Community Ministry Board at its next regularly scheduled meeting.

#### **4.6 REAPPOINTMENTS AND REQUESTS FOR MODIFICATION OF STAFF STATUS OR PRIVILEGES**

##### **4.6-1 Application**

- a. In the year of expiration, at least one hundred and thirty-five (135) days prior to the expiration of Medical Staff membership and/or clinical privileges excluding temporary privileges, an application form for reappointment consistent with Section 4.5 shall be emailed or delivered to the member. If an application for reappointment is not received at least ninety (90) days prior to the expiration date, written notice shall be promptly sent to the applicant advising that the application has not been received. Each Medical Staff member shall submit to the Medical Staff Office the completed application form for renewal of appointment to the staff and for renewal and/or revision of clinical privileges at least seventy-five (75) days prior to the expiration of Medical Staff membership and/or privileges. If extenuating circumstances prohibit submission of the application within seventy-five (75) days of expiration, a fifteen (15) day extension may be made for good cause. Failure to do so submit the application within these timeframes shall be interpreted as a voluntary resignation of membership and clinical privileges effective the date of expiration of the current appointment. The member shall bear the burden of submitting additional information as set forth in Section 4.2. Upon receipt of a complete application, it shall be processed as set forth commencing at Section 4.5-3.
- b. A Medical Staff member who seeks a change in Medical Staff status or modification of clinical privileges may submit such a request at any time, except that such application may not be filed within one (1) year of the time a similar request has been denied, absent a showing of good cause.

##### **4.6-2 Effect of Application**

The effect of an application for reappointment or modification of staff status or privileges is the same as that set forth in Section 4.5-1 through 4.5-8.

##### **4.6-3 Standards of Procedure for Review**

When a staff member submits the first application for reappointment, and every two (2) years thereafter, or when the member submits an application for modification of staff status or clinical

privileges, the member shall be subject to an in-depth review generally following the procedures set forth in Section 4.5. In each such instance, the member's eligibility for Medical Staff membership as set forth in Article II, and the member's eligibility for assignment to a category of the Medical Staff as set forth in Article III, shall be redetermined. With the exception of Affiliate and Emeritus Medical Staff members, a member who has failed to engage in patient care or Medical Staff activities for the preceding two (2) years shall be ineligible to apply for reappointment or modification of staff status or privileges, and the procedures set forth in Article VII shall not apply. Exceptions to 4.6-3 may be made by the Medical Executive Committee for good cause.

#### **4.6-4 Limited Reappointment**

If it appears that an application for reappointment will not be fully processed by the expiration date of the member's appointment for reasons other than due to the applicant's failure to return documents or otherwise cooperate with reappointment process in a timely manner, the Medical Executive Committee and the Governing Body may grant temporary privileges if an important patient care need exists. Any time-limited reappointment pursuant to this section does not create a vested right in the member for continued appointment through the entire next term but only until such time as processing of the full reapplication is concluded. The member shall continue to be subject to the reappointment review process as outlined in Section 4.5.1 through 4.5-8. Failure by the member to timely complete and return the reappointment application form or provide other documentation or cooperation will result in termination of the member's appointment.

#### **4.6-5 Failure to File Reappointment Application**

Failure to timely file a completed application for reappointment and/or provide required documentation shall result in the automatic expiration of Medical Staff membership and/or privileges at the end of the current staff appointment. In the event membership and/or privileges expire as set forth herein, the procedures set forth in Article VII shall not apply.

### **4.7 LEAVE OF ABSENCE**

#### **4.7-1 Leave Status**

At the discretion of the Medical Executive Committee, a Medical Staff member may obtain a voluntary leave of absence from the staff upon submitting a written request to the Medical Executive Committee stating the approximate period of leave desired, which may not exceed one (1) year. During the period of the leave, the member shall not exercise clinical privileges at the hospital and membership rights and responsibilities shall be inactive, but the obligation to pay dues shall continue unless waived by the Medical Staff. Periods of leave shall not be considered in calculating a member's satisfaction of requirements relating to patient care and Medical Staff activities.

#### **4.7-2 Medical Leave of Absence**

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

#### **4.7-3 Termination of Leave**

At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff member may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee. The staff member shall submit a summary of relevant activities during the leave. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the member's privileges and prerogatives, and follow the reappointment procedures described in Article IV.

#### **4.7-4 Failure to Request Reinstatement**

Failure to timely request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership and privileges. A member who is so terminated shall be entitled to the procedural rights provided in Article VII for the sole purpose of determining whether the failure to request reinstatement was excusable. A request for Medical Staff membership subsequently received from a member so terminated shall be treated as an application for initial appointment.

#### **4.7-5 Notification and Update to the Medical Staff**

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

- a. Receipt of written notice of any adverse action by the Medical Board of California taken or pending, including but not limited to a temporary restraining order, or imposition of any interim suspension, probation, or limitations affecting license to practice medicine or the practitioner's designated profession.
- b. Any action taken by any health care organization which has resulted in the filing of a Section 805 report with the Medical Board of California or a report with the National Practitioner Data Bank.
- c. The denial, revocation, suspension, reduction, limitation on renewal, or voluntary relinquishment by resignation of Medical Staff membership or clinical privileges at any health care organization.
- d. Any material reduction in professional liability coverage including changes in the scope of coverage.
- e. Receipt of notice of any legal action related to a filed or served malpractice suit or malpractice-related arbitration action.
- f. Conviction of any crime excluding minor traffic violations.
- g. Receipt of any proposed or actual exclusion or adverse action under Medicare or Medicaid programs or any other federally funded or state health care programs including but not limited to fraud and abuse proceedings or convictions.

## **ARTICLE V CLINICAL PRIVILEGES**

### **5.1 EXERCISE OF PRIVILEGES**

A member or other person providing clinical services at this hospital shall be entitled to exercise only those clinical privileges specifically granted. Said privileges must be hospital specific and within the scope of the person's license, certificate or other legal credential authorizing practice in this State. Clinical privileges shall be granted using the same process as for appointment and reappointment but will be exercised pursuant to the rules and regulations of the appropriate clinical department, and subject to the authority of the department chairpersons and the Medical Executive Committee.

### **5.2 MEDICAL RECORDS**

#### **5.2-1 History and Physical**

It is the responsibility of the Medical Staff to assure that a medical history and appropriate physical examination (H&P) is performed on patients being admitted for inpatient care, as well as prior to operative and complex invasive procedures in either an inpatient or outpatient setting.

Patients requiring an H&P will receive a full H&P, an abbreviated H&P, or an update note as set forth in these rules and regulations by a Medical Staff member with appropriate privileges. A history and physical which has been performed by someone who is not authorized/privileged by the Medical Staff/Hospital may be used provided that a Medical Staff member with the appropriate privileges reviews the history and physical examination document, conducts a second assessment to confirm the information and findings, updates any information and findings as necessary (including a summary of the patient's condition and course of care during the interim period) and the current physical/psychosocial status and signs, dates and times the information as an attestation to it being current.

The history and physical must be physically present prior to surgery, either on the paper record or in the electronic medical record (EMR). When the history and physical examination report is not recorded before any elective operation or any potentially hazardous diagnostic procedure, the procedure will not proceed until the appropriate history and physical documentation has occurred. If this does not occur, the procedure will be canceled.

#### **5.2-2 History and Physical Content Criteria**

The minimum required content of each H&P is noted below:

- a. A full H&P is defined as an H&P that contains the following data elements:
  1. A chief complaint; reason for admission
  2. Details of the present illness
  3. Past medical and surgical history
  4. Relevant past psycho-social history (appropriate to the patient's age)
  5. Relevant past Family History
  6. A physical examination inventoried by body systems. Unless relevant to the chief complaint or necessary to establish diagnosis, a pelvic and/or rectal exam need not be performed
  7. A statement on the conclusions or impressions drawn from the history and physical examination

8. A statement on the course of action planned for the patient for that episode of care
- b. An abbreviated H&P is defined as an H&P that contains the following data elements:
    1. A chief complaint
    2. Details of present illness
    3. Relevant past medical and surgical history pertinent to the operative or invasive procedure being performed
    4. Relevant past psycho-social history pertinent to the operative or invasive procedure being performed
    5. A relevant physical examination of those body systems pertinent to the operative or invasive procedure performed, but including at a minimum an appropriate assessment of the patient's cardio-respiratory status
    6. A statement on the conclusions or impressions drawn from the history and physical examination
    7. A statement on the course of action planned for the patient for that episode of care
  - c. An update note is defined as a statement entered into the patient's medical record that the H&P was reviewed, the patient was examined, and that,
    1. There are no significant changes to the findings contained in the H&P since the time it was performed, or
    2. There are significant changes and such changes are subsequently documented in the patient's medical record.
  - d. While it is recommended that the update note be documented on or appended to the H&P, documentation may be entered anywhere in the medical record. For patients undergoing outpatient surgical or complex invasive procedures, the performance of a pre-anesthesia/sedation assessment that includes a pertinent history and physical examination may be considered an update note to the H&P provided the assessment was performed on the day of the surgery or the procedure and after the patient was admitted.

The requirement as to which type of H&P must be performed, and associated time frames are noted in the following table:

PATIENT TYPE	H&P REQUIREMENTS
Inpatient Admission Except OB Admissions for Vaginal Delivery	<p>A full H&amp;P is required. The H&amp;P must be completed no more than 30 days prior to admission or within 24 hours after admission.</p> <p>If the H&amp;P is performed within 30 days prior to admission, an update note must be entered into the record within 24 hours after admission.</p>

PATIENT TYPE	H&P REQUIREMENTS
Inpatient Surgical Procedure	<p>A full H&amp;P is required. If the surgery is performed more than 24 hours after admission, the admission H&amp;P is considered the surgical procedure H&amp;P as well. No update is needed since the physician progress notes constitute an “updating” of the patient’s condition.</p> <p>If surgery is to be performed within the first 24 hours of admission, but an admission H&amp;P has not been done, an H&amp;P must be completed on the day of surgery prior to the start of the procedure and after the patient is admitted. In an emergent situation, the H&amp;P should be completed as soon as possible after surgery.</p> <p>If surgery is to be performed within the first 24 hours of admission, and an H&amp;P was performed prior to admission, an update note must be entered into the record on the day of surgery prior to the start of the procedure and after the patient is admitted. In an emergent situation, the update note should be completed as soon as possible after surgery.</p>
Outpatient Surgical Procedure	<p>A full or abbreviated H&amp;P is required. The H&amp;P must be completed no more than 30 days prior to surgery or on the day of surgery prior to the start of the procedure and after the patient is admitted. If the H&amp;P was performed within 30 days prior to surgery, an update note must be entered into the record on the day of surgery prior to the start of the procedure and after the patient is admitted.</p>
Outpatient Complex Invasive Procedure	<p>A full or abbreviated H&amp;P is required. The H&amp;P must be completed no more than 30 days prior to the procedure or on the day of the procedure prior to the start of the procedure and after the patient is admitted.</p> <p>If the H&amp;P was performed within 30 days prior to the procedure, an update note must be entered into the record on the day of the procedure prior to the start of the procedure and after the patient is admitted.</p>
Observation Patient (non-surgical)	<p>A full or abbreviated H&amp;P is required. The H&amp;P must be completed no more than 30 days prior to admission or within 24 hours after admission.</p> <p>If the H&amp;P was performed within 30 days prior to admission, an update note must be entered into the record within 24 hours after admission.</p>
OB Admissions for Vaginal Deliveries	<p>A full H&amp;P, abbreviated H&amp;P, or the patient’s prenatal record is required. The H&amp;P must be completed no more than 30 days prior to admission or within 24 hours after admission.</p> <p>If the H&amp;P is performed within 30 days prior to admission, an update note must be entered into the record within 24 hours after admission.</p> <p>If the patient’s prenatal record is used in lieu of an H&amp;P, the last entry on the prenatal record must be within 30 days of admission and an update note must be entered into the record within 24 hours after admission. The prenatal record must be legible and transferred to the hospital before admission. Otherwise, an H&amp;P must be done.</p> <p>Completion of the newborn record shall constitute an adequate medical history and physical assessment for newborns.</p>

### 5.2-3 Oral and Maxillofacial Surgeons

Oral and Maxillofacial Surgeons may perform an H&P if they possess the clinical privileges to do so in order to assess the medical, surgical, and/or anesthetic risks of the proposed operative and/or other procedure.

### 5.2-4 Dentists and Podiatrists

Doctors of dentistry or podiatry are responsible for that part of the patient’s history and physical examination that relate, respectively, to dentistry and podiatry whether or not they are granted clinical privileges to take a complete history and perform a complete examination. Doctors of dentistry or podiatry may perform a complete H&P if they possess the clinical privileges to do so.

If the Dentist or Podiatrist does not possess such privileges, then a qualified Physician must perform the H&P.

#### **5.2-5 Licensed Dependent Practitioners**

If a licensed dependent practitioner (e.g. physician assistant, nurse practitioner, etc.) is granted privileges to perform part or all of an H&P, the findings and conclusions are confirmed or endorsed by a qualified Physician.

### **5.3 DELINEATION OF PRIVILEGES IN GENERAL**

#### **5.3-1 Requests**

Each application for appointment and reappointment to the Medical Staff, or for clinical privileges, must contain a request for the specific clinical privileges desired by the applicant. Limited licensed practitioners who seek to exercise clinical privileges must specifically delineate the privileges desired.

#### **5.3-2 Basis for Privilege Determinations**

- a. Not all clinical privileges are exercised at this hospital. Requests for privileges not exercised at this hospital cannot be considered.
- b. Requests for clinical privileges shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance, current health status and the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges.
- c. The burden of providing sufficient information to evaluate a request rests with the applicant. The provisions of Section 4.2 apply to requests for privileges.

### **5.4 PROCTORING**

#### **5.4-1 General Provisions**

Any member of the Medical Staff in good standing who has completed his or her proctoring requirements may act as a proctor at the request of the department chairperson. All initial appointees to the Medical Staff and limited licensed practitioners granted new independent clinical privileges shall be assigned to the appropriate department where performance of an appropriate number of cases shall be observed during a period as specified in the Medical Staff rules and regulations or Medical Staff policy. Proctoring is mandatory for all practitioners. New clinical privileges granted to an existing Medical Staff member shall be proctored as determined by the Medical Executive Committee. Absent a showing of good cause, the period of proctoring shall be not more than one (1) year. The department may utilize proctoring reports from other accredited hospitals, providing that:

- a. the proctoring occurred within the last four (4) years;
- b. the proctoring reports are complete as determined by the Department Chairperson; and
- c. copies of the original proctoring reports are retained in the applicant's credential file. Retrospective chart review may be used solely to evaluate the competency of non-procedural practitioners. Departmental review of procedural practitioners by a member of the department will use a combination of methods: retrospective, concurrent, and proctoring, with the requirement for at least one concurrent observation of care. The Medical Executive Committee may impose additional consultation, monitoring or proctoring requirements as a



condition of granting a privilege. A practitioner shall remain subject to the proctoring requirement until the Medical Executive Committee:

- d. has been furnished with a report from the chairperson of the department to which the member is assigned describing: 1) the types and numbers of cases observed, 2) an evaluation of the applicant's performance, 3) that the applicant meets the qualifications for unsupervised practice for specific clinical privileges, 4) that the applicant has discharged all the responsibilities of Medical Staff membership; and
- e. has been furnished with a report signed by the chairperson of the other department(s) in which the appointee has exercised clinical privileges, describing the types and number of cases observed and the evaluation of the applicant's performance and a statement that the member has satisfactorily demonstrated the ability to exercise these specific clinical privileges; and
- f. has determined that any relevant conditions which it has imposed have been satisfied; and
- g. at least one (1) case has been reviewed from this institution.

#### **5.4-2 Failure to Complete Proctoring Requirements**

If, (1) an initial appointee fails to be relieved of a proctoring requirement, or (2) if an individual exercising a new clinical privilege fails to be relieved of a proctoring requirement, due solely to the appointee or individual's failure to perform the required number or type of procedures within one (1) year of the initial granting of said privileges, the Medical Executive Committee may, at its sole discretion, extend the time for proctoring for an additional period of up to one (1) year, for good cause shown. If the Medical Executive Committee declines to so extend the time for proctoring, all such clinical privileges shall automatically expire and the provisions of Article VII shall not apply.

If an initial appointee fails to be relieved of a proctoring requirement, or if an individual exercising a new clinical privilege fails to be relieved of a proctoring requirement for any medical disciplinary cause or reason, the failure will constitute a termination of the clinical privilege(s) in question and the provisions of Article VII shall apply.

#### **5.4-3 Medical Staff Advancement**

The failure to be relieved of a proctoring requirement for any specific clinical privilege shall not, of itself, preclude advancement in Medical Staff category.

### **5.5 LIMITATIONS ON PRIVILEGES OF DENTISTS AND LIMITED LICENSED PRACTITIONERS**

#### **5.5-1 Dentists and Podiatrists**

The following general provisions shall apply to dentists and podiatrists:

- a. admitting and other clinical privileges of dentists, and podiatrists may not exceed the scope of their licensure;
- b. patients admitted by dentists and podiatrists must receive all necessary and appropriate medical evaluations and care;
- c. any dispute between a dentist or podiatrist and a physician member regarding proposed treatment must be promptly resolved by the department chairperson; and
- d. for an inpatient admission by a dentist or podiatrist, a physician member of the Medical Staff must conduct or directly supervise the admitting history and physical examination and assume

responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the dentist/podiatrist's scope of licensure or privilege.

#### **5.5-2 Limited Licensed Practitioners**

The following general provisions apply to all limited licensed practitioners:

- a. limited licensed practitioners shall not admit patients or otherwise exceed the scope of their licensure and clinical privilege; and
- b. a physician member is primarily responsible for the care of each patient to whom a limited licensed practitioner provides care.

### **5.6 TEMPORARY CLINICAL PRIVILEGES**

#### **5.6-1 Requirement of Need**

- a. Care of a Specific Patient: Temporary privileges may be granted for a specified period, not to exceed sixty (60) days, to a physician, dentist, or podiatrist for the care of a specific patient. No individual shall be granted such privileges on more than three (3) occasions per calendar year.
- b. Pending Completion of the Credentialing Process: Temporary privileges may be granted for a specified period, not to exceed one hundred twenty (120) days, to an applicant for Medical Staff membership whose services are required to maintain or enhance the quality of care of the hospital.

#### **5.6-2 Application and Review**

- a. Pending Completion of Application Process: Temporary privileges for new applicants may be granted while awaiting review and approval of the Medical Staff Executive Committee and the Governing Body, upon verification of the following: current licensure, relevant training or experience, current competence, ability to perform the privileges requested, other criteria required by the Organized Medical Staff Bylaws, a query and evaluation of the National Practitioner Data Bank information, a complete application, no current or previously successful challenge to licensure or registration, no subjection to involuntary termination of medical staff membership at another organization, no subjection to involuntary limitation, reduction, denial, or loss of clinical privileges.
- b. Care of a Specific Patient/Locum Tenens: Upon receipt of a completed Medical Staff application and a request for temporary privileges related to 5.5-1 I or a temporary privilege application related to 5.5-1 (a) through (b), and all required fees and supporting documentation, including responses to all requests for information from a physician, dentist, or podiatrist who is authorized to practice in California, and who meets one of the requirements for need of Section 5.5-1, the Governing Body administrative representative may grant temporary privileges to an individual who appears to have qualifications, ability and judgment consistent with Section 2.2-1, but only after:
  - 1. the passage of a minimum of seven (7) days to permit verification of information, although exceptions may be made for good cause;
  - 2. primary source verification in writing or through a documented telephone conversation of licensure status, current competence, and insurance status is obtained. A National Practitioner Data Bank query should also be submitted;

3. the appropriate Department Chairperson or designee has interviewed the applicant and has contacted at least one (1) person who:
  - i. has recently worked with the applicant;
  - ii. has directly observed the applicant's professional performance over a reasonable time; and provides reliable information regarding the applicant's current professional competence, ethical character, and ability to work well with others so as not to adversely affect patient care.
4. all practitioners requesting temporary privileges pursuant to Section 5.5-1(a) must demonstrate active staff membership at an accredited hospital, although exceptions may be made by the Chief of Staff or designee for good cause;
5. written or verbal concurrence has been obtained from the chairperson or designee of each department from which the applicant is requesting privileges;
6. the applicant's file, including the recommendation of the department chairpersons or designee, is reviewed on behalf of the Medical Executive Committee by the Chief of Staff or designee; and
7. the Chief of Staff or designee recommends and the Governing Body, through the Chief Executive, concurs in the granting of temporary privileges.
- c. In the event of a disagreement between the Governing Body and the Medical Executive Committee regarding the granting of temporary clinical privileges, the matter shall be referred to the Medical Staff Joint Conference Committee for resolution.
- d. The omission of any information, response or recommendation specified in this section shall preclude the granting of temporary privileges.

#### **5.6-3 General Conditions**

- a. Temporary privileges shall be exercised under the supervision of the chairperson of each department to which the applicant has been assigned. The applicant shall ensure that the chairperson, or the chairperson's designee, is kept closely informed as to the applicant's activities within the hospital.
- b. All temporary privileges are time limited and shall automatically terminate at the end of the designated period. The provisions of Article VII shall not apply to such termination.
- c. Requirements for proctoring will be required for all practitioners granted temporary privileges. The requirements shall be determined by the Chief of Staff after consultation with the chairperson of any department to which the applicant is assigned.
- d. All persons requesting or receiving temporary privileges shall be bound by the Bylaws and Rules and Regulations and policies of the Medical Staff.

#### **5.7 EMERGENCY PRIVILEGES**

- a. In the case of an emergency, any physician, to the degree permitted by his or her license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The physician shall make every reasonable effort to communicate promptly with the appropriate department chairperson concerning the need for emergency care and assistance by members of the Medical Staff with appropriate clinical privileges; and, once the emergency has passed or assistance has been made available, shall defer to the department chairperson with respect to further care of the patient at the hospital.

- b. In the event of an emergency, any non-physician shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such non-physicians shall promptly yield such care to qualified members of the Medical Staff when it becomes reasonably available.

## **5.8 DISASTER PRIVILEGES**

In times of a local, state, or national disaster emergent situation, it may become necessary to grant disaster privileges to external physicians to help care for an unusually high number of critically ill patients.

Practitioners who are not members of the consolidated Medical Staff at Providence St. Joseph Hospital and who do not possess Medical Staff privileges may be practicing at Providence St. Joseph Hospital during an “emergency” (defined as any officially declared emergency, whether it is local, state, or national).

Any practitioner providing patient care must be granted privileges prior to providing patient care, even in a disaster situation.

Disaster privileges may only be granted to a licensed independent practitioner (LIP) when the following two criteria have been met:

1. The organization’s emergency management plan has been formally activated, and;
2. The organization is unable to meet immediate patient needs.

An individual who presents as a volunteer LIP should be directed to the Medical Staff pool or other area as designated by the emergency management Command Center. Granting of disaster privileges must be authorized by the Chief of Staff, or the Disaster Medical Director, or authorized designee. Disaster privileges will be granted on a case by case basis.

A volunteer LIP must present a valid government issued photo identification issued by a state or federal agency (e.g., driver’s license or passport). In addition, the volunteer LIP must provide at least one of the following:

1. A current hospital picture identification card that clearly identifies the individual’s professional designation.
2. Current and valid professional license to practice in California or other state license with primary source verification of that license.
3. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organization or group(s).
4. Identification indicating that the individual has been granted authority to render patient care, treatment, or services in disaster circumstances (such as authority having been granted by a federal, state or municipal entity).
5. Identification by a current member of the organization or Medical Staff who possesses personal knowledge regarding the individual’s ability to act as a LIP during a disaster, and each of the following:
6. Information regarding current malpractice carrier.
7. List of current hospital affiliations where the practitioner holds Active Staff privileges.
8. All necessary information required to conduct a NPDB query and complete the Temporary Disaster Privileges Request Form.

Volunteer LIPs will be identified by a name badge or tag provided by the organization. The badge/tag will list the name and professional designation of the volunteer (e.g., John Smith, MD), as well as the notation that the individual is a volunteer. The volunteer LIP will be required to wear the badge/tag on his or her person while performing in that role/capacity.

As soon as the immediate situation is under control, the organization should obtain primary source verification of the volunteer LIP's license and above information within seventy-two (72) hours from the time the volunteer LIP presented to the organization. In extraordinary circumstances (e.g., no means of communication or a lack of resources), verification may exceed seventy-two (72) hours, but must be completed as soon as possible by the Medical Staff Services Department. A record of this information should be retained.

Primary source is the entity or agency that has the legal authority to issue the credential in question. If the entity or agency has designated another entity or agency to communicate information about the status of a staff member's credential, then the other entity or agency may be considered the primary source.

Volunteer LIPs will be assigned to a member of the Medical Staff who is a peer in the volunteer's area of practice and experience. The Medical Staff member will serve as a mentor and resource for the volunteer practitioner. The Medical Staff member will be responsible for overseeing the professional performance of the volunteer LIP. This may be accomplished by:

1. Direct observation
2. Clinical review of care documented in the patient's medical record.

Volunteer LIPs will cease providing care, treatment, or service if any one of the following criteria is met:

1. Implementation of the emergency management plan ceases,
2. The capability of the organization's staff becomes adequate to meet patient care needs,
3. A decision is made that the professional practice of the volunteer LIP does not meet professional standards.

## **5.9 LAPSE OF APPLICATION**

If a Medical Staff member requesting initial privileges, renewal of existing privileges or modification of existing privileges or department assignments fails to furnish the information necessary to evaluate the applicant within one hundred and twenty (120) days of being requested to do so by the Medical Staff, the application shall automatically lapse and the applicant shall not be entitled to a hearing as set forth in Article VII. The applicant may file a new application with the supporting information. Exceptions to this provision may be made by the Medical Executive Committee for show of good cause.

**ARTICLE VI**  
**CORRECTIVE ACTION INVESTIGATION AND CORRECTIVE ACTION**

**6.1 CORRECTIVE ACTION INVESTIGATION AND NON-SUMMARY ACTION**

**6.1-1 Criteria for Initiation of Corrective Action Investigation**

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members or limited license practitioners who exercise clinical privileges. When reliable information indicates a member may have exhibited acts, demeanor, or conduct which is reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care services; (2) compromising to the ability of other members, hospital employees, or others to deliver quality patient care; (3) unethical; (4) contrary to Medical Staff Bylaws, Rules and Regulations or represent a failure to meet a significant obligation which was voluntarily undertaken, such as an agreement to provide Emergency Department specialty coverage; or (5) below applicable professional standards, a request for an investigation may be initiated by the Chief of Staff, a department chairperson, the Medical Staff Executive Committee, or the Chief Executive.

**6.1-2 Initiation of Corrective Action Investigation**

A request for an investigation by other than the Medical Executive Committee must be submitted to the Medical Executive Committee in writing and must make reference to specific activities or conduct upon which the request is based. If the Medical Executive Committee elects to initiate an investigation, it shall make an appropriate recordation of the request and its basis. The Medical Executive Committee may deny a request for a formal investigation and the matter may be dismissed by the Medical Executive Committee or referred for review through other existing Medical Staff mechanisms, including but not limited to, established quality assurance and improvement and peer review processes.

**6.1-3 Corrective Action Investigation**

If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself, or may assign the task to an appropriate Medical Staff officer, staff department, or standing or ad hoc committee. The Medical Executive Committee may appoint practitioners who are not members of the Medical Staff as temporary members for the purpose of conducting or aiding in the conduct of an investigation. The investigation shall be conducted promptly. The individual who is the subject of the investigation shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may conduct interviews and request documents. Should the individual who is the subject of the investigation fail to cooperate or otherwise impede the investigation, such conduct shall itself be sufficient grounds for immediate termination of Medical Staff membership and privileges. An investigation shall not constitute a "hearing" and the provisions of Article VII shall not apply. At all times, the Medical Executive Committee shall retain authority and discretion to take action as may be warranted by the circumstances, including summary suspension, termination of the investigation process, or other action.

**6.1-4 Corrective Action**

As soon as practicable after the conclusion of the investigation, a written report of the investigation shall be submitted to the Medical Executive Committee. After consideration of the report, the Medical Executive Committee shall take corrective action by:

- a. determining no further action;
- b. deferring action to obtain additional information;

- c. issuing, in accordance with Section 14.9, a letter of admonition, censure, or warning (“letter of reprimand”) with inclusion of copies, of the letter, in the practitioner’s credential file. In the event such a letter of reprimand is issued by the Medical Executive Committee, the affected individual may make a written response which shall be placed in the individual’s credential file pursuant to Section 14.9. The Medical Executive Committee must authorize the issuance of the letter of reprimand and also authorize that the letter be inserted into the practitioner’s credential file. Nothing herein shall be deemed to preclude department chairpersons or the Medical Executive Committee from issuing an informal written or oral warning outside of the mechanism for formal issuance of a letter of reprimand or initiation of an investigation as defined in these Bylaws.
- d. recommending the imposition of terms of probation or special conditions for continued Medical Staff membership or the exercise of clinical privileges, including, without limitation, requirements for co-admission, mandatory consultation or monitoring;
- e. recommending reduction, modification, suspension or revocation of clinical privileges;
- f. recommending reduction of membership status or limitation of any prerogatives directly related to the member’s delivery of patient care;
- g. recommending suspension, revocation or probation of Medical Staff membership; and
- h. taking other actions deemed appropriate under the circumstances.

#### **6.1-5 Subsequent Action**

If corrective action as set forth in Section 7.2 is recommended by the Medical Executive Committee, the recommendation shall be transmitted to the Governing Body and the provisions of Article VII shall apply.

#### **6.1-6 Initiation by the Governing Body**

If the Medical Executive Committee fails to investigate or take corrective action, contrary to the weight of the evidence, the Governing Body may direct the Committee to initiate a corrective action investigation or take corrective action, but only after consultation with the Medical Executive Committee. If the Medical Executive Committee fails to follow the Governing Body’ direction, the Governing Body may initiate a corrective action investigation and take corrective action. Such corrective action investigation and action must comply with Articles VI and VII.

### **6.2 SUMMARY ACTION**

#### **6.2-1 Criteria for Initiation**

Whenever the conduct of a member or limited licensed practitioner may result in an imminent danger to the health of any person or whenever his or her conduct either is, or could become, unacceptably disruptive to the operations of the Hospital or the Medical Staff, the Chief of Staff, the Medical Executive Committee, or the chairperson of the department in which the individual holds privileges, may summarily restrict or suspend the Medical Staff membership or clinical privileges of that practitioner. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the restricted or suspended individual, the Governing Body, the Medical Executive Committee, and the Chief Executive. The summary restriction or suspension may be limited in duration and shall remain in effect for the stated time or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member’s patients shall be promptly assigned to another member by the chairperson or by the Chief of Staff considering, where feasible, the wishes of the patient in the choice of a substitute member.

#### **6.2-2 Medical Executive Committee Action**

Within five (5) days after the summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee shall be convened to review and consider the action. The restricted or suspended individual shall be given notice of the meeting and may attend for the purpose of making a statement and responding to questions. The meeting shall not constitute a hearing and the provisions of Article VII shall not apply. At the conclusion of the meeting, the Medical Executive Committee shall modify, continue, or terminate the summary restriction or suspension and shall furnish the restricted or suspended member with notice of its decision as soon as reasonably possible.

#### **6.2-3 Procedural Rights**

After the practitioner is advised of the decision of the Medical Executive Committee, the restricted or suspended individual shall be entitled to the procedural rights afforded by Article VII. The institution of a summary suspension shall be deemed an interim precautionary action and not a final professional peer review action. The institution of a summary suspension shall not imply any final finding of responsibility for the situation that caused the suspension.

#### **6.2-4 Initiation by the Governing Body**

If no authorized person is available to summarily restrict or suspend membership or clinical privileges, the Governing Body may immediately suspend membership and/or privileges if a failure to do so may result in an immediate danger to the health of any person. Such a suspension is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within five (5) working days, excluding weekends and holidays, the summary suspension shall terminate automatically.

### **6.3 AUTOMATIC SUSPENSION OR LIMITATION**

In the following instances, privileges or membership may be revoked, suspended or limited as described.

#### **6.3-1 Licensure**

- a. **Revocation and Suspension:** Whenever a practitioner's license or other legal credential authorizing practice in this State is revoked or suspended, Medical Staff membership and/or clinical privileges shall be automatically revoked as of the date such action becomes available. Should the practitioner's license be allowed to expire, membership and privileges shall be suspended until such time as the license is renewed. Failure after written notice to provide a current license or other legal credential authorizing practice in the State of California within ninety (90) days after the suspension shall be deemed to be a voluntary resignation from the Medical Staff.
- b. **Restriction:** Whenever a member's license or other legal credential authorizing practice in this State is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the member has been granted at the hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
- c. **Probation:** Whenever a member is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.



### **6.3-2 Controlled Substances**

- a. Whenever a member's Drug Enforcement Administration certificate or State Controlled Substance certificate is revoked, limited or surrendered, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term. Should the practitioner's State Controlled Substance and Federal DEA certificate expire, the right to prescribe medications covered by the certificate shall be suspended until such time as the DEA is renewed. Failure after written notice to provide a current State Controlled Substance certificate and/or Federal DEA certificate within ninety (90) days after the suspension shall be deemed to be a voluntary withdrawal of the divested right to prescribe medications covered by the certificates.
- b. Probation: Whenever a member's Drug Enforcement Administration certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

### **6.3-3 Professional Liability Insurance**

Failure to maintain professional liability insurance, as required, shall be grounds for an automatic suspension of a practitioner's clinical privileges and if within ninety (90) days of written warning of the delinquency, the practitioner does not provide evidence of the required professional liability insurance, the practitioner's membership shall automatically be terminated.

### **6.3-4 Exclusion from Federal and State Health Care Programs**

Whenever a practitioner is excluded from any federal or state healthcare program, immediate termination of Medical Staff membership and all clinical privileges shall occur as of the date said exclusion becomes known.

A practitioner whose membership and/or clinical privileges have been terminated or restricted under this section shall not be entitled to the procedural rights afforded by Article VII. The practitioner shall be entitled to present evidence to the Medical Executive Committee solely on the issue of whether he or she was excluded from a Federal or State healthcare program. Nothing in this section shall preclude the Medical Staff from investigating the circumstances of any exclusion from a Federal or State program or from taking additional corrective action under these Bylaws, should circumstances so warrant such action.

### **6.3-5 Failure to Satisfy Special Attendance Requirement**

Failure of a practitioner, without good cause, to appear and satisfy the requirements of Section 12.8 (b) (c) shall be a basis for corrective action.

### **6.3-6 Medical Records**

Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the Medical Executive Committee. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed shall be imposed by the Chief of Staff, or his or her designee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this Section, "related privileges" means scheduling surgeries, assisting in surgery, consulting on hospital cases, voluntary "on-call" services to the Emergency Department and providing professional services within the hospital for future patients. Bona fide vacation or illness may constitute an excuse subject to approval by the Medical Executive Committee. Members whose privileges have been suspended for delinquent records may be granted temporary privileges to admit patients in life threatening situations. The suspension shall continue until lifted by the Chief of Staff or his or her designee.

### **6.3-7 Failure to Pay Dues/Assessments**

Failure without good cause as determined by the Medical Executive Committee to pay dues or assessments as required under Section 14.2 shall be grounds for automatic suspension of a member's clinical privileges. If within six (6) months, after written warning of the delinquency, the member does not pay the required dues or assessments, the member's membership shall be automatically terminated.

### **6.3-8 Medical Executive Committee Deliberation**

As soon as practical after action is taken or warranted as described in Sections 6.3-1 through 6.3-5, the Medical Staff Executive Committee shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth commencing at Section 6.1.

## **ARTICLE VII HEARINGS AND APPELLATE REVIEWS**

### **7.1 PREAMBLE AND DEFINITIONS**

#### **7.1-1 Intra-organizational Remedies**

The intra-organizational remedies and the hearing and appellate review bodies provided for in this Article VII are strictly quasi-judicial in structure and function and said bodies shall have no power or authority to hold quasi-legislative, notice and comment type hearings or to make legislative determinations, or determinations as to the substantive validity of bylaws, rules, regulations, or other intra-organizational legislation. Notwithstanding the foregoing, the Governing Body otherwise may entertain challenges to the substantive validity of intra-organizational legislation and in all proper cases shall hear and decide those questions. Where the substantive validity question is the sole issue, the petitioner may be permitted a direct meeting, in the first instance, with the Governing Body or its Executive Committee. The final determination by the body conducting such meeting shall be a condition precedent to petitioner's right to seek judicial review in a court of law.

#### **7.1-2 Exception of Hearing Rights**

The procedures described herein do not apply to a practitioner or limited license practitioner whose application for Medical Staff membership or privileges was denied on the basis that the privileges he or she seeks are the subject of an agreement or arrangement providing for exclusive or limited access to a particular department. Such practitioners shall have the right, however, to request that the Governing Body review the denial and the Governing Body shall have the discretion to determine whether to review such a request and, if it decides to review the request, to determine whether the practitioner may personally appear before and/or submit a statement in support of his or her position.

#### **7.1-3 Exhaustion of Remedies**

If an adverse ruling is made with respect to a practitioner's staff membership, staff status, or clinical privileges at any time, regardless of whether he/she is an applicant or a Medical Staff member, he/she must exhaust the intra-organizational remedies afforded by these Bylaws before resorting to formal legal action challenging the decision, the procedures used to arrive at it, or asserting any claim against the Hospital or participants in the decision-making process.

#### **7.1-4 Definitions**

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

- a. Body whose decision prompted the hearing refers to the Executive Committee in all cases where the Executive Committee or authorized officers, members or committees of the Medical Staff took the action or rendered the decision which resulted in a hearing being requested; and refers to the Governing Body in all cases where the Governing Body or authorized officers, directors or committees of the Governing Body took the action or rendered the decision which resulted in a hearing being requested.
- b. Notice refers to a written communication delivered personally to the required addressee or sent by United States Postal Service First-class postage prepaid, certified or registered mail, return receipt requested, addressed to the required addressee at the address as it appears in the records of the Hospital.
- c. Practitioner refers to the practitioner who has requested a hearing pursuant to Section 7.3 of these Bylaws.

- d. Date of Receipt of any notice or other communication shall be deemed to be the date such notice or communication was delivered personally to the required addressee or, if delivered by mail, such notice or communication shall be deemed received forty-eight (48) hours after being deposited, postage prepaid, in the United States mail in compliance with paragraph (b) of this Section 7.1.4.

## **7.2 GROUNDS FOR A HEARING**

Any one or more of the following actions or recommended actions shall constitute grounds for a hearing unless otherwise expressly provided in these Bylaws:

- a. denial of Medical Staff membership;
- b. denial of requested advancement in Medical Staff membership status;
- c. denial of Medical Staff reappointment;
- d. demotion to a Medical Staff category or membership status which has significantly fewer prerogatives or privileges;
- e. suspension of Medical Staff membership until completion of specific conditions or requirements;
- f. suspension or restriction of Medical Staff membership for greater than 30 days in a consecutive 12 month period;
- g. expulsion from Medical Staff membership;
- h. denial of requested privileges;
- i. reduction in privileges;
- j. suspension of privileges for greater than 30 days in a consecutive 12 month period;
- k. summary suspension or restriction of privileges;
- l. termination of privileges;
- m. requirement of consultation; and
- n. any other action which requires a report to be made to the Medical Board of California under the provisions of Section 805 of the California Business and Professions Code.

Recommendation of any of these actions will constitute an “adverse recommendation” for the purposes of these Bylaws.

## **7.3 REQUESTS FOR A HEARING**

### **7.3-1 Notice of Action or Proposed Action**

In all cases in which the body which, under these Bylaws, has the authority, and pursuant to that authority, has recommended or taken any of the actions constituting grounds for hearing as set forth in Section 7.2 of this Article, then said body shall give the affected practitioner notice of its recommendation, decision or action, notice that the action, if adopted, shall be taken and whether it will be reported pursuant to California Business and Professions Code Section 805, and notice of his or her right to request a hearing pursuant to Section 7.3.2, below.

### **7.3-2 Request for a Hearing**

The petitioner shall have thirty (30) days following the date of receipt of notice of such action to request a hearing by a Judicial Hearing Committee. Said request shall be effected by notice to the Chief of Staff with a copy to the Administrator. In the event the petitioner does not request a hearing within the time and in the manner hereinabove set forth, he/she shall be deemed to have accepted the recommendation, decision, or action involved and it shall thereupon become the final action of the Medical Staff, subject to appellate review pursuant to Section 7.5 of these Bylaws.

### **7.3-3 Time and Place of Hearing**

Upon receiving a request for hearing, the Chief of Staff, on behalf of the Executive Committee, shall schedule and arrange for a hearing. He/she shall give notice to the petitioner of the time, place, and date of the hearing. The date of the commencement of the hearing shall not be fewer than thirty (30) days from the date of the notice of hearing, nor more than sixty (60) days after the receipt of the request for a hearing by the Chief of Staff; provided, however, when the request is received from a practitioner who is under a suspension which is then in effect, the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed forty-five (45) days from the date of receipt of the request for hearing by the Chief of Staff. However, the date of the hearing may be postponed upon a decision issued by the presiding officer based upon good cause in accord with these Bylaws.

### **7.3-4 Notice of Charges or Grounds for Action**

As a part of or together with the notice of hearing required by Section 7.3.3 above, the Chief of Staff, on behalf of the Executive Committee, shall state in writing the acts or omissions with which the practitioner is charged, including a list of the charts being questioned, or the grounds upon which the application or request was denied, where applicable.

### **7.3-5 Judicial Hearing**

When a hearing is requested, the Chief of Staff shall appoint a Judicial Hearing Committee consisting of at least three members and one or more additional members as alternates as appropriate. The Judicial Hearing Committee shall be composed of individuals who shall gain no direct financial benefit from the outcome of the hearing, who have not acted as accusers, investigators, fact finders, or initial decision-makers in the matter at any previous level, and shall include, where feasible, an individual practicing the same specialty as the practitioner. The Chief of Staff shall designate a Chair who shall preside in the manner described in Sections 7.4.1 and 7.4.3 below, and address all prehearing matters and preside until a hearing officer, as described in Section 7.4.4 below, is appointed.

### **7.3-6 Failure to Appear**

Failure without good cause of the practitioner to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions involved and it shall thereupon become the final decision of the Medical Staff subject to appellate review pursuant to Section 7.5 of these Bylaws.

### **7.3-7 Continuances**

Continuances may be granted upon agreement of the parties or by the presiding officer on a showing of good cause.

## **7.4 HEARING PROCEDURE**

### **7.4-1 Prehearing Procedure**

At the request of either party, the parties shall exchange lists of witnesses expected to testify and copies of all documents expected to be introduced. If witnesses are added after this list has been provided, it shall be the duty of that party to notify the other party of the change. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance.

- a. It shall be the duty of the member and the Executive Committee, or its designee, to exercise reasonable diligence in notifying the hearing officer or the Judicial Hearing Committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, so that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be made at the hearing;
- b. the practitioner shall have the right to inspect and copy at the practitioner's expense any documentary information relevant to the charges which the Executive Committee has in its possession or under its control, as soon as practicable after the receipt of the practitioner's request for a hearing;
- c. the Executive Committee shall have the right to inspect and copy at the Executive Committee's expense any documentary information relevant to the charges which the practitioner has in his or her possession or control as soon as practicable after the Executive Committee's request;
- d. the failure by either party to provide access to such information at least thirty (30) days before the hearing shall constitute good cause for a continuance; and
- e. the right to inspect and copy by either party does not extend to confidential information referring to individually-identifiable practitioners, other than the practitioner. The presiding officer shall consider and rule upon any request for access to information, and may impose any safeguards the protection of the peer review process and justice requires. When ruling upon requests for access to information and determining the relevancy thereof, the presiding officer shall, among other factors, consider the following:
  1. whether the information sought may be introduced to support or defend the charges;
  2. the exculpatory or inculpatory nature of the information sought, if any;
  3. the burden imposed on the party in possession of the information sought, if access is granted; and
  4. any previous requests for access to information submitted or resisted by the parties to the same proceeding.

#### **7.4-2 Representation at the Judicial Hearing**

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, or character.

The member shall be entitled to representation by legal counsel in any phase of the hearing, should he/she so choose, and shall receive notice of the right to obtain representation. In the absence of legal counsel, the member shall be entitled to be accompanied by and represented at the hearing only by a practitioner licensed to practice in the State of California who is not also an attorney at law, and the Executive Committee shall appoint a representative who is not an attorney. The Executive Committee shall not be represented by an attorney at law if the member is not so represented.

#### **7.4-3 The Presiding Officer**

The presiding officer at the hearing shall be a hearing officer as described in Section 7.4.4 or, if no such hearing officer has been appointed, the Chair of the Judicial Hearing Committee. The presiding officer shall act to assure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant and documentary evidence, and that proper

decorum is maintained. He or she shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing. He or she shall have the authority and discretion, in accordance with these Bylaws, to make all rulings on questions which, with reasonable diligence, could not have been raised prior to the hearing and which pertain to matters of law, procedure, or the admissibility of evidence.

#### **7.4-4 The Hearing Officer**

At the request of the practitioner, the Executive Committee, the Judicial Hearing Committee, or the Governing Body, the Administrator or his/her designee may appoint a hearing officer to preside at the hearing. The hearing officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, preferably with experience in Medical Staff matters. The hearing officer shall gain no direct financial benefit from the outcome of the hearing. He/she must not act as a prosecuting officer, as an advocate for the Hospital, Governing Body, Executive Committee, the body whose action prompted the hearing, or the practitioner. If requested by the Judicial Hearing Committee, he/she may participate in the deliberations of the Committee and be a legal advisor to it, but shall not be entitled to vote.

#### **7.4-5 Record of the Hearing**

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

#### **7.4-6 Rights of the Parties**

At a hearing both sides shall have the following rights: to ask Judicial Hearing Committee members and the hearing officer questions which are directly related to determining whether they are qualified to serve in accord with these Bylaws and to challenge the impartiality of any member or hearing officer if warranted; to call and examine witnesses; to introduce exhibits or other documents; to cross-examine or otherwise attempt to impeach any witness who shall have testified orally on any matter relevant to the issues, and otherwise to rebut any evidence; and to be provided with all information made available to the Judicial Hearing Committee. The petitioner may be called by the body whose decision prompted the hearing and examined as if under cross-examination. Any challenge directed at one or more members of the Committee or hearing officer shall be ruled on by the presiding officer.

#### **7.4-7 Miscellaneous Rules**

The rules of law relating to the examination of witnesses and presentation of evidence shall not apply in any hearing conducted hereunder. Any relevant evidence, including hearsay, shall be admitted by the presiding officer if it is the sort of evidence which responsible persons are accustomed to rely on in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a written statement in support of his/her position and the Judicial Hearing Committee may request that such a statement be filed following the conclusion of the presentation of oral testimony. The Judicial Hearing Committee may question the witnesses or call additional witnesses if it deems such action appropriate. Furthermore, the Administrator or designate may attend and observe meetings of a Judicial Hearing Committee whenever the parties to the hearing are present.

#### **7.4-8 Basis of Decision**

The decision of the Judicial Hearing Committee shall be based on the evidence produced at the hearing.

#### **7.4-9 Burdens of Presenting Evidence and Proof**

- a. The Executive Committee shall have the initial duty to present evidence which supports the corrective action or recommended action.
- b. When the hearing involves an applicant, the applicant shall bear the burden of persuading the Judicial Hearing Committee by a preponderance of the evidence of his/her qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning his/her current qualifications for Medical Staff privileges, and membership. Initial applicants shall not be permitted to introduce information not produced upon request of the Executive Committee during the credentialing process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.
- c. Except as provided above for initial applications, the Executive Committee shall bear the burden of persuading the Judicial Hearing Committee, by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.

#### **7.4-10 Adjournment and Conclusion**

The presiding officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation or oral and written evidence and argument, the hearing shall be closed. The Judicial Hearing Committee shall thereupon, outside of the presence of any other person except the hearing officer, conduct its deliberations and render a decision and accompanying report.

#### **7.4-11 Decision of the Judicial Hearing Committee**

Within thirty (30) days after final adjournment of the hearing (provided that in the event the petitioner is currently under suspension, this time shall be fifteen (15) days), the Judicial Hearing Committee shall render a decision which shall be accompanied by a written report that contains findings of fact and any conclusions explaining the connection between the evidence and the decision. The decision shall also describe the procedure for appealing the decision. The decision and report shall be delivered to the Executive Committee, the Administrator and the Governing Body. At the same time, a copy of the report and decision shall be delivered to the practitioner by registered or certified mail, return receipt requested. The decision of the Judicial Hearing Committee shall be considered final, subject only to the right of appeal to the Governing Body as provided in Section 7.5.

### **7.5 APPEALS TO THE GOVERNING BODY**

#### **7.5-1 Time for Appeal**

Within thirty (30) days after the date of receipt of the Judicial Hearing Committee decision, either the practitioner or the body whose decision prompted the hearing may request an appellate review by the Governing Body. Said request shall be delivered to the Administrator in writing either in person, or by certified or registered mail, return receipt requested, and it shall include a brief statement of the reasons for the appeal. If such appellate review is not requested within such period, both sides shall be deemed to have accepted the action involved and it shall thereupon become the final action of the Medical Staff.

#### **7.5-2 Grounds for Appeal**

The written request for an appeal shall include the grounds for appeal, and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be:

- a. substantial noncompliance with the procedures required by these Bylaws or applicable law so as to deny a fair hearing;



- b. the decision was not supported by substantial evidence based on the hearing record or such additional information as may be permitted pursuant to Section 7.5.5; or

### **7.5-3 Time, Place, and Notice**

When appellate review is requested pursuant to the preceding subsection, the Governing Body shall schedule and arrange for an appellate review. The Governing Body shall give the practitioner notice of the time, place, and date of the meeting with the parties which is to be included in the appellate review. The date of appellate review meeting shall not be fewer than thirty (30) nor more than ninety (90) days from the date of receipt of the request for appellate review; provided, however, that when a request for appellate review is from a practitioner who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed forty-five (45) days from the date of receipt of the request for appellate review. The time for appellate review may be extended for good cause by the Governing Body, its chair or its designee, or appeal board (if any).

### **7.5-4 Appeal Board**

When an appellate review is requested, the Governing Body may sit as the Appeal Board or it may appoint an Appeal Board which shall be composed of Governing Body members and shall have at least three (3) members. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person did not take part in a prior corrective action investigation or hearing on the same matter.

### **7.5-5 Appellate Procedure**

The proceedings by the Appeal Board or Governing Body shall be an appellate review based upon the record of the hearing before the Judicial Hearing Committee, provided that the Appeal Board or Governing Body may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Judicial Hearing Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the Judicial Hearing Committee hearing or may remand the matter to the Judicial Hearing Committee for the taking of further evidence and for decision. Each party shall have the right to present a written statement in support of his/her position on appeal, the right to appear and respond, and the right to be represented by an attorney or any other representative designated by the party. At the conclusion of the argument, the Appeal Board or Governing Body may thereupon conduct deliberations, at a time convenient to itself, outside the presence of the appellant and respondent and their representatives. If an Appeal Board is appointed, the Appeal Board shall present to the Governing Body its written recommendations as to whether the Governing Body should affirm, modify, or reverse the Judicial Hearing Committee decision, or remand the matter to the Judicial Hearing Committee for further review and decision. If no Appeal Board is appointed, the procedures outlined in this subsection shall apply to a proceeding before the Governing Body.

### **7.5-6 Decision**

Within thirty (30) days after the conclusion of the appellate review proceedings, the Governing Body shall render a final decision in writing. The Governing Body may affirm, modify, or reverse the Judicial Hearing Committee decision, or, in its discretion, remand the matter for further review and recommendation by the Judicial Hearing Committee. Copies of the decision shall be delivered to the practitioner and to the Executive Committee by personal delivery or by certified registered mail, return receipt requested.

### **7.5-7 Further Review**

Except where the matter is remanded for further review and recommendation pursuant to Section 7.5.6, the final decision of the Governing Body following the appeal procedures set forth in this Article shall be effective immediately and shall not be subject to further review. However, if the matter is remanded to the Judicial Hearing Committee, said committee shall promptly conduct its

review and render its decision to the Governing Body in accordance with the instructions given by the Governing Body.

**7.5-8 Right to One Hearing**

Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a matter of right to more than one (1) hearing and one (1) appellate review on any matter which shall have been the subject of action by either the Executive Committee or the Governing Body or by both.

## **ARTICLE VIII OFFICERS**

### **8.1 OFFICERS OF THE MEDICAL STAFF**

#### **8.1-1 Identification**

The officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, and a Secretary-Treasurer.

#### **8.1-2 Qualification**

Officers must be members of the Active Staff at the time of their nominations and election, and must remain members of the Active Staff in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

#### **8.1-3 Nominations**

- a. The Medical Staff election shall occur every other year at the annual meeting of the Medical Staff. A nominating committee shall be appointed by the Medical Executive Committee not later than ninety (90) days prior to the annual staff meeting for an election year or at least forty-five (45) days prior to any special election. The Nominating Committee shall consist of the four (4) immediate past Chiefs of Staff of the Medical Staff. If all four (4) immediate past Chiefs of Staff are not available to serve on the nominating committee, then additional members of the nominating committee will be appointed by the Medical Executive Committee to assure that the total number of members on the nominating committee is four (4).
- b. The nominating committee shall nominate one (1) or more nominees for each office. The nominations of the committee shall be reported to the Medical Executive Committee at least forty (40) days prior to the election and shall be delivered or mailed to the voting members of the Medical Staff at least twenty (20) days prior to the election.
- c. The nominating committee, using the mechanism described above, shall also nominate the two (2) at-large members of the Medical Executive Committee as described in Section 10.6-1. These nominees shall also be added to the officers' ballot.
- d. Further nominations for officers or at-large members to the Medical Executive Committee may be made from the floor at the annual meeting of the Medical Staff for any office or at-large member position by any voting member of the Medical Staff, provided that the nominee is present and consents.

#### **8.1-4 Elections**

The Chief of Staff, Vice Chief of Staff, Secretary-Treasurer and Members-at-large shall be elected at the annual meeting of the Medical Staff every other year. Active members who are eligible to vote may vote either by submitting a written ballot at the time of the meeting or by mailing an authenticated sealed ballot to the Medical Staff Office. In order for a mailed ballot to be counted, it must be received prior to the commencement of the meeting at which the election is held. A nominee shall be elected upon receiving the greatest number of ballot votes cast.

#### **8.1-5 Term of Elected Office**

Each officer shall serve a two (2) year term, commencing on the first day of the Medical Staff year following his or her election. Each officer shall serve in each office until the end of his or her term, or until a successor is elected, unless he or she shall sooner resign or be removed from office. Elected Officers may succeed themselves for a total of eight (8) terms.

#### **8.1-6 Removal of Officers**

Removal of an officer or At Large Member may be initiated for failure to carry out the duties and responsibilities of the office as set forth in Article VIII. Except as otherwise provided, removal of a Medical Staff officer or At Large Member may be initiated by the Medical Executive Committee, the Governing Body, or by a petition signed by at least one-third of the members of the active Medical Staff eligible to vote for officers. A recall vote shall be considered at a special Medical Executive Committee meeting called for that purpose. A simple majority will determine the outcome provided that two-thirds of the Medical Staff have voted either in person or through written mailed ballot.

#### **8.1-7 Vacancies in Elected Office**

Vacancies in office occur upon the death or disability, resignation, or removal of the Officer or At Large Member, or the Officer's/At Large Member's loss of membership in the active Medical Staff. Vacancies, other than that of Chief of Staff, shall be filled by appointment by the Medical Executive Committee until the next regular election. If there is a vacancy in the office of the Chief of Staff, then the Vice Chief of Staff shall serve out the remaining term. The Medical Executive Committee would then appoint a Vice Chief of Staff to serve until the next regular election.

### **8.2 DUTIES OF THE OFFICERS**

#### **8.2-1 Chief of Staff**

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

- a. enforcing the Medical Staff Bylaws and Rules and Regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards;
- b. calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;
- c. serving as chairperson of the Medical Executive Committee;
- d. serving as an Ex Officio member of all other staff committees without vote, unless his or her membership in a particular committee is required by these Bylaws;
- e. interacting with the Chief Executive and Governing Body in all matters of mutual concern within the hospital;
- f. appointing, with the Medical Executive Committee approval, committee members for all standing and special Medical Staff, liaison, or interdisciplinary practice committees, except where otherwise provided by these Bylaws and, except where otherwise indicated, designating the chairperson of those committees;
- g. representing the views and policies of the Medical Staff to the Governing Body and to the Chief Executive;
- h. being a spokesperson for the Medical Staff in external professional and public relations;
- i. performing such other functions as may be assigned to him or her by these Bylaws, the Medical Staff, or by the Medical Executive Committee;
- j. serving on liaison committees with the Governing Body and Administration; and
- k. serving as liaison to outside licensing or accreditation agencies; and
- l. any action of the Chief of Staff taken on behalf of the Medical Executive Committee may be modified or overturned by vote of the Medical Executive Committee.

### **8.2-2 Vice Chief of Staff**

The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. Other duties will include:

- a. calling meetings on the order of the Chief of Staff or Medical Executive Committee;
- b. attending to all appropriate correspondence and notices on behalf of the Medical Staff;
- c. excusing absences from meetings on behalf of the Medical Executive Committee; and
- d. performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

### **8.2-3 Secretary-Treasurer**

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

- a. maintaining a roster of members;
- b. overseeing accurate and complete minutes of all Medical Executive Committee and general Medical Staff meetings;
- c. calling meetings on the order of the Chief of Staff or Medical Executive Committee;
- d. attending to all appropriate correspondence and notices on behalf of the Medical Staff;
- e. receiving and safeguarding all funds of the Medical Staff;
- f. excusing absences from meetings on behalf of the Medical Executive Committee; and
- g. performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

**ARTICLE IX  
CLINICAL DEPARTMENTS AND ORGANIZATIONAL SERVICES**

**9.1 ORGANIZATION OF CLINICAL DEPARTMENTS**

The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a chairperson selected and entrusted with the authority, duties, and responsibilities specified in Section 9.5-5.

**9.2 CURRENT DEPARTMENTS OF THE MEDICAL STAFF**

**9.2-1 Current Departments**

- a. Medical Department: includes physicians holding clinical privileges related to emergency medicine, family practice, general practice, internal medicine, psychiatry, radiology, and all medical subspecialties.
- b. Surgical Department: includes all physicians holding clinical privileges related to anesthesia, dentistry, general surgery, gynecology, oral surgery, orthopedics, pathology, podiatry, and all surgical subspecialties.
- c. Perinatal Department: includes physicians holding clinical privileges related to pediatrics and obstetrics.

**9.3 ASSIGNMENT TO DEPARTMENTS**

Each member shall be assigned membership in one (1) department but may also be granted privileges in the other department. Limited licensed practitioners shall be granted primary privileges in one (1) department but may also be granted clinical privileges in another department.

**9.4 FUNCTIONS OF DEPARTMENTS**

**9.4-1 Functions of Departments**

The functions of each department shall include:

- a. Educating the department membership regarding changes in medical staff and hospital policy and procedure, clinical practice guidelines, and other important aspects of clinical care.
- b. Providing, as requested by the Department Chairperson or Medical Executive Committee, information and guidance regarding guidelines for the granting of clinical privileges and recommendations regarding the performance of specific clinical privileges within the department.
- c. Providing, as requested, information and recommendations to the Department Chairperson regarding the qualifications of applicants seeking appointment and/or reappointment and/or clinical privileges within the department.
- d. Conducting and making recommendations regarding continuing education programs pertinent to clinical practices in the department.
- e. Meeting at least quarterly for the purpose of considering patient care findings and the results of the department's other review and evaluation activities as well as reports from other departments and/or committees.
- f. Establishing such committees, teams or other mechanisms as may be necessary and desirable to perform properly the functions assigned to it by the Medical Executive Committee or the Medical Staff Clinical Peer Review Committee.

- g. Formulating recommendations for departmental rules and regulations reasonably necessary for proper discharge of its responsibilities subject to the approval of the Medical Executive Committee and the Governing Body.
- h. Recommending to the Medical Executive Committee policies and procedures related to the performance of clinical services within the department.
- i. Taking all reasonable steps to monitor the adequacy of the Emergency Department specialty coverage by members of the Department and assisting the Medical Staff leadership in efforts to arrange for adequate coverage.

## **9.5 DEPARTMENT CHAIRPERSON**

### **9.5-1 Qualifications**

- a. Each Department Chairperson shall be a physician member of the Active Staff qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the department.
- b. Each chairperson shall be certified by an appropriate specialty board, or shall affirmatively establish through the privilege delineation process that he or she possesses comparable competence.

### **9.5-2 Selection**

Nominations for the Department Chairperson shall be made by the Medical Executive Committee at least three (3) weeks prior to the department meeting held in the fourth quarter of an election year. A mail-in ballot will be sent to each voting member of the department, along with a notice of the department meeting, at least two (2) weeks prior to the department meeting at which the vote is to occur. Additional nominations may be made from the floor at this meeting if the nominated member is present and agrees to the nomination. Each Active member, primarily assigned to the department, shall cast one (1) vote for the Department Chairperson and one (1) vote for the Vice Chairperson. In order for a vote to be counted, the vote must be either cast in person during the department meeting or submitted to the Medical Staff Office on an official ballot form prior to the commencement of the department meeting at which the election is to be held. The Active physician member receiving the highest number of votes for either the Chairperson or Vice-Chairperson position, shall be elected.

### **9.5-3 Term of Office**

Each Department Chairperson and Vice-Chairperson shall serve a two (2) year term commencing January 1<sup>st</sup> of the new year. Department Chairpersons and Vice-Chairpersons may succeed themselves.

### **9.5-4 Removal**

Removal of a Department Chairperson may be initiated for failure to carry out the duties and responsibilities as set forth in Section 9.5-5. Removal of a Department Chairperson requires a two-thirds (2/3) majority vote of active Medical Staff members in the department. The vote may be held at any regular or special meeting of the department and votes may be submitted in person or through written ballot.

### **9.5-5 Duties of a Chairperson**

Each Department Chairperson shall:

- a. direct and supervise all clinically related activities within the department;

- b. direct and supervise all administrative related activities of the department unless otherwise provided for by the hospital;
- c. perform continued surveillance of the professional performance of all individuals who have delineated clinical privileges in the department;
- d. recommend to the Medical Executive Committee the criteria for clinical privileges in the department;
- e. recommend to the Medical Executive Committee specific clinical privileges for each member of the department both at the time of appointment and reappointment. The Department Chairperson may wish to discuss such recommendations with the CPRC or department as a whole. However, the responsibility and duty for recommending privileges to the Medical Executive Committee rest with the chairperson;
- f. act as presiding officer at departmental meetings;
- g. report to the Medical Executive Committee regarding all professional and administrative activities within the department;
- h. develop and implement programs for concurrent and retrospective patient care review, ongoing monitoring of practice, monitoring of utilization, and quality assessment and improvement activities;
- i. serve as a member of the Medical Executive Committee and give guidance on the overall medical policies and procedures of the Medical Staff and hospital and make specific recommendations to the Medical Executive Committee regarding policies and procedures to be utilized in his or her department;
- j. transmit to the Medical Executive Committee any recommendations regarding a request for corrective action investigation or recommendations for corrective action regarding any person holding clinical privileges within his or her department;
- k. recommend department specific rules and regulations to the Medical Executive Committee;
- l. integrate the department into the primary functions of the organization;
- m. coordinate and integrate inter and intra-departmental clinical activities;
- n. recommend to the Medical Executive Committee policies and procedures necessary for the department;
- o. assure the maintenance of quality control programs as may be necessary;
- p. serve as a member on the CPRC;
- q. assess and recommend to the relevant hospital authority off-site sources for needed patient care services not provided by the department or organization; and
- r. take all reasonable steps to monitor the adequacy of the Emergency Department specialty coverage by members of the department and assist the Medical Staff leadership in efforts to arrange for adequate coverage;
- s. recommend a sufficient number of qualified and competent persons to provide care, treatment and services;
- t. determine the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services;



- u. orient and provide continuing education of all persons in the department or service; and
- v. recommend space and other resources needed by the department or service.

## **9.6 DEPARTMENT VICE CHAIRPERSON**

### **9.6-1 Qualifications**

- a. Each Department Vice Chairperson shall be a physician member of the Active Staff qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the department.
- b. Each Department Vice Chairperson shall be certified by an appropriate specialty board, or shall affirmatively establish through the privilege delineation process that he or she possesses comparable competence.

### **9.6-2 Selection**

Nominations for the Department Vice Chairperson shall be made by the Medical Executive Committee at least three (3) weeks prior to the department meeting held in the fourth quarter of each year. A mail-in ballot will be sent to each voting member of the department, along with a notice of the department meeting, at least two (2) weeks prior to the department meeting at which the vote is to occur. Other nominations may be made from the floor at this meeting if the nominated member is present and agrees to the nomination. The Department Vice Chairperson shall be the physician member receiving the highest number of votes. Each member of the Active Staff primarily assigned to the department shall cast one (1) vote for the Department Vice Chairperson. In order for the vote to be counted, the vote must either be cast in person at the department meeting or submitted to the Medical Staff Office on an official ballot form prior to the commencement of the department meeting at which the election is to be held.

### **9.6-3 Term of Office**

Each Department Vice Chairperson shall serve a two (2) year term which coincides with Medical Staff election year, unless he or she shall sooner resign or be removed from office or lose Medical Staff membership or clinical privileges in that department. Department Vice Chairpersons may succeed themselves.

### **9.6-4 Removal**

Removal of a Department Vice Chairperson may be initiated for failure to carry out the duties and responsibilities as set forth in Section 9.6-5. Removal of a Department Vice Chairperson requires a two-thirds (2/3) majority vote of active Medical Staff members in the department. The vote may be held at any regular or special meeting of the department and votes may be submitted in person or through written ballot.

### **9.6-5 Duties of a Chairperson**

Each Department Vice Chairperson shall assume the duties of the Department Chairperson in the absence of the Department Chairperson and shall perform other duties as may be assigned to him or her by the Department Chairperson.

## **ARTICLE X COMMITTEES**

### **10.1 DESIGNATION**

All Medical Staff committees shall include but not be limited to, the Medical Staff meeting as a committee of the whole, meetings of departments, meetings of committees established under this Article X, and meetings of special or ad hoc committees. The committees described in this Article shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee, the departments or other standing Medical Staff committees to perform specified tasks. Unless otherwise specified, the chairperson and members of all committees shall be appointed by and may be removed by the Chief of Staff, subject to approval by the Medical Executive Committee. Members appointed to ad hoc committees shall be appointed by the Department Chair of the group appointing the ad hoc committee. All Medical Staff committees shall report to the Medical Executive Committee.

The purpose of Medical Staff committees shall be to monitor and perform functions relative to the needs of the facility, the regulations of the State and Federal Government and the standards of an accredited Health Care Organization. Unless otherwise specified in these Bylaws, all non-Medical Staff members appointed to Medical Staff committees shall be nonvoting. When non-physician members have been granted a vote on a Medical Staff committee such votes shall only be exercised relative to the practitioner's area of clinical expertise and restricted by scope of licensure. The Chief of Staff shall be an Ex Officio member on all committees to which he/she is not otherwise specifically assigned.

The records and proceedings of all Medical Staff Committee meetings are protected from discovery.

### **10.2 GENERAL PROVISIONS**

#### **10.2-1 Terms of Committee Members**

Unless otherwise specified, committee members shall be appointed for a term of one (1) year corresponding with the terms of the Medical Staff officers.

#### **10.2-2 Removal**

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

#### **10.2-3 Vacancies**

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

#### **10.2-4 Coordination with Other Functions**

In addition to the provisions of this Article, the Medical Staff has adopted plans for the performance of certain interdisciplinary monitoring functions. The Medical Staff participates in such interdisciplinary activities and such activities may impose additional duties on certain committees listed below.

#### **10.2-5 Addition, Deletion or Modification of Standing Committees of the Medical Staff**

The Organized Medical Staff may recommend to the Governing Body the addition, deletion, or modification of any standing committees of the Medical Staff as may be described in these Bylaws, or as has otherwise been appointed with the exception of the Medical Executive Committee. Modification of the Medical Executive Committee requires vote of the General Medical Staff pursuant to Bylaws modification requirements. Any other changes made to committees, as may be described in these Bylaws, may be recommended by the Medical Executive Committee and shall be enacted following approval by the Governing Body.

### **10.2-6 Executive Session**

The chairperson of any standing, special, or ad hoc committee of the Medical Staff, including departments, may call an executive session meeting. Only members of the active Medical Staff holding voting privileges on the committee shall attend the executive session meeting. The chairperson, at his or her discretion, may request other individuals to attend the meeting in an informational capacity. The CEO and/or the CMO may attend as Ex Officio members.

### **10.2-7 Monthly Meeting Frequency**

Any Medical Staff committee which is described as meeting monthly shall meet at least ten (10) times a year to meet the monthly meeting requirement.

## **10.3 CANCER COMMITTEE/INSTITUTIONAL REVIEW COMMITTEE**

### **10.3-1 Composition**

#### **a. Cancer Committee**

The physician representatives shall be appointed by the Chief of Staff. The membership for Cancer Committee is outlined in the American College of Surgeons, Commission on Cancer Program. The Committee shall consist of physicians from the clinical departments of specialty areas involved in treating cancer patients, such as medical oncology, pathology, diagnostic radiology, ACOS liaison (cancer liaison physician), radiation oncology, and general surgery. Members shall also include a representative from Administration, oncology nursing, social work or Case Management, Cancer Registry Services, specifically a Certified Tumor Registrar, and performance improvement or quality management professional. Additional members may be added, based on major cancer sites seen by the facility and agency partnerships as appropriate, e.g., American Cancer Society, Humboldt Community Breast Health, etc. Other disciplines to consider for membership include Nutrition Services (dietician), Pharmacy, and Pastoral Care. A pain control specialist/palliative care physician or specialist is required for program category of a Comprehensive Community Cancer Program. All non-physician representatives participating in Committee deliberations by virtue of the required composition stated herein shall have the right to vote on Committee matters. Other representatives from applicable services may participate in this committee, including, but not limited to, Home Health, Providence St. Joseph Hospital and/or Redwood Memorial Hospital.

#### **b. Institutional Review Board**

The Institutional Review Board (IRB) function is outsourced to Western IRB (W-IRB) or to a qualified recognized review board. Appropriateness review for research proposals is coordinated through the Hospital Feasibility Committee (HFC) prior to referral to the W-IRB for complete review.

### **10.3-2 Duties**

The Cancer Committee shall:

- a. establish a mechanism for consultative services to patients,
- b. establish a mechanism for presenting educational programs,
- c. receive and analyze reports,
- d. evaluate the quality of care for cancer patients through:

1. reviewing the monitoring/evaluation studies of cancer care and the Cancer Registry Services;
2. reviewing and approving multi-disciplinary and comprehensive protocols on prevention, diagnosis, treatment and follow-up of different cancers;
3. reviewing the monitoring/evaluation from other clinical departments pertaining to the care of cancer patients;
4. supporting and analyzing the Cancer Registry on a regular basis, including providing physician advisors; and
5. establishing program goals and objectives for the Cancer Committee in accordance with standards recommended by the American College of Surgeons.

The Cancer Committee will not undertake any physician specific peer review activities. Such peer review activities will be referred to the Clinical Peer Review Committee.

### **10.3-3 Meetings**

The Cancer Committee shall meet at least quarterly and report its findings and recommendations to the Medical Executive Committee.

## **10.4 CREDENTIALS/INTERDISCIPLINARY PRACTICE COMMITTEE**

### **10.4-1 Composition**

The Credentials /Interdisciplinary Practice Committee shall consist of not less than four (4) members of the Active Medical Staff on the basis that will ensure, insofar as feasible, representation from all major clinical specialties. For purposes of credentialing allied health practitioners the committee shall add the following voting members: the Nurse Executive, registered nurses appointed by the Nurse Executive performing duties regarding standardized procedures, other licensed or certified health professionals other than registered nurses who follow a job description and/or standardized procedure and an administrative representative and an equal number of physicians.

### **10.4-2 Duties**

The Credentials /Interdisciplinary Practice Committee shall:

- a. review and evaluate the qualifications of each licensed independent practitioner applying for initial appointment, reappointment, or modification of clinical privileges;
- b. submit required reports and information on the qualifications of each licensed independent practitioner applying for membership or particular clinical privileges including recommendations with respect to appointment, membership category, clinical privileges, and special conditions;
- c. investigate, review and report on matters referred by the Chief of Staff or the Medical Executive Committee regarding the qualifications, conduct, professional character or competence of any applicant, Medical Staff member or allied health practitioner; and
- d. submit periodic reports to the Medical Executive Committee on its activities and the status of pending applications.
- e. With respect to matters concerning allied health practitioners:

1. identifying functions which require standardized procedures and/or job descriptions and physician supervision;
2. preparing and initiating standardized procedures and/or job descriptions and physician supervision requirements;
3. reviewing and approving standardized procedures and/or job descriptions and the physician associated supervision requirements;
4. assuring that standardized procedures and/or job descriptions and physician supervision requirements conform to state laws and regulations; and
5. evaluating and making recommendations regarding:
  - i. the mechanism for evaluating the licensure, certification and qualifications of supervised practitioners;
  - ii. defining the minimum standards of training, education, experience, character, competence and overall fitness of supervised practitioners;
  - iii. the granting of permission to supervised practitioners to perform functions requiring standardized procedures and/or job descriptions and physician supervision;
  - iv. the monitoring and supervision of supervised practitioners; and
  - v. the termination of permission to perform a function requiring standardized procedures and/or job descriptions and physician supervision
6. recommending to the Medical Executive Committee and the Governing Body those categories of allied health practitioners that will be eligible for clinical privileges at the Hospital and the scope of such privileges for each category.

#### **10.4-3 Meetings and Reporting**

The Credentials Committee shall meet at least quarterly and maintain a permanent record of its proceedings and actions. The Credentials Committee shall report to the Medical Executive Committee.

### **10.5 JOINT CONFERENCE COMMITTEE**

#### **10.5-1 Composition**

The Joint Conference Committee shall be composed of an equal number of members, or designates, of the Governing Body and of the Medical Executive Committee. The Medical Executive Committee representatives shall include the Chief of Staff, the Chief of Staff-elect, the immediate past Chief of Staff and/or the Chief Medical Officer. The Administrator or President of the Hospital may serve as a designate of the Governing Body. The chairmanship of the Committee shall be elected by a majority vote of the Committee at the first meeting.

#### **10.5-2 Duties**

The duties of the Joint Conference Committee shall include:

- a. Addressing areas of conflict and/or disagreement between the Medical Staff and the Governing Body.
- b. Making recommendations to the Medical Staff and the Governing Body regarding any resolutions or disagreements.

- c. The Joint Conference Committee is not empowered to act on behalf of either the Medical Executive Committee or the Governing Body, but rather makes recommendations to both bodies related to specific issues which have been referenced to the committee.

### **10.5-3 Meetings and Reporting**

The Joint Conference Committee shall meet on an as-needed basis as called by the Chief of Staff, the Administrator, or the Chairman of the Governing Body. The Joint Conference Committee shall report to the Medical Executive Committee and the Governing Body.

## **10.6 MEDICAL EXECUTIVE COMMITTEE**

### **10.6-1 Composition**

The Medical Executive Committee shall consist of the Chief of Staff, Vice Chief of Staff, Secretary-Treasurer, Immediate Past Chief of Staff, Chairpersons for the Medical, Surgical, and Perinatal Departments, Vice Chairpersons for the Medical, Surgical, and Perinatal Departments, Chairperson of the Credentials/Interdisciplinary Practice Committee, and three (3) Members-at-large elected by the Medical Staff as described in Section 8.1-3 I.

The Chief Executive, the Chief Nursing Officer, and the Chief Medical Officer shall attend the Medical Executive Committee meetings on an Ex Officio basis without vote. Additional representatives may attend at the pleasure of the Committee without vote.

### **10.6-2 Duties**

The duties of the Medical Executive Committee shall include but not be limited to:

- a. coordinating and implementing the professional and organizational activities and policies of the Medical Staff;
- b. representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by the Bylaws;
- c. receiving and acting upon reports and recommendations from the Medical Staff departments, and committees and assigned activity groups;
- d. reporting at each general staff meeting;
- e. participating in the development of all Medical Staff and hospital policy, practice, and planning, and implementing policies of the Medical Staff not otherwise the responsibility of the departments;
- f. providing liaison between Medical Staff, the Chief Executive, and the Governing Body;
- g. recommending actions to the Governing Body on matters of a medical-administrative nature;
- h. evaluating the quality and appropriateness of medical care rendered to patients in the hospital;
- i. ensuring the Medical Staff complies with the standards for an accredited Health Care Organization and other regulatory requirements related to hospital accreditation;
- j. taking responsible steps to develop continuing education activities and programs for the Medical Staff;

- k. establishing the structure of the Medical Staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of quality assessment and improvement activities, peer review activities, mechanisms for termination of Medical Staff membership privileges and fair hearing procedures, as well as other matters relevant to the operation of the organized Medical Staff;
- l. taking all reasonable steps to ensure professional ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;
- m. establishing a mechanism for dispute resolution between Medical Staff members (including limited licensed practitioners) involving the care of a patient;
- n. designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving/rejecting appointments to those committees by the Chief of Staff;
- o. developing and maintaining methods for protection and care of patients and others in the event of an internal or external disaster and reviewing and acting upon reports of activities of Medical Staff departments, committees, and the hospital Safety Committee relative to the clinical aspects of patient safety;
- p. reviewing the quality and appropriateness of services provided by contract physicians;
- q. reviewing and approving the designation of the hospital's authorized representative for National Practitioner Data Bank purposes;
- r. receiving and acting upon the reports of administration, Medical Staff departments or committees relative to identified actual or potential areas of patient risk;
- s. organizing the quality assessment and improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate and review such activities;
- t. assigning a representative from the Medical Staff to participate in any hospital deliberation affecting the discharge of Medical Staff responsibilities;
- u. reviewing the organization and upgrading of the Medical Staff Library and its materials;
- v. reviewing the Medical Staff Bylaws at least annually and submitting a report to the General Medical Staff regarding any recommended additions or modifications; and
- w. taking all reasonable steps to monitor the adequacy of Emergency Department specialty coverage and to assist the Hospital and Medical Staff leadership, and the clinical departments, in efforts to arrange for adequate coverage.

### **10.6-3 Meetings and Reporting**

The Medical Executive Committee shall meet monthly and maintain a permanent record of its proceedings and actions. The Medical Executive Committee shall report to the General Medical Staff and Governing Body.

## **10.7 PHYSICIAN SUPPORT COMMITTEE**

### **10.7-1 Composition**

The Humboldt Del-Norte Medical Society Physician Support Committee is the Physician Support Committee of Providence St. Joseph Hospital. At least one member of the aforementioned Committee will hold Active status on the Providence St. Joseph Hospital Medical Staff.

### **10.7-2 Duties**

The Committee shall be available as a resource for any member of the Medical Staff who has concerns regarding potential chemical or substance abuse, disability, impairment, or comparable health limitations. The Committee may, on a voluntary basis, advise or counsel Medical Staff members and provide appropriate referrals, with regard to the member's personal concerns or his concerns about a Medical Staff colleague. The activities of the Committee shall be confidential, but if the information received by the Committee demonstrates that the health limitations of a Medical Staff member might pose an unacceptable risk of harm to patients, the Committee shall present that concern and information to an appropriate Medical Staff officer for potential corrective action. The Committee shall also consider general matters related to the health and well-being of the Medical Staff and develop educational programs.

### **10.7-3 Meetings**

The Committee shall meet as often as necessary. It shall maintain appropriate records of its confidential activities, and shall submit periodic reports to the Executive Committee.

## **10.8 PHARMACY AND THERAPEUTICS COMMITTEE**

### **10.8-1 Composition**

The Pharmacy and Therapeutics Committee shall consist of at least five (5) members of the Medical Staff.

### **10.8-2 Duties**

- a. assisting in the formulation of professional practices and policies regarding the continuing evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the hospital, including antibiotic usage;
- b. advising the Medical Staff and pharmaceutical service on matters pertaining to the choice of available drugs;
- c. making recommendations concerning drugs to be stocked on the nursing unit floors and by other services;
- d. periodically developing and reviewing a formulary or drug list for use in the hospital;
- e. evaluating clinical data concerning new drugs or preparations requested for use in the hospital;
- f. maintaining a record of all activities relating to pharmacy and therapeutics functions and submitting periodic reports and recommendations to the Medical Executive Committee concerning those activities;
- g. reviewing untoward drug reactions.

### **10.8-3 Meetings**

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

## **10.9 PROFESSIONAL STANDARDS COMMITTEE**



### **10.9-1 Composition**

The Professional Standards Committee shall be chaired by the Chief of Staff or his/her designee and include the Department Chairpersons and/or their designees. In addition, the Chief Executive and the Chief Medical Officer may serve as ex-officio members without vote.

### **10.9-2 Duties and Authority**

The Professional Standards Committee shall perform the following key functions:

- a. Review reports of disruptive behavior as well as violations of the Rules and Regulations and Medical Staff or Hospital Policies and Procedures.
- b. When warranted, initiate an assessment that:
  1. May require the Medical Staff member to respond to questions from the Committee.
  2. May request additional information from other individuals who are familiar with the concern and/or events leading up to the concern, if the individuals familiar with the concern are employees of the hospital.
  3. Assess a Medical Staff Member's interpersonal skills, communication skills and professionalism.
- c. Implement the processes identified in the Medical Staff Disruptive Behavior and Rule Violation Policies in order to educate and correct identified practitioner specific conduct issues.
- d. Implement intensified assessment (Focused Professional Practice Evaluation) when warranted.
- e. Recommend other corrective action, as appropriate, to the MEC.

### **10.9-3 Meetings and Reporting**

The Professional Standards Committee shall meet monthly or as often as necessary. Activities will be reported to the Medical Executive Committee.

## **10.10 CLINICAL PEER REVIEW COMMITTEE**

### **10.10-1 Composition**

The Clinical Peer Review Committee (CPRC) shall be a standing committee of the Medical Staff with members appointed to monitor the quality and appropriateness of clinical care provided by those holding clinical privileges. When requested, the CPRC shall make recommendations to the Credentials and Medical Executive Committee related to specific credentialing issues. The Chairperson of the CPRC shall be the vice chief of staff. The membership of the CPRC shall consist of five members from each medical staff department. Department representatives shall be appointed by their respective Department Chairpersons and approved by the Medical Executive Committee. To the greatest extent possible, the appointed members shall represent the specialties responsible for the majority of the clinical activities of their departments. Ad hoc members may be appointed to the CPRC for the assessment of a specific episode or episodes of care when the standing membership of the CPRC lacks the relevant expertise to make a meaningful assessment. The Chair of the CPRC, with the approval of the relevant Department Chairperson, shall make such ad hoc appointments.

### **10.10-2 Duties**

The duties of the CPRC shall include:

- a. Developing objective criteria and measures to be used in the evaluation of patient care.
- b. Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the Medical Staff pursuant to the Medical Staff Peer Review Policy and Procedure. Such reviews shall include routine collection of data and information concerning important aspects of patient care, periodic assessment of this information and taking such steps as are necessary to improve patient care processes. These reviews shall include the development of objective criteria used in evaluating patient care and shall include all clinical work performed under the jurisdiction of the medical staff. 65ctiveity shall be designed to assess practitioners' medical knowledge, clinical judgment, and technical skills.
- c. Reviewing and acting on reported clinical incidents which involve Medical Staff members.
- d. Performing peer review and/or other practitioner-specific intensified assessments when indicated.
- e. Implementing intensified assessment (Focused Professional Practice Evaluation) when warranted pursuant to the Medical Staff Peer Review Policy And Procedure.
- f. Identifying system problems requiring process improvement activity and making such recommendations to the Quality Steering Committee of the Medical Staff.
- g. Submitting written reports to the Medical Executive Committee concerning the CPRC's quality assurance and peer review activities, the actions taken thereon, the results of such actions and the specific recommendations for maintaining and improving the quality of patient care provided by the Medical Staff and those with delineated clinical privileges.
- h. Taking appropriate actions when opportunities to improve patient care are identified.
- i. Communicating the significant results of peer review and performance improvement activities to relevant Medical Staff members.
- j. When requested, the CPRC shall also make recommendations to the Medical Executive Committee related to specific credentialing issues. The respective Department Chairpersons, however, shall have the ultimate duty and responsibility to make recommendations regarding credentialing issues to the Medical Executive Committee.
- k. Recommending to the Department Chairpersons and Medical Executive Committee those Medical Staff policies and procedures as may be necessary to conduct patient care and administrative Medical Staff activities.
- l. Implementing programs that address the implementation of clinical practice guidelines and assessing compliance with practice guidelines and other recognized standards of care.
- m. The CPRC shall assume duties and responsibilities of the departments related to quality assurance, peer review and performance improvement which have not been otherwise assigned to the Department Chairperson, and as may be described in these Bylaws and/or Rules and Regulations.

#### **10.10-3 Meetings and Reporting**

The Clinical Peer Review Committee shall meet monthly. The Committee shall report to the Medical Executive Committee and submit informational reports to the departments they represent.

### **10.11 QUALITY STEERING COMMITTEE**

#### **10.11-1 Composition**

The composition of the Quality Steering Committee shall include the Secretary-Treasurer, who shall serve as chairperson of the committee. Additionally, the Committee shall include the Chairs or Vice Chairs of Medicine, Surgery, and Perinatal Departments, as well as the Departmental Medical Directors.

#### **10.11-2 Duties**

The duties of the Quality Steering Committee shall include:

- a. Reviewing patterns and trends of care for Medical Staff and hospital services.
- b. Undertaking continuing self-education regarding approaches and methods of performance improvement.
- c. Overseeing all organizational performance improvement activities, to include but not be limited to:
  1. medication administration
  2. blood usage review
  3. infection control
  4. medical records review
  5. operative and invasive procedure review
  6. Medical Staff customer service
- d. Monitoring the progress and outcomes of organizational performance improvement teams.
- e. Receiving reports on support service performance improvement activities.
- f. Receiving routine reports on all organizational quality control measures.
- g. Developing training programs to assist the organization's staff in assessing and improving processes that are related to patient outcomes. This training should include information related to team dynamics and facilitating process improvement teams.
- h. Fostering communication among all departments and services within the organization and assisting in coordination of all performance improvement activities.
- i. Overseeing the development of a plan, review of aggregate data, and assessing performance related to the following organizational functions:
  1. Leadership
  2. Improving Organizational Performance
  3. Risk Management
- j. Provide oversight and review of patient organizational safety activities.
- k. Developing an annual appraisal of the organization's performance improvement program.
- l. Acting as a "clearinghouse" for any organizational concerns related to identified process and system problems.

### 10.11-3 Meetings and Reporting

The Quality Steering Committee shall meet monthly and report its activities to the Medical Executive Committee and provide a summary report to the Governing Body.

## 10.12 UTILIZATION REVIEW/MANAGEMENT COMMITTEE

### 10.12-1 Composition/Attendance

The Committee shall consist of sufficient members, with a minimum of two (2) physicians, to afford, insofar as feasible, representation from major departments or clinical services. Subcommittees may be established by the Committee as it deems appropriate. The Chief Medical Officer and Director of Quality Management shall serve as Ex Officio non-voting members. Other Committee members may be appointed and subcommittees formed as needed to carry out the Utilization Review Plan. Members are required to attend at least 50% of scheduled meetings.

### 10.12-2 Duties

The duties of the Utilization Review Committee shall include:

- a. **General Duties:** Oversees the review of the medical necessity for admissions, extended stays and services rendered. The Committee addresses over-utilization, under-utilization, and inefficient scheduling and use of resources. Patterns of care will be followed, and focused review may be undertaken as deemed necessary. The Committee shall also work toward maintaining proper continuity of care upon discharge. The Committee shall communicate pertinent data and results of review to the Medical Executive Committee and shall make recommendations for the utilization of resources and facilities commensurate with quality patient care and safety.
- b. **Utilization Review Plan:** The Committee shall establish and follow a Utilization Review Plan which shall be approved by the Medical Executive Committee and Governing Board, and shall comply with applicable Federal and State regulations.
- c. **Evaluation:** The Committee shall evaluate the medical necessity of continued hospital services for particular patients, where appropriate. In making such evaluations, the Committee shall be guided by the following criteria:
  1. No practitioner shall have review responsibility for any extended stay cases in which he or she was professionally involved.
  2. Each decision that further inpatient stay is not medically necessary shall be made by the Medical Staff members of the Committee and only after opportunity for consultation has been given the attending practitioner by the Committee and full consideration has been given to the availability of hospital facilities and services.
  3. All decisions that further inpatient care is not medically necessary shall be given by written notice, in accordance with the written utilization review plan.
- d. **Liaison:** The Committee will act only upon the direct instruction of the Medical Executive Committee as the liaison committee for the government agencies and third-party providers.
- e. **Continuity of Care:** The Committee shall promote continuity of care upon discharge and supervise the accumulation of data on the availability of health care resources outside the hospital.

- f. **Education:** The Committee shall assure that the overall results of quality improvement activities are used to guide educational programs throughout the hospital.

#### **10.12-3 Meetings**

The Committee shall meet at least quarterly and report its activities to the Clinical Departments, Quality Steering Committee, and Medical Executive Committee.

## **ARTICLE XI MEDICAL STAFF MEETINGS**

### **11.1 REGULAR MEETINGS**

The General Medical Staff shall meet on a quarterly basis and all Medical Staff members are invited to attend. The last General Medical Staff meeting of the year will be held in November or December and shall be designed as the Annual Meeting of the General Medical Staff. The election of the officers will occur at the Annual Meeting of the Medical Staff.

### **11.2 SPECIAL MEETINGS**

- a. The Chief of Staff may call a special meeting of the Medical Staff at any time. The Chief of Staff shall call a special meeting within fifteen (15) days after receipt of a written request for same from the Medical Executive Committee or not less than ten percent (10%) of the Active Staff stating the purpose of such meeting. The Chief of Staff shall designate the time and place for any special general Medical Staff meeting.
- b. Written or printed notice stating the place, day and hour and nature of business to be conducted for any special general Medical Staff meeting shall be delivered, either personally or by mail, to each member of the active staff not less than ten (10) days before the date of such meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each staff member at his address as it appears on the records of the hospital. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

### **11.3 QUORUM**

The presence of twenty percent (20%) of the total membership of the Active Medical Staff either in person or through written validated ballot at any regular or special Medical Staff meeting shall constitute a quorum for purposes of amendment of these Bylaws, Rules and Regulations, and the presence of ten percent (10%) either in person or through written validated ballot of such membership a quorum for all other actions.

### **11.4 MANNER OF ACTION**

Except as otherwise specified, the action of a majority of the members voting in person or by validated ballot at a meeting at which a quorum is present pursuant to Section 11.3 shall be the action of the group.

### **11.5 AGENDA**

- a. The agenda at any regular Medical Staff meeting shall be:
  1. call to order;
  2. acceptance of the minutes of the last regular and of all special meetings;
  3. unfinished business;
  4. communications;
  5. report from the Chief of Staff;
  6. reports of the Chief Executive of the hospital;
  7. new business (including elections, where appropriate);
  8. educational presentations; and

9. adjournment.
- b. The agenda of special meetings shall be:
  1. reading of the notice calling the meeting;
  2. transaction of business for which the meeting was called; and
  3. adjournment.

#### **11.6 MINUTES**

Minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of attendance and votes taken on significant matters. Minutes shall be signed by the presiding officer of the meeting.

**ARTICLE XII**  
**COMMITTEE/DEPARTMENT MEETINGS**

**12.1 REGULAR MEETINGS**

Committees and departments shall meet regularly in accordance with these Bylaws and may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

**12.2 SPECIAL MEETINGS**

A special meeting of any committee or department may be called by or at the request of the chairperson, by the Chief of Staff, or by one-third (1/3) of the group's members, but not less than two (2) members.

**12.3 NOTICE OF SPECIAL MEETINGS**

Written or oral notice stating the place, day and hour of any special meeting shall be given to each member of the committee or department not less than three (3) days before the time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his/her address as it appears on the records of the hospital with postage thereon prepaid.

**12.4 QUORUM**

The following committee and department meeting quorum requirements have been established:

- a. Twenty-five (25%) percent of the voting Medical Staff members of a committee or department shall constitute a quorum at any committee or department meeting other than the Medical Executive Committee and the Medicine Department.
- b. Fifty (50%) percent of voting Medical Staff members of the Medical Executive Committee shall constitute a quorum at any regular or special meeting of the Medical Executive Committee.
- c. Five voting members of the Medicine Department, including the Chair or designee, shall constitute a quorum at the Medicine Department meeting.

**12.5 MANNER OF ACTION**

The action of a majority of the voting members present at a meeting at which a quorum is present shall be the action of a committee or department. Action may also be taken without a meeting by written resolution stating the proposed action and signed by a majority of the members entitled to vote.

**12.6 RIGHTS OF EX OFFICIO MEMBERS**

Persons serving under these Bylaws as Ex Officio nonvoting members of a committee shall have all rights and privileges of regular members, except they shall not be counted in determining the existence of a quorum and they shall not vote.

**12.7 MINUTES**

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. Each committee and department shall maintain a permanent file of the minutes of each meeting.

**12.8 ATTENDANCE REQUIREMENTS**

- a. Members of the Medical Executive Committee are expected to attend at least fifty (50%) percent of all regular Medical Executive Committee meetings. Failure of a Medical Executive Committee member to attend fifty (50%) percent of regularly scheduled Medical Executive Committee meetings shall constitute a voluntary resignation of Medical Executive Committee membership and the office or



position which granted them Medical Executive Committee membership. Any vacancies created by such a voluntary resignation will be filled through the mechanism described to originally fill the position which has been vacated. Exceptions to this requirement may be made by the Medical Executive Committee for cause.

- b. A Chairperson of any committee or department may give notice to a practitioner that his/her attendance at a meeting to discuss his/her clinical competence or conduct is mandatory. The notice to the practitioner shall so state and shall be given by certified mail, return receipt requested.
- c. A practitioner's failure to attend any meeting with respect to which he/she was given notice that attendance was mandatory, unless excused by the Medical Executive Committee upon a showing of good cause, shall result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the Medical Executive Committee may direct, and such suspension shall remain in effect until the matter is resolved through any mechanism that may be appropriate, including corrective action, if necessary. If the practitioner makes a timely request for postponement supported by an adequate showing that his/her absence will be unavoidable, his/her attendance may be postponed to the next regular or special meeting by the Chairperson or by the Medical Executive Committee. If the Chairperson is the practitioner involved, such a postponement may only be granted by the Medical Executive Committee. This department shall not preclude any committee or department from reviewing the competence or conduct of any practitioner in his/her absence.
- d. Each member of the active Medical Staff shall be required to attend not less than fifty (50) percent of all regular meetings of the committees to which the member has been assigned. The failure to meet these attendance requirements may be grounds for dismissal from the committee. Vacancies shall be filled in accord with Article 10.2-3.
- e. Each member of the active Medical Staff shall be required to attend not less than fifty (50) percent of his/her respective quarterly departmental meetings and not less than fifty (50) percent of the quarterly general Medical Staff meetings or if a member of the Executive Committee, at least fifty (50%) percent of the monthly Medical Executive Committee meetings.

**ARTICLE XIII**  
**CONFIDENTIALITY, IMMUNITY AND RELEASES**

**13.1 AUTHORIZATION AND CONDITIONS**

By applying for and/or exercising clinical privileges within this Hospital, an individual:

- a. authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the individual's professional ability and qualifications;
- b. authorizes persons and organizations to provide information concerning the individual to the Medical Staff;
- c. agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital who acts in accordance with the provisions of this article to the fullest extent permitted by law; and
- d. acknowledges that the provisions of this Article are express conditions to the granting of Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges at this Hospital.

**13.2 CONFIDENTIALITY OF INFORMATION**

**13.2-1 General**

Medical Staff, department or committee minutes, files, and records, including information regarding any applicant, member or other individual exercising clinical privileges, shall, to the fullest extent permitted by law, be confidential. Dissemination of such information and records shall only be made where expressly required by law, or pursuant to officially adopted policies of the Medical Staff or, where no officially adopted policy exists, only with the express approval of the Medical Executive Committee or its designee.

**13.2-2 Breach of Confidentiality**

Inasmuch as effective peer review and consideration of the qualifications of Medical Staff applicants, members and other individuals exercising clinical privileges, to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff departments or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the hospital. If it is determined that such a breach has occurred pursuant to the actions of a committee member, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

**13.3 IMMUNITY FROM LIABILITY**

**13.3-1 For Action Taken**

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

**13.3-1 For Providing Information**

Each representative of the Medical Staff and hospital and all third parties shall be exempt, to the fullest extent permitted by law, from liability to any applicant, member or other individual

exercising clinical privileges, for damages or other relief by reason of providing any information concerning such person in connection with any evaluation of his or her competence or conduct.

### **13.4 ACTIVITIES AND INFORMATION CONVERED**

#### **13.4-1 Activities**

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

- a. applications for appointment, reappointment, or clinical privileges;
- b. corrective action;
- c. hearings and appellate reviews;
- d. utilization reviews;
- e. other department, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and
- f. queries and reports concerning the National Practitioner Data Bank, medical boards, and the actions of peer review organizations that engage in the monitoring or evaluation of professional competence or conduct.

### **13.5 RELEASES**

Each applicant and each member or other individual exercising clinical privileges, shall, upon request of the Medical Staff or hospital, execute general and specific releases in accordance with the express provisions and general intent, of this Article. Execution of such releases, however, shall not be deemed a prerequisite to the effectiveness of this Article.

### **13.6 INDEMNIFICATION**

The Hospital shall indemnify, defend and hold harmless the Medical Staff and its individual members from and against losses and expenses (including attorney's fees, judgments, settlements and all other costs, direct or indirect) incurred or suffered by reason or based upon any threatened, pending or completed action, suit, proceeding, corrective action investigation, or other dispute as a result of the members' participation in credentialing, quality assurance, and peer review activities including, but not limited to: (1) as a member of or witness for a Medical Staff department, service committee or hearing panel, (2) as a member or witness for the hospital board or any hospital task force group or committee and (3) as a person providing information to any Medical Staff or hospital group, officer, board member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a Medical Staff member or applicant.

The Medical Staff member may seek indemnification for such losses and expenses under this bylaw provision, statutory and case law, any available liability insurance or otherwise as the Medical Staff member sees fit, and concurrent or in such sequence as the Medical Staff or member may choose. Payment of any losses or expenses by the Medical Staff or member is not a condition precedent to the hospital's indemnification obligation hereunder.

**ARTICLE XIV  
GENERAL PROVISIONS**

**14.1 RULES AND REGULATIONS AND MEDICAL STAFF POLICIES**

- a. The Medical Staff shall initiate and adopt such general rules and regulations as it may deem necessary for the proper conduct of its work and shall periodically review and revise its rules and regulations to comply with current Medical Staff practice. Additions or recommended changes to the general Medical Staff rules and regulations shall be submitted to the Medical Executive Committee for review and evaluation prior to presentation for consideration and approval by the Governing Body in accordance with this article.
- b. The Medical Staff departments, through the recommendation of the department chairperson, may adopt department rules and regulations as may be necessary for proper conduct of work. The department chairperson shall periodically review and revise such rules and regulations to comply with current Medical Staff practices. Department rules and regulations may not conflict with general rules and regulations or Medical Staff Bylaws and the general rules and regulations and/or Bylaws shall prevail in any area of conflict. Recommended adoption and/or changes to the department rules and regulations shall be submitted to the Medical Executive Committee for review and approval by the chairperson of the department to which the rules and regulations apply.
- c. The Medical Executive Committee may elect to adopt specific Medical Staff policies and procedures as they may be necessary for proper conduct of work and shall periodically review and revise such Medical Staff policies and procedures to comply with current Medical Staff practices. The Medical Staff policies and procedures adopted by the Medical Executive Committee may not conflict with Medical Staff Rules and Regulations or Bylaws and Medical Staff Rules and Regulations and/or Bylaws shall prevail in any area of conflict. Recommendations, adoptions and/or changes to Medical Staff policies and procedures may be submitted to the Medical Executive Committee for review and approval from any Medical Staff department or committee. Any policy adopted by the Medical Executive Committee may be modified or overturned by vote of the General Medical Staff pursuant to the mechanism described in Section 11.2.
- d. Following approval of general rules and regulations by the MEC, or following Medical Executive Committee approval of department specific rules and regulations or Medical Staff policies as noted above, such rules and regulations or policies shall become effective following approval by the Governing Body. Governing Body approval shall not be withheld unreasonably and approval shall occur automatically within ninety (90) days if no action is taken by the Governing Body.
- e. In cases of a documented need for an urgent amendment of rules and regulations necessary to comply with law or regulation, the MEC may provisionally adopt and the Board may provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the MEC immediately informs the medical staff. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the MEC, the provisional amendment stands. If there is conflict over the provisional amendment, the process of resolving the conflict between the organized medical staff and the MEC is implemented. If necessary, a revised amendment is then submitted to the Board for action.
- f. Applicants and members of the Medical Staff and others holding clinical privileges shall be governed by such rules and regulations and Medical Staff policies as are properly initiated and adopted. If there is a conflict between the Bylaws and the rules and regulations, the Bylaws shall prevail. If there is a conflict between Medical Staff policies and rules and regulations, the rules and regulations shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff rules and regulations and policies.

## **14.2 DUES OR ASSESSMENTS**

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

## **14.3 CONSTRUCTION OF TERMS AND HEADINGS**

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

## **14.4 AUTHORITY TO ACT**

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

## **14.5 DIVISION OF FEES**

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

## **14.6 NOTICES**

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing properly sealed, and shall be sent through the United States Postal Service, first class postage prepaid. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained.

## **14.7 DISCLOSURE OF INTEREST**

All nominees for election or appointment to Medical Staff offices, department or the Medical Executive Committee shall, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

## **14.8 NOMINATIONS OF MEDICAL STAFF REPRESENTATIVES**

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

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

- a. The Medical Executive Committee shall review and make recommendations to the Governing Body regarding all quality of care issues related to exclusive arrangements for physician and/or professional services prior to action by the Governing Body. Such arrangements include:
  1. execution of an exclusive contract in a previously open department or service;
  2. renewal or modification of an exclusive contract in a department or service; and
  3. termination of an exclusive contract in a department or service.
- b. The Governing Body may conduct a notice and comment process to assess the quality of care issues related to such arrangements. As part of that process, the views of the Medical Executive Committee will be sought.

- c. The Governing Body shall give great weight to the recommendations of the Medical Executive Committee on quality of care issues.
- d. In the event that any proposed exclusive arrangement will result in termination or limitation of any Medical Staff membership and/or privileges for reasons related to professional conduct or competence, all adversely affected individuals shall be entitled to the procedural rights afforded by Article VII. All proceedings pursuant to Article VII arising from a specific proposed exclusive arrangement may be consolidated.
- e. In the event that any proposed exclusive arrangement will result in termination or limitation of any Medical Staff membership and/or privilege for reasons not related to professional conduct or competence, affected individuals shall not be entitled to procedural rights afforded by Article VII.

**ARTICLE XV**  
**ADOPTION AND AMENDMENTS OF BYLAWS**

**15.1 PROCEDURE**

These Bylaws may be amended after consideration by the Medical Executive Committee and submission to members of the active Medical Staff at least twenty (20) days prior to a regular or special meeting of the Medical Staff pursuant to Section 11.1 through 11.4. These Bylaws may also be amended by mail ballot as described below in Section 15.2.

**15.2 ACTION ON BYLAWS CHANGES**

If a quorum is present pursuant to Section 11.3 for the purposes of enacting a Bylaws and/or General Rules and Regulations change, the change shall require an affirmative vote of the majority of members voting in person or by validated mail ballot. In order for a member's vote to be counted, it must be submitted prior to the commencement of the regular or special meeting of the Medical Staff.

Alternatively, the Executive Committee, after following the preliminary process described hereinabove, may decide to present the matter to the Active Medical Staff for consideration by mail ballot, in which case the proposed amendment shall be disseminated to the members of the Active Medical Staff along with a suitable secret written ballot, which is to be returned within the designated time. Adoption of such an amendment shall require a majority vote of those returning valid ballots.

**15.3 APPROVAL**

Bylaws and/or General Rules and Regulations changes adopted by the Medical Staff shall become effective following approval of the Governing Body, which approval shall not be withheld unreasonably. Neither the Governing Body nor the Medical Staff may unilaterally amend or cancel the Medical Staff Bylaws and its Rules and Regulations. If approval by the Governing Body is withheld, the reason for doing so shall be specified by the Governing Body in writing and shall be forwarded to the Chief of Staff, the Medical Executive and Bylaws Committees. Changes in the Bylaws and Rules and Regulations adopted at any regular or special meeting of the Medical Staff shall replace any previous Bylaws and Rules and Regulations.

**15.4 EXCLUSIVE MECHANISM**

The mechanism described herein shall be the sole method for the initiation, adoption, amendment or repeal of the Medical Staff Bylaws and General Rules and Regulations.

**15.5 REVIEW**

These Bylaws and Rules and Regulations shall be reviewed at least every two (2) years and revisions made according to the described amendment procedure.

**15.6 SUCCESSOR IN INTEREST**

These Bylaws and the membership privileges accorded under these Bylaws will be binding upon the Medical Staff and the Governing Body of any successor in interest in this hospital except where hospital Medical Staffs are being combined.



## APPROVALS

<b>Status</b>	<b>MEC Recommendation</b>	<b>Medical Staff Approval</b>	<b>MEC Approval</b>	<b>Governing Board Approval</b>
Approved	10/13/2009	1/11/2010		1/19/2010
Revision	7/13/2010			9/21/2010
Revision			7/10/2012	7/24/2012
Revision		4/11/2016	5/10/2016	5/25/2016
Revision		6/13/2019	6/14/2016	6/22/2016
Revision	6/10/2019	6/20/2019	8/13/2019	8/28/2019
Revision	7/9/2019	6/20/2019	9/10/2019	9/19/2019
Revision	8/13/2019	11/8/2019	11/12/2019	11/20/2019
Revision	9/10/2019	12/12/2019	6/9/2020	6/17/2020
Revision	2/11/2020	4/9/2020	6/9/2020	6/17/2020
Revision	1/12/2021	3/18/2021	5/11/2021	5/19/2021
Revision	1/11/2022	3/10/2022	4/12/2022	4/20/2022
Revision	6/7/2022	6/29/2022	7/12/2022	7/20/2022
Revision	8/9/2022	9/8/2022	10/11/2022	10/19/2022
Revision	7/11/2023	8/7/2023	8/14/2023	8/24/2023