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QUEEN OF THE VALLEY MEDICAL CENTER
MEDICAL STAFF BYLAWS

PREAMBLE

WHEREAS, the Queen of the Valley Medical Center is a non-profit medical center organized under the laws of the State of California; and,

WHEREAS, its purpose is to serve as a medical center providing patient care, education, and research; and,

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care provided by the members of the Medical Staff in the medical center and must accept and discharge this responsibility, and that the cooperative efforts of the Medical Staff, the Chief Executive Officer, and the governing body are necessary to fulfill the medical center's obligations to its patients; and,

WHEREAS, the Medical Staff shall be self-governing; and,

WHEREAS, these bylaws recognize that the organized medical staff has the authority to establish and maintain patient care quality standards. This includes participation in the development of relevant medical center policies involving the oversight of care, treatment and services provided by members and others in the medical center. The medical staff is also responsible for and involved with other aspects of delivery of health care within the medical center including, but not limited to, the treatment and services delivered by practitioners credentialed and privileged through the mechanisms described in these bylaws and the functions of credentialing and peer review; and,

WHEREAS, these bylaws acknowledge that the provision of quality medical care in the medical center depends on the mutual accountability, interdependence and responsibility of the medical staff, the medical center administration and the medical center governing board for the proper performance of their respective obligations; and,

THEREFORE, be it resolved that the physicians, dentists, and podiatrists in this medical center hereby organize themselves into a medical staff in conformity with these bylaws, and the Medical Staff shall consist only of those members approved by both the Medical Staff and governing body.

DEFINITIONS

- 1. Attending Practitioner:** The attending practitioner is the physician who has admitted the patient. He/she is responsible for the patient's care until such time that they have appropriately transferred the care to another accepting practitioner (Rule and Regulation 1.4).
- 2. Chief Executive Officer or President:** Chief administrative officer of the medical center.

3. **Chief of Staff:** Individual elected by the Medical Staff to act on its behalf in the overall management of the medical center Medical Staff activities. The title shall be that of "Chief of Staff."
4. **Clinical Privileges or Privileges:** Permission granted to medical staff members or Allied Health Professionals to provide patient care, and includes unrestricted access to those medical center resources (including equipment, facilities, and medical center personnel) that are necessary to effectively exercise those privileges.
5. **Credentialed Personnel:** Allied Health Professionals whose professional credentials have been reviewed and approved by appropriate Medical Staff committees. Allied Health Professionals are not members of the Medical Staff.
6. **Emergency Medical Condition:** A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, psychiatric disturbances, and or symptoms of substance abuse, such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. With respect to a woman who is pregnant and is having contractions: an emergency condition is when there is inadequate time to effect a safe transfer to another hospital prior to delivery or such transfer may pose a threat to the health and safety of the woman or the unborn child.
7. **Medical Staff Executive Committee (MSEC):** The Executive Committee of the Medical Staff unless specific reference is made to the executive committee of the governing body, or executive committees of medical staff departments.
8. **Governing Body:** Board of Trustees of the medical center.
9. **In Good Standing:** Means a member is currently not under suspension or serving with any limitation of voting.
10. **Investigation:** An information-gathering process conducted under the auspices of the MSEC pursuant to Article VI of these Bylaws.
11. **Medical Staff:** All California-licensed physicians and surgeons, dentists and podiatrists, who are accepted as members of the Medical Staff by the organized Medical Staff and the governing body of the medical center.
12. **Medical Staff Year:** Means the period from January 1 to December 31.
13. **Practitioner:** A California-licensed physician and surgeon, dentist, or podiatrist.
14. **Primary Source:** The entity or agency that has the legal authority to issue the credential being verified. If the entity or agency has designated another entity or agency to communicate information about the status of a staff members' credential, then the other entity or agency may be considered the primary source.

15. **Special notice:** Notice deemed effective when placed in the U.S. Mail, certified, return receipt requested, to the address of the practitioner on file at the medical center, or when personally delivered to the practitioner or practitioner's office.
16. **Telemedicine:** The use of medical information exchanged from one site to another via electronic communications.

Originating Site: refers to the patient's location at the time the service is provided.

Distant site: refers to the location of the practitioner providing the professional service.

ARTICLE I

NAME

The name of this organization shall be the QUEEN OF THE VALLEY MEDICAL CENTER MEDICAL STAFF.

ARTICLE II

MEDICAL STAFF MEMBERSHIP

2.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff of Queen of the Valley Medical Center is a privilege that shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws.

Medical Staff membership shall confer only such clinical privileges and prerogatives as have been granted in accordance with these bylaws.

2.2 QUALIFICATIONS FOR MEMBERSHIP

With the exception of Honorary status, only practitioners licensed to practice as a physician, podiatrist, or dentist in the State of California, who can document their background, experience, training, and demonstrated competence, their adherence to the ethics of their profession, their good reputation, their physical and mental health, and their ability to work with others to the extent that it is directly related to considerations of patient care with sufficient adequacy to assure the Medical Staff and the governing body that any patient treated by them in the medical center will be given quality medical care, shall be qualified for membership on the Medical Staff.

2.2-1 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership in the medical staff merely because that person holds a certain degree, is licensed to practice in this or any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at another health care facility. Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, surgery center or other outpatient service facility, independent practice

association (IPA), preferred provider organization (PPO), physician-hospital organization (PHO), medical center sponsored foundation or other organization or in contracts with a third party which contracts with this medical center, with the exception of privileges which are subject to an exclusive contract or arrangement. Medical staff membership or clinical privileges shall not be revoked, denied, or otherwise infringed based on the member's professional or business interests.

2.3 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

2.3-1 RESPONSIBILITIES

The ongoing responsibilities of each member of the Medical Staff include the following, as applicable:

- (a) providing patients with the quality of care meeting the professional standards of the Medical Staff of this medical center.
- (b) abiding by the Medical Staff Bylaws, Medical Staff Rules and Regulations, Code of Conduct, and Policies and Procedures of the Medical Staff and medical center policies as approved by the Medical Staff Executive Committee (MSEC).
- (c) abiding by the requirements as set forth in the Health Insurance Portability and Accountability Act (HIPAA).
- (d) discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments.
- (e) preparing and completing in timely fashion medical records for all the patients to whom the member provides care in the medical center.
- (f) agreeing to abide by the Principles of Medical Ethics of the American Medical Association; the American Osteopathic Association Code of Ethics; the American Dental Association Principles of Ethics and Code of Professional Conduct; or the Code of Ethics of the American Podiatric Medical Association, as appropriate to the practitioner's degree and/or licensure; and by the Ethical and Religious Directives for Catholic Healthcare Services, as the same are made a part of these Bylaws.
- (g) aiding in any Medical Staff approved educational programs for medical students, interns, resident physicians, resident dentists, staff physicians and dentists, nurses and other personnel as reasonable and as may be requested from time to time.
- (h) working cooperatively with members, nurses, medical center administration and others so as not to adversely affect patient care.
- (i) providing for continuous care or making appropriate arrangements for coverage, including on-call coverage, of the member's patients as stipulated by the Medical Staff Rules and Regulations, Section V.

- (j) refusing to engage in improper inducements for patient referral, ghost surgical or medical care and legally prohibited fee splitting.
- (k) participating in continuing education programs as determined by the Medical Staff.
- (l) participating in such emergency service coverage or consultation panels as may be determined by the Medical Staff.
- (m) notifying the Chief of Staff within ten (10) days, in writing through the Medical Staff Services Department, of
 - (1) a lapse, reduction in the limits or scope of coverage, or cancellation of professional liability insurance;
 - (2) any investigation initiated, and/or accusation filed, and/or disciplinary action taken, by the licensing body of any state that regulates the practitioner, including the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the California Board of Dentistry;
 - (3) the initiation of formal proceedings by a licensing authority or the Drug Enforcement Agency (DEA), including the filing of an Accusation or Complaint, to suspend, revoke or place on probation a license or a DEA certificate;
 - (4) an action or recommendation by the MSEC or the governing body of another healthcare facility to suspend, limit, restrict, reduce, revoke or deny clinical privileges at that healthcare facility for reasons related to professional competence or conduct;
 - (5) the development of any mental or physical condition or other situation that could significantly compromise the member's ability to perform the functions associated with the member's clinical privileges in a safe and effective manner;
 - (6) any disciplinary action, whether initiated or taken, that affects or could affect the member's ability to participate in the Medicare or Medicaid (Medi-Cal) programs;
 - (7) any exclusion from participation in any state or federal healthcare program, including, but not limited to, Medi-Cal or Medicare; or
 - (8) any formal allegations of fraud or abuse or illegal activity relating to the member's professional practice or conduct made by any state or federal government agency foreign or domestic.
- (n) Completing a medical history and physical examination no more than thirty (30) days before or twenty-four (24) hours after admission for each patient. When the medical history and physical examination are completed within thirty (30) days before admission, an updated medical record entry documenting an examination

for any changes in the patient's condition must be completed and documented in the patient's medical record immediately prior to a surgical procedure or within twenty-four (24) hours after a medical admission. See Medical Staff Rules and Regulations Section XI for additional requirements.

- (o) discharging from time to time, such other staff obligations as may be lawfully established by the Medical Staff or MSEC.

2.3-2 FAILURE TO COMPLY

Failure to perform any of the responsibilities listed above may be reported to the MSEC for reprimand, censure, or other disciplinary measures as provided in Article VI.

2.4 NONDISCRIMINATION

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

2.5 REQUIREMENTS OF PROFESSIONAL LIABILITY INSURANCE

As a condition of clinical privileges, including all temporary privileges, each practitioner shall carry at all times (unless otherwise noted in these Bylaws, Rules/Regulations or by exception approved by the MSEC) professional liability insurance coverage in an amount not less than the minimum established by the MSEC. The MSEC shall have the authority to review and revise the minimum amount of coverage with the approval of the governing body. At the time of application and reapplication to the Medical Staff, the MSEC shall be advised of the member's insurance carrier and the minimum limits of the member's policy. The MSEC shall have the right to require evidence of coverage at any time.

2.6 CONDITIONS AND DURATION OF APPOINTMENT

The governing body shall make initial appointments and reappointments to the Medical Staff. The governing body shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Staff as provided in these Bylaws; provided that in the event of unwarranted delay on the part of the Medical Staff, the governing body may act without such recommendation on the basis of documented evidence of the applicant's or staff member's professional and ethical qualifications obtained from reliable sources other than the Medical Staff. The governing body may not claim that there has been unwarranted delay until at least one hundred (100) days have passed since the Medical Staff received a complete application; however, merely because 100 days have passed since the Medical Staff received a complete application does not in and of itself constitute an unwarranted delay. Notice of intent of the governing body to act in the absence of a recommendation of the Medical Staff in the event of such unwarranted delay is to be sent to the MSEC and any Joint Conference Committee of the Medical Staff and governing body before such action is taken by the governing body.

Initial appointments to the Medical Staff shall be not longer than twenty-four (24) months and shall be subject to the provisions of Article III of these Bylaws. Reappointments to staff membership shall be for a period of up to twenty-four (24) months.

Appointments to the Medical Staff by the governing body shall confer on the appointee only such clinical privileges as have been approved and recommended by the Medical Staff in accordance with these Bylaws.

2.7 HARASSMENT PROHIBITED

Harassment by a medical staff member against any individual on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation shall not be tolerated. Any individual includes, but is not limited to, another medical staff member, credentialed personnel, medical center employee, patient or volunteer.

Sexual harassment is unwelcome verbal or physical conduct of a sexual nature that may include verbal harassment (including, but not limited to, epithets, derogatory comments or slurs), physical harassment (including, but not limited to, unwelcome touching, assault, or interference with movement or work), and visual harassment (including, but not limited to, the display of derogatory cartoons, drawings, or posters).

Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment.

Sexual harassment also includes conduct that indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities. All allegations of prohibited harassment shall be immediately investigated by the medical staff, and, if confirmed, will result in appropriate corrective action, from reprimands up to and including termination of medical staff privileges and membership, if warranted by the facts.

For non-patient complaints, individuals involved in a medical staff harassment conflict should be offered a confidential mediation process at the initial meeting with each party and, if confidential mediation is refused by any party, all investigations and proceedings surrounding the medical staff harassment allegations shall be conducted within the medical staff committee structure. If all parties accept confidential mediation, it may be held outside of the medical staff committee structure. Any resulting formal, corrective action against a medical staff member shall be held within the usual medical staff committee structure. Complaints brought by patients or others involving patient care to any degree shall be handled wholly within the medical staff structure. (Also see Medical Staff Code of Conduct.)

2.8 MEDICAL-ADMINISTRATIVE OFFICER

Any member of the Medical Staff who has a contract with the medical center which requires membership on the Medical Staff and/or clinical privileges, is subject to the

same procedures as all other applicants for membership or privileges. These individuals shall not have Medical Staff membership terminated without the same rights of hearing and appeal as are available to all members of the Medical Staff, except in cases of exclusive contracts (see Section 7.6).

2.9 LEAVE OF ABSENCE

2.9-1 LEAVE STATUS

(a) Routine Leave of Absence

A Staff member who intends to be absent from practice at the medical center for a period of six (6) months or longer shall request a voluntary leave of absence from the Medical Staff by submitting written notice to the Department Chair and the Chief Executive Officer stating the approximate period of time of the leave which may not exceed two (2) years. A practitioner who requests a leave of less than two years may request that the leave be extended to a total of two years.

(b) Medical Leave of Absence

The Chief of Staff, in consultation with the appropriate Department Chair, may approve a medical leave of absence to accommodate a practitioner's treatment for, or recovery from, a mental or physical condition affecting the practitioner's fitness to practice safely. A medical leave of absence may not exceed two (2) years.

2.9-2 TERMINATION OF LEAVE

As early as possible prior to the proposed termination of a leave of absence, the member must request reinstatement, in writing, through the Medical Staff Services Department. The Department Chair and the Chief of Staff shall each have the prerogative to request from the member an accounting of his/her activities during the leave. The member may be required to produce documentation or demonstration of fitness to return to practice, with specific reference to his/her specialty and clinical privileges.

If during the leave of absence the member's appointment will expire, the member will be required to complete a reappointment application upon expiration of the appointment period as prescribed in Section 4.7. In all instances, the Department Chair shall make a determination of current clinical competence. This determination shall be forwarded to the Credential's Committee. The MSEC shall receive the Credentials Committee's report and make a recommendation to the governing body concerning the reinstatement of the member's privileges and prerogatives.

Failure, without good cause, to request an extension of the leave of absence or reinstatement or to provide a requested summary of activities or documentation or demonstration of fitness or to complete a reappointment application as above provided shall be deemed a voluntary resignation from the Staff and result in automatic termination of Staff membership, privileges, and prerogatives. A practitioner whose membership is so terminated shall be entitled to the procedural rights provided in Article VII for the sole purpose of determining whether good cause existed for the failure to

request an extension or reinstatement or to provide the requested information. A request for Staff membership subsequently received from a Staff member who has been terminated pursuant to this paragraph shall be submitted and processed as an application for initial appointment.

2.10 RESIGNATION

Resignation from the Medical Staff should be made in writing but may be made verbally and shall be effective upon receipt of notice by any Medical Staff Officer, Department Chair, or the Medical Staff Services Department. The Medical Staff Officer, Department Chair, or Medical Staff Services Department shall document verbal resignations.

ARTICLE III

CATEGORIES OF THE MEDICAL STAFF

3.1 THE MEDICAL STAFF

The Medical Staff shall be divided into Provisional, Active, Courtesy, Consulting, Honorary, Affiliate and Administrative categories.

3.2 PROVISIONAL MEMBERSHIP

3.2-1 INITIAL APPOINTMENT

All initial appointments to the Medical Staff shall be for a period of two (2) years and shall be on a provisional basis for at least the first year. Failure to advance an appointee from Provisional to either Active, Consulting, Courtesy, Administrative or Affiliate Staff shall result in a termination of Staff appointment. A provisional appointee whose status is so terminated shall have the rights afforded by these Bylaws as a member of the Medical Staff who has failed to be reappointed if the termination results from a medical disciplinary cause or reason.

3.2-2 PROVISIONAL APPOINTEES

Provisional appointees shall be assigned to the appropriate department where their performance shall be observed by the Chair of the department or delegated representative to determine the eligibility of such provisional appointees for regular Staff membership and for exercising the clinical privileges provisionally granted to them. It shall be the responsibility of the appropriate department to review and evaluate the competence, skill and professional judgment of the provisional appointee. A member shall remain on the Provisional Staff for a period of at least one year but not to exceed a total of two years. The Department Chair whose recommendation is forwarded shall make consideration for advancement to the Credentials Committee and Medical Staff Executive Committee (MSEC) and their recommendations shall consider the recommendation of the appropriate Department Chair.

Prerogatives: Provisional appointees:

- (a) may serve on departmental or standing medical staff committees and may vote on such committees;
- (b) may not hold office on the Medical Staff or vote in General Staff or department meetings;
- (c) may admit patients consistent with his/her privileges, unless otherwise provided in the Medical Staff Bylaws or Rules and Regulations;
- (d) exercise such clinical privileges as are granted to him/her pursuant to Article V.

Responsibilities:

Each Provisional Staff member shall be required to discharge the applicable responsibilities that are specified in Section 3.3 for Active Staff members. Failure to fulfill those responsibilities shall be grounds for denial of advancement to Active, Courtesy, Consulting, Affiliate or Administrative Staff status and for termination of Provisional Staff status.

3.3 THE ACTIVE MEDICAL STAFF

Qualifications:

The Active Medical Staff shall consist of practitioners who have satisfactorily completed their designated term in the provisional staff category, regularly admit patients to, or are otherwise involved regularly in the care of patients in the medical center, who have offices or residences which, in the opinion of the MSEC, are located closely enough to the medical center to provide appropriate continuity of quality care, and who assume all the functions and responsibilities of membership on the Active Staff as designated by the MSEC, including where appropriate, emergency service care, consultation and proctoring assignments. Active staff members shall have a minimum of ten (10) patient encounters per year. This would include admissions, services, procedures or clinical consultations. Members of the Active Medical Staff shall be appointed to a specific department.

Prerogatives:

The prerogatives of the Active staff shall be to:

- (a) admit patients consistent with his/her privileges, unless otherwise provided in the Medical Staff Bylaws or Rules and Regulations;
- (b) exercise such clinical privileges as are granted to him/her pursuant to Article V;
- (c) vote, hold office, and serve on Medical Staff committees, of which he/she is a member, unless otherwise provided in the Medical Staff Bylaws;
- (d) vote for Medical Staff officers, on Bylaws amendments, and on all matters presented at General and Special meetings of the Medical Staff and of the Department and committees of which he/she is a member, unless otherwise provided in the Medical Staff Bylaws.

Responsibilities:

Each Active Medical Staff member shall:

- (a) meet the basic responsibilities set forth in Section 2.3;
- (b) actively participate in and regularly assist the medical center in fulfilling its obligations related to patient care within the areas of his/her professional competence, including, but not limited to, emergency service and back up function, peer review, utilization management, case management, quality evaluation and related monitoring activities required of the Medical Staff in supervising and proctoring initial appointees and allied health professionals, and in discharging such other functions as may be required by the MSEC from time to time;
- (c) participate in such emergency service coverage or consultation panels as may be determined by the medical staff.

3.4 THE AFFILIATE MEDICAL STAFF

Qualifications:

The Affiliate Medical Staff shall consist of practitioners who meet the general qualifications set forth in Section 2.2, and who 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.

The Affiliate member shall be appointed in the same manner as other members of the Medical Staff, as outlined in Article IV.

Prerogatives:

The prerogatives of the Affiliate staff shall be:

- (a) Affiliate Staff members may have access to the medical records of his or her patients with whom they have an established patient/physician relationship, but will not be allowed to make written entries in said records;
- (b) Affiliate Staff members shall be able to attend educational activities of the medical staff or other general or departmental medical staff meetings;
- (c) Affiliate Staff members shall not be eligible to hold clinical privileges;
- (d) Affiliate Staff members shall not be eligible to vote, hold elective office, or serve on medical staff committees.

Responsibilities:

Each Affiliate Medical Staff member shall:

- (a) meet the basic responsibilities set forth in Section 2.3, as applicable.

3.5 THE COURTESY MEDICAL STAFF

Qualifications:

The Courtesy Medical Staff shall consist of practitioners who normally admit or care for no more than ten patients annually to the medical center. The Courtesy member must be an Active member of a Medical Staff at another accredited facility where they are subject to a patient care audit program and which has quality review, evaluation and monitoring activities similar to those required of the Active Staff of this medical center. The Courtesy member shall be appointed in the same manner as other members of the Medical Staff, as outlined in Article IV, with clinical privileges delineated in accordance with Article V.

Prerogatives:

The prerogatives of the Courtesy staff shall be to:

- (a) admit patients consistent with his/her privileges, unless otherwise provided in the Medical Staff Bylaws or Rules and Regulations;
- (b) exercise such clinical privileges as are granted to him/her pursuant to Article V;
- (c) Courtesy Staff members shall not be eligible to vote or hold elective office but they may be asked to serve on committees; the right to vote on the committee shall be specified at the time of appointment.

Responsibilities:

Each Courtesy Medical Staff member shall:

- (a) meet the basic responsibilities set forth in Section 2.3.

3.6 THE CONSULTING MEDICAL STAFF

Qualifications:

The Consulting Medical Staff shall consist of recognized specialists for whom there is a need. Consulting Staff members must:

- (a) meet the general qualifications for Medical Staff membership;
- (b) possess clinical and professional expertise required by the Medical Staff consistent with the requested privileges;
- (c) be willing and able to come to the medical center on schedule or promptly respond when called to render consultation services within their area of competence.

Prerogatives:

Consulting Staff:

- (a) may consult on patients consistent with his/her privileges;
- (b) may exercise such clinical privileges as are granted to him/her pursuant to Article V;
- (c) may not vote or hold elective office.

Responsibilities:

Each Consulting Medical Staff member shall:

- (a) meet the basic responsibilities set forth in Section 2.3.

3.7 THE HONORARY MEDICAL STAFF

Qualifications:

The Honorary Medical Staff shall consist of practitioners who are not active in the medical center or who are honored by emeritus positions. These may be practitioners who have retired from active hospital practice or who are of outstanding reputation and not necessarily residing in the community.

Prerogatives:

Honorary Staff members shall not be eligible to admit patients, hold or exercise clinical privileges, to vote, hold office, or serve on standing Medical Staff committees, but may attend meetings of the Medical Staff.

Responsibilities:

Honorary Staff members shall have no specific responsibilities and shall not be required to pay fees. They shall be required to abide by these Bylaws, the Rules and Regulations of the Medical Staff and policies of the Medical Staff and medical center as they may apply.

3.8 THE ADMINISTRATIVE STAFF

Qualifications:

The Administrative Medical Staff shall consist of members who are otherwise not eligible for another staff category and are retained by the medical center in an administrative capacity. They shall:

- (a) meet the minimum qualifications for Medical Staff membership as outlined in Section 2.2;
- (b) be willing to participate in Medical Staff activities, work cooperatively with others, and properly discharge the responsibilities that are assigned to them.

Prerogatives:

Administrative Staff members shall not be eligible to vote or hold elective office but they may be asked to serve on committees; the right to vote on the committee shall be specified at the time of appointment. Administrative Staff members shall not admit patients and/or exercise clinical privileges.

Responsibilities:

Administrative Staff members are to act as a liaison between the medical center Administration and the Medical Staff and shall meet such responsibilities as may be assigned by medical center Administration. They shall not be required to pay fees. They shall be required to abide by these Bylaws, Rules and Regulations of the Medical Staff and policies of the Medical Staff and the medical center as they may apply.

ARTICLE IV

PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

4.1 APPLICATION FOR APPOINTMENT OR REAPPOINTMENT

By applying for medical and/or allied health professional staff membership and/or privileges, each applicant for initial appointment or for reappointment agrees to abide by these Bylaws, the Medical Staff Rules and Regulations, and the Medical Staff and medical center policies and procedures established by the Medical Staff Executive Committee (MSEC) and approved by the Board of Trustees of Queen of the Valley Medical Center.

Credentialing and privileging processes for medical and/or allied health professional staff will follow all applicable federal and state regulatory guidelines.

If requested, process descriptions for credentialing and privileging of medical and/or allied health professional staff will be made available to the applicant.

All applications for appointment or reappointment to the Medical Staff shall be in writing or in electronic format, shall be signed by the applicant, and shall be submitted on a form prescribed by the governing body after consultation with the MSEC.

Only a completed application for appointment or reappointment qualifies for consideration according to the Medical Staff credentialing process described in these Bylaws. A completed application must include all of the information requested on the application form or otherwise during the course of the credentialing process as specified in these bylaws.

By applying for appointment or reappointment to the Medical Staff, each applicant thereby signifies willingness to appear for interviews with respect to the application; authorizes the Hospital to consult with members of the medical staffs of other hospitals with which the applicant has been associated, and with others who may have information bearing on the applicant's competence, character, health and ethical qualifications; consents to the Hospital's inspection of all records and documents that may be material to an evaluation of professional qualifications and competence to carry out the clinical privileges requested, including criminal background checks, as well as of the applicant's health and moral and ethical qualifications for Staff membership; releases from any liability all representatives of the Hospital and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and the applicant's credentials, and releases from any liability all individuals and organizations who provide information to the Hospital concerning the applicant's competence, ethics, character, and other qualifications for Staff appointment and clinical privileges, including otherwise privileged or confidential information, to the full extent that the law permits.

The applicant for appointment or reappointment shall have the burden of producing adequate information for a proper evaluation of the applicant's competence, ability to perform the mental and physical functions associated with the privileges requested, character, ethics, training, experience, and other qualifications, and for resolving any reasonable doubts about such qualifications. Applications with material omissions or

misrepresentations will be deemed as incomplete and are not eligible for further processing. Any individual who has previously had an application for membership or clinical privileges deemed ineligible for processing due to misrepresentation or material omission will be ineligible to apply for a period of two (2) years.

If a member of the medical staff is not recommended for reappointment due to lack of sufficient clinical activity as determined by the departmental policy, the reappointment candidate may not reapply for medical staff membership or privileges unless an explanation is submitted in writing and accepted by the Credentials Committee as to how the physician's situation has substantially changed so as to meet the departmental activity requirements.

An application which is determined to be incomplete shall not qualify for a credentialing recommendation, regardless of any assessment or determination. If the applicant fails to complete the application within thirty (30) days of receiving notice of the incomplete application, the credentialing process will be terminated, without action being taken on the application. Termination of the credentialing process under this provision shall not entitle the applicant for appointment or reappointment to any hearing or appeal under ARTICLE VII.

Until notice is received from the governing body regarding final action on an application for appointment, reappointment or new clinical privileges, the applicant shall be responsible for keeping the application current and complete by informing the Medical Staff Services Department, in writing, of any material change in the information provided or new information that might reasonably have an effect on the applicant's candidacy. Failure to meet this responsibility shall be grounds for denial of the application, nullification of an approval if granted, and/or termination of Medical Staff membership.

4.2 APPOINTMENT PROCESS

4.2-1 DEPARTMENT CHAIR EVALUATION AND RECOMMENDATION

At the time the review and recommendation on initial appointment and privileges is made, the assigned Department Chair may also make a recommendation on expedited consideration of the application.

4.2-2 EXPEDITED CONSIDERATION

- (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 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 medical center, 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 MSEC. The action will be reported to the Credentials Committee at its next regularly scheduled meeting.
- (c) The MSEC shall review the application and make a recommendation. If the MSEC's recommendation is adverse or has limitations, the application is ineligible for expedited consideration by the Governing Body. If the recommendation is favorable, the application will be forwarded to a duly authorized subcommittee of the Governing Body for expedited action. The subcommittee must include at least two voting members of the Governing Body.

4.2-3 APPLICANTS FOR TELEMEDICINE ONLY

The Medical Staff may accept all or part of the credentialing information required for appointment or reappointment from a Joint Commission-accredited organization; however, the application shall be processed in a manner similar to all other applicants.

- (a) Individuals providing telemedicine services shall be credentialed and granted privileges in accordance with this section.
- (b) In processing a request for initial grant or renewal of telemedicine privileges pursuant to this section, the Hospital may:
- (1) credential and grant/renew privileges to the practitioner in accordance with the provisions of these Bylaws in the same manner as for any other applicant; or
- (2) credential and grant/renew privileges to the practitioner in accordance with the provisions of these bylaws utilizing the credentialing information from the practitioner's group, provided that group is accredited by The Joint Commission.
- (c) Individuals practicing only telemedicine will be appointed to the Consulting category of the medical staff after the initial provisional appointment.
- (d) Individuals granted telemedicine privileges shall be subject to the Medical Center's Performance Improvement and professional and peer review activities.

4.2-4 CONSIDERATION OF THE APPLICATION

Applications not recommended for expedited consideration will proceed to the Credentials Committee, MSEC, and Governing Body in accordance with provisions outlined below:

- (a) Within sixty (60) days after receipt of the completed application for membership, the Credentials Committee shall make a written report of its findings to the MSEC. Prior to making this report, the Credentials Committee shall examine the evidence of the character, professional competence, past or pending malpractice actions, qualifications and ethical standing of the practitioner and shall determine, through information contained in references given by the practitioner and from other sources available to the Committee, including an appraisal and recommendation from the Chair of the clinical department in which privileges are sought, whether the practitioner has established and meets all the necessary qualifications for the category of Staff membership and the clinical privileges requested. The Credentials Committee shall transmit to the MSEC the completed application and a recommendation that the practitioner be either provisionally appointed to the Medical Staff or rejected for Medical Staff membership, or that the application is deferred for further consideration. Where non-acceptance or deferment is recommended, the reasons for such recommendations shall be stated along with the recommendations of the Credentials Committee.
- (b) At its next regular meeting after receipt of the application and the report and recommendation of the Credentials Committee, the MSEC shall determine whether to recommend to the governing body that the practitioner be provisionally appointed to the Medical Staff or be rejected for Medical Staff membership, or that the application be deferred for further consideration. All recommendations to appoint must also specifically recommend the applicable clinical privileges to be granted.
- (c) When the recommendation of the MSEC is to defer the application for further consideration, it must be followed up within sixty (60) days with subsequent recommendation for provisional appointment with specified clinical privileges or for rejection of the Staff membership.

4.3 EFFECT OF MSEC ACTION

Approvals, denials and revocations of medical staff membership and or privileges 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 6.1-5 and Section 7.5-6.

4.4 ACTION ON THE APPLICATION

The governing body may accept or reject (pursuant to the following procedures) the recommendation of the MSEC or may refer the matter back to the MSEC for further consideration, stating the purpose for such referral. The following procedures shall apply with respect to action on application:

- (a) If the MSEC issues a favorable recommendation and

- (1) the governing body concurs in that recommendation, the decision of the governing body shall be deemed final action.
 - (2) the tentative final action of the governing body is unfavorable, the chief executive officer shall give the applicant written notice of the tentative adverse recommendation and the applicant shall be entitled to the procedural rights set forth in Article VII. If the applicant waives procedural rights, the decision of the governing body shall be deemed final action.
- (b) In the event the recommendation of the MSEC is unfavorable to the applicant and a report to the Medical Board of California or the National Practitioner Data Bank is required, the procedural rights set forth in Article VII shall apply, and,
- (1) if no Judicial Review Committee hearing is requested by the applicant, the recommendation of the MSEC shall be forwarded to the governing body.
 - (2) if the applicant requests a hearing following the adverse MSEC recommendation pursuant to paragraph 4.2-4 or an adverse governing body tentative final action pursuant to paragraph 4.4(a)(2), the governing body shall take final action only after the applicant has exhausted all procedural rights as established by Article VII. After exhaustion of the procedures set forth in Article VII, the governing body shall make a final decision and shall affirm the decision of the Judicial Review Committee if the Judicial Review Committee's decision is supported by substantial evidence, following a fair procedure. The governing body's decision shall be in writing and shall specify the reasons for the action taken.

4.5 NOTICE OF FINAL DECISION

- (a) Notice of the final decision shall be given to the applicant and Medical Staff Services personnel for dissemination as appropriate.
- (b) A decision and notice of appointment or reappointment shall include, if applicable:
 - (1) the staff category to which the applicant is appointed;
 - (2) the department to which the applicant is assigned;
 - (3) the clinical privileges granted; and,
 - (4) any special conditions attached to the appointment.

4.6 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of twenty-four (24) months. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

4.7 REAPPOINTMENT PROCESS

4.7-1 REAPPOINTMENT FORM

- (a) The Medical Staff Services Department shall, at least one hundred thirty (130) days prior to the expiration date of the present Staff appointment of each Medical Staff member, send each Staff member a reappointment application form. A deadline of no less than thirty (30) days from date sent should be given for the return of the reappointment application. Such form must be completed and delivered to the office of the Medical Staff Services Department. Failure to return the form to the Medical Staff Services Department in a timely manner shall be addressed as provided in Section 4.7-7.
- (b) The application shall be on a form approved by the governing body after consultation with the MSEC. Required information shall be as specified within the Reappointment Form.

4.7-2 VERIFICATION OF INFORMATION

The Medical Staff Services Department, acting as an agent of the Credentials Committee, shall, prior to expiration of the Staff member's present Staff appointment, seek to collect and verify the additional information made available on each reapplication form, including activities at other facilities, and to collect any other materials or information deemed pertinent, including, but not limited to, information regarding the Staff member's professional activities, performance and conduct in this medical center and fulfillment of Staff membership obligations, peer references, and shall request a copy of any and all information required by California law from the Staff member's licensure board and from the National Practitioner Data Bank and the Department of Health and Human Services Office of the Inspector General List of Excluded Individuals and System for Award Management (SAM) Exclusion Records. The Medical Staff Services Department shall promptly notify the Staff member of any problems in obtaining the information required, and it shall be the Medical Staff member's obligation to obtain the required information and to provide it to the Medical Staff Services Department. When collection and verification are accomplished, the reapplication form and supporting materials shall be transmitted to the chair of each department in which the Staff member requests privileges. A Medical Staff representative may make additional requests for information at any time in the credentialing process.

4.7-3 DEPARTMENT ACTION

The Chair of the Staff member's assigned Department shall, at least thirty (30) days prior to expiration of a member's present Staff appointment, review the reapplication form and the Staff member's file and shall transmit to the Credentials Committee a report and recommendation that appointment be renewed, renewed with modified Staff category, Department affiliation and/or clinical privileges, or denied. A Chair may also recommend that action be deferred. Each such report shall satisfy the requirements of Section 4.7-6.

4.7-4 CREDENTIALS COMMITTEE ACTION

The Credentials Committee shall, at least thirty (30) days prior to the expiration of a member's present Staff appointment, review all other information available on each member being considered for reappointment and transmit to the MSEC its report and recommendation that appointment be either renewed, renewed with modified Staff

category and/or clinical privileges, or denied. The Committee may also recommend that the MSEC defer action. Each such report shall satisfy the requirements of Section 4.7-6.

4.7-5 MSEC ACTION

At least ten (10) days prior to the expiration of a member's present Staff appointment, the MSEC shall review each reapplication recommendation and all other relevant information available to it and forward to the governing body its report and recommendation that appointment be renewed, renewed with modified Staff category, department affiliation and/or clinical privileges, or denied. The MSEC may also defer action. When the recommendation of the MSEC is to defer the application for further consideration, it must be followed up within thirty (30) days with subsequent recommendation for appointment with specified clinical privileges or for rejection of the Staff membership. Each such report shall satisfy the requirement of Section 4.7-6. The recommendation of the Medical Staff shall be transmitted by the Chief Executive Officer to the governing body.

Thereafter, the procedure provided in Sections 4.3 through 4.6 shall be followed. For purposes of reappointment, the terms "applicant" and "appointment" as used in those sections shall be read, respectively, as "Staff member" and "reappointment".

4.7-6 BASIS FOR RECOMMENDATION

With the exception of Honorary Staff members, each recommendation concerning the reappointment of a Staff member and the clinical privileges to be granted upon reappointment shall be based upon the factors specified in Article V, including the member's professional ethics, discharge of Staff obligations, compliance with these Bylaws, the rules and regulations of the Medical Staff, departmental rules and regulations and policies, the policies of the medical center not in conflict with the provisions of the Bylaws of the Medical Staff, continued physical and mental health, cooperation with other practitioners and with patients to the extent that such cooperation is directly related to considerations of patient care, and other matters bearing on the member's ability and willingness to contribute to quality patient care in the medical center. In instances where there is doubt about the ability of the Staff member to practice satisfactorily because of defect in physical and/or mental health, the MSEC shall have the authority to require submission of any evidence of the member's current health status including, but not limited to, laboratory results of blood and body fluid examination, physical examination, or psychological examination.

4.7-7 TIME PERIOD FOR PROCESSING

Transmittal of the reapplication form to a Staff member and return of it shall be carried out in accordance with Section 4.7-1. Thereafter, and except for good cause, each person, department and committee required by these Bylaws to act thereon shall complete such action within the time limits specified such that all reports and recommendations concerning the reappointment of a Staff member shall be transmitted to the MSEC for its consideration and action and to the governing body for its action, all prior to the expiration date of the Staff membership of the member being considered for reappointment.

The time periods specified herein are to guide the acting parties in accomplishing their tasks. If the processing has not been completed with final action being taken by the governing body by the expiration date of the appointment, the practitioner's appointment and clinical privileges shall expire unless a time-limited reappointment was recommended by the MSEC as allowed in Section 4.7-8.

Members will be assigned a submission date for their reappointment applications. The member shall receive a certified letter regarding the lack of reappointment application.

If practitioner fails to render a timely complete application, including any fees, and after being given an opportunity to respond to a request for additional information or assistance, the reappointment credentialing process shall be terminated as of the deadline given for the submission of the information, without action being taken on the application. In that event, the practitioner's Medical Staff membership and privileges will expire naturally at the end of the current term of appointment, without renewal. The practitioner may reapply for Medical Staff membership at any time as a new applicant, including paying any new applicant fees and any additional fees that were originally due with the application.

The MSEC shall have the discretion to accept and consider information or comments on any issue, but there shall be no hearing rights pursuant to Article VII for expirations of Medical Staff membership and/or clinical privileges, solely pursuant to this Section.

4.7-8 TIME LIMITED APPOINTMENT

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 the member's failure to return documents or otherwise timely cooperate with the reappointment process, the MSEC and the Board of Trustees (or its duly appointed committee in expedited cases) may approve a time-limited appointment of the member's status and clinical privileges.

Any time-limited appointment 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 application is concluded. The member shall continue to be subject to the reappointment process as outlined in Section 4.7

4.7-9 REQUESTS FOR MODIFICATIONS OF MEMBERSHIP STATUS OR PRIVILEGES

A Staff member may, either in connection with reappointment or at any other time, request a modification of Staff category, Department assignment, or clinical privileges by submitting a written request to the Medical Staff Services Department. Such request shall be processed as follows:

Requests for additional privileges must be accompanied by documentation of education, training and/or experience to demonstrate the ability and competence to perform the requested privileges. The documentation may consist of, but not be limited to, certificates of formal educational or training programs, clinical activity list and evidence that the requested privileges are unrestricted at other facilities, written statement that formal training was received during previous education that has already been

documented and verified within the member's credentials file. The approval process, beginning with the Chair of the Department within which the requested privileges are offered and ending with the governing body, will be provided for in Article IV.

Requests for change in Staff category will be deemed acceptable if the member meets the qualifications of the category being requested. The approval process, beginning with the Chair of the member's Department and ending with the governing body, will be followed as provided in Article IV.

ARTICLE V

CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

- (a) Every practitioner practicing at this medical center by virtue of Medical Staff membership or through the privileging process outlined by the Allied Health Practitioner Rules and Regulations, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted by the governing body, on recommendation of the Medical Staff, except as provided in Article V.
- (b) Members of the Medical Staff who are MDs or DOs are authorized and privileged to perform history and physical examinations and recording of same (excluding affiliate, administrative and honorary staff status categories). Dentists and podiatrists are authorized and privileged to perform focused history and physical examinations pertaining to their specialty.
- (c) When applicable, initial applications for Staff appointment must contain a request for specific clinical privileges desired by the applicant. The evaluation of such requests shall be based on the applicant's licensure, education, training, experience, demonstrated physical ability to perform the requested privileges, data from professional practice review by an organization(s) that currently privileges the applicant, peer and/or faculty recommendation(s), and other relevant information, including an appraisal by the clinical department in which privileges are sought. The applicant shall have the burden of establishing qualifications and competency in the clinical privileges requested.
- (d) Periodic re-determination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided, review of the records of patients treated in this or other hospitals, patient satisfaction and review of the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical care, or any other pertinent information (professional practice evaluations). Applications for additional clinical privileges must be in writing. Such applications shall be processed in the same manner as applications for initial appointment.
- (e) Dentists (with the exception of oral/maxillofacial surgeons) and podiatrists who are members of the medical staff may only admit patients if a physician member of the medical staff conducts or directly supervises the admitting history and physical examination (except the portion related to dentistry or podiatry), and assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice. Privileges granted to dentists or podiatrists shall be based on their training, experience, and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist or podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists or podiatrists shall be under the overall supervision of the Chair of the Department of Surgery. All dental and podiatric patients shall receive the same basic medical appraisals as patients admitted to other surgical services.

5.2 PROCTORING

Proctorship is the informed observation and evaluation of the diagnostic and therapeutic (or surgical) skills of a practitioner to determine whether he/she is qualified to retain privileges based on demonstrated competence. The terms of proctorship may vary in furtherance of this purpose. Proctorship is not intended to serve as a substitute for training, and it is not the responsibility of the proctor to provide instruction or to act as a consultant. Additional proctorship specifications may be established in the Medical Staff Rules and Regulations, policies and Department policies.

All Active Status members who have completed proctoring must cooperate with reasonable requests to proctor, and a failure to fulfill this responsibility shall be grounds for corrective action, as specified in Article VI of these Bylaws.

5.2-1 GENERAL PROVISIONS

Except as otherwise determined by the Medical Staff Executive Committee (MSEC), all initial appointees to the Medical Staff and all members granted new or additional clinical privileges, as deemed required by the Chair of the Department within which the requested privileges are offered, shall be subject to a period of proctoring. Each appointee or recipient of new or additional clinical privileges shall be assigned to a Department where performance on an appropriate number of cases shall be observed by the Chair of the Department, or the Chair's designee, if proctoring is determined by the Department Chair to be needed, to determine suitability to continue to exercise the clinical privileges granted in that Department. The exercise of clinical privileges in any other Department shall also be subject to proctoring by that Department's Chair or designee. The member shall remain subject to such proctoring until removal is recommended by the MSEC and approved by the Board of Trustees. The MSEC will be furnished with the following certification:

A report signed by the Chair of the Department describing the types and numbers of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that Department, has discharged all of the responsibilities of Staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made.

5.2-2 FAILURE TO OBTAIN CERTIFICATION

If an initial appointee fails within the time of Provisional membership to furnish the certification required, or if a member exercising new or additional clinical privileges fails to furnish such certification within the time allowed by the Department, those specific clinical privileges shall automatically terminate. If the termination shall result in a report to the Medical Board of California or the National Practitioner Data Bank, the member shall be entitled to a hearing pursuant to Article VII.

If the member of the Provisional Staff fails to obtain appropriate certification for clinical privileges requested, that individual's Medical Staff membership shall terminate. If the termination shall result in a report to the Medical Board of California or the National

Practitioner Data Bank, the member shall be entitled to a hearing upon request pursuant to Article VII.

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

Practitioners who have applied for and are granted new or additional privileges shall have a minimum of one year to meet the proctoring requirement for that privilege. Should the proctoring requirement not be met the privilege will be automatically terminated at the completion of the reappointment cycle. The practitioner can reapply for the privilege, but must submit evidence of current clinical competence in the procedure.

5.3 BASIS FOR PRIVILEGES DETERMINATION

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

5.4 CRITERIA FOR "CROSS-SPECIALTY" PRIVILEGES WITHIN THE MEDICAL CENTER

Any request for clinical privileges, either new to the medical center or that overlaps more than one department, shall initially be reviewed by the appropriate departments in order to establish the need for, and appropriateness of, the new procedure or services. The decision by the MSEC not to recommend, or the governing body not to establish, a new procedure or service shall not be grounds for a hearing. The MSEC shall facilitate the establishment of campus wide credentialing criteria for new or trans-specialty procedures, with the input of all appropriate departments, with a mechanism designed to ensure that quality patient care is provided for by all individuals with such clinical privileges. In establishing the criteria for such clinical privileges, the MSEC may establish an ad-hoc committee with representation from all appropriate Departments.

5.5 TEMPORARY PRIVILEGES

Temporary privileges are allowed under two circumstances only: to address a patient care need and to permit patient care to be provided while a complete application is pending. Temporary privilege(s) may be granted to practitioners requesting a privilege previously held by the practitioner at Queen of the Valley Medical Center or another accredited institution. A physician may not hold more than one class of temporary privileges at any given time.

5.5-1 PATIENT CARE NEEDS

Care of Specific Patient

Temporary clinical privileges may be granted where good cause exists to allow a physician, dentist, or podiatrist to provide care to a specific patient for a period of not more than one hundred twenty (120) days for each grant of temporary privileges (but not

more than ten (10) patients during a calendar year) provided that the applicant has satisfied the requirements for the procedure described in Article IV of these bylaws.

5.5-2 OTHER IMPORTANT PATIENT CARE NEEDS

Temporary clinical privileges may be granted to allow a physician, dentist or podiatrist to fulfill an important patient care treatment or service need (but not more than sixty (60) days during a calendar year) provided that the applicant has satisfied the requirements for the procedure described in Article IV of these bylaws.

Locum Tenens: Such person may attend only patients of the member(s) for whom that person is providing coverage, for a period not to exceed sixty (60) cumulative days per year, unless the MSEC recommends a longer period for good cause. Liability insurance may be provided by the member being replaced for the locum tenens physician on a time-limited/time-specific basis. Written evidence of such coverage must be provided prior to grant of privileges.

5.5-3 PENDING APPLICATION FOR MEDICAL STAFF MEMBERSHIP

Temporary clinical privileges may be granted to an applicant while that person's application for initial medical staff membership and privileges is completed and awaiting review and approval of the MSEC, provided that the procedure described in Article IV of these bylaws has been completed, and that the applicant has no current or previously successful challenge to professional licensure or registration, no involuntary termination of medical staff membership at any other organization, no involuntary limitation, reduction, denial or loss of clinical privileges, and no other circumstance that would be grounds for corrective action or automatic suspension at this medical center. Such persons may only attend patients for a period not to exceed one hundred twenty (120) days.

5.5-4 APPLICATION AND REVIEW

Upon receipt of a completed application and supporting documentation from a physician, dentist, or podiatrist authorized to practice in California, the chief executive officer on the recommendation of either the applicable clinical department chair or the chief of staff, may grant temporary privileges to a member who appears to have qualifications, ability and judgment consistent with Article IV, but only after the following has been completed:

- (a) Verification of the following:
 - i. Current licensure
 - ii. Relevant training or experience
 - iii. Current competence
 - iv. Ability to perform the privileges requested
 - v. A query and evaluation of the National Practitioner Data Bank and the Medical Board of California reports
 - vi. A complete application
 - vii. No current or previously successful challenge to licensure or registration

- viii. No subjection to involuntary termination of medical staff membership at another organization
 - ix. No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges.
 - x. Evaluation of criminal background check.
- (b) if applicable, the appropriate department chair has interviewed the applicant and has contacted at least one person who:
- i. has recently worked with the applicant;
 - ii. has directly observed the applicant's professional performance over a reasonable time; and
 - iii. provides reliable information regarding the applicant's current professional competence to perform the privileges requested, ethical character, and ability to work well with others so as not to adversely affect patient care, or other criteria required by medical staff bylaws.
- (c) the applicant's file, including the recommendation of the department chair of the applicable department when available, or the chief of staff in all other cases, is forwarded to the credentials committee and the MSEC.
- (d) the MSEC through the chief of staff, after reviewing the applicant's file and attached materials, recommends granting temporary privileges.
- (e) In the event of a disagreement between the chief executive officer or his or her designee and the MSEC regarding the granting of temporary clinical privileges, the matter shall be resolved as set forth in Article IV.

5.5-5 GENERAL CONDITIONS

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

representative of the Queen of the Valley Medical Center governing body after approval by the departmental chair or the chair's designee.

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

5.6 EMERGENCY PRIVILEGES

In the case of an emergency medical condition, practitioner, to the degree permitted by the practitioner's license and regardless of service or Staff status, or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility in the medical center necessary, including the call for any consultation necessary or desirable. When an emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or the practitioner does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff. In the case of a critical patient care, treatment or service need, emergency privileges may be granted to a practitioner for a limited period of time, or for one patient. The Chief Executive Officer, the Chief of Staff, or their designees, may grant emergency privileges. When emergency privileges are granted, the matter shall be reported to the Credentials Committee, the MSEC, and the governing body.

5.7 DISASTER PRIVILEGES

Disaster Privileges may be granted when the medical center's emergency management plan has been activated and the medical center has important and immediate patient needs it is unable to meet without the assistance of practitioners in addition to those who currently hold Medical Staff membership and/or clinical privileges and are available to respond to the disaster. In such situation, the Chief Executive Officer, the Chief of Staff, or their designees, may grant disaster privileges. The granting of disaster privileges is not required and such privileges shall be granted only on a case-by-case basis. A volunteer licensed independent practitioner granted disaster privileges should be assigned to a specific department or departments, consistent with the privileges granted. Unassigned volunteer practitioners shall be sent to the Medical Staff labor pool.

General Conditions:

- (1) Disaster privileges may be granted only after the volunteer licensed practitioner has presented a valid picture ID issued by a state, federal or regulatory agency (driver's license, passport, etc.); and one or more of the following:
 - (a) a current picture identification card from a medical center where the volunteer practitioner holds clinical privileges that clearly identifies professional designation;
 - (b) presentation of a current license to practice or primary source verification of licensure;

- (c) identification indicating that the volunteer practitioner is a member of a recognized Disaster Medical Assistance Team (DMAT); Medical Reserve Corps, Emergency System for Advance Registration of Volunteer Health Professionals (ESAROVHP) or other recognized state or federal organization or group;
- (d) identification issued by a federal, state, or municipal entity showing that the practitioner has been granted authority to render patient care in emergency circumstances by a federal, state, or local government entity; OR
- (e) a recommendation presented by a current Medical Staff member with personal knowledge regarding the volunteer practitioner's identity and ability to act as a licensed independent practitioner during a disaster.

Once one or more of the above has been presented and a Volunteer Licensed Independent Practitioner Data Form completed, an identification badge will be issued to the volunteer licensed practitioner. The badge will include his/her name, professional designation and volunteer status. It shall be issued in accordance with provisions of the medical center Emergency Management Plan. Identification will be worn on his/her person for duration of time volunteering. It will be returned when relieved of duties.

Unless extraordinary circumstances present, each volunteer practitioner granted disaster privileges will be asked to submit a completed temporary privileges application to be processed by Medical Staff Services personnel in the manner described in Article V of these Bylaws.

- (2) Disaster privileges shall be exercised under the supervision of the Chair of each department to which the practitioner has been assigned.

Requirements for proctoring shall be imposed on individuals granted disaster privileges at the discretion of the Chief of Staff or designee or of the Chair, or designee, of any department to which the volunteer licensed independent practitioner has been assigned. Oversight of the professional performance may be accomplished by direct observation and/or clinical review of care documented in the patient's medical record. As circumstance permits, a peer may be designated by the Chair to serve as mentor and resource for the volunteer practitioner who shall assume responsibility for closely monitoring the volunteer practitioner's activities within the medical center.

- (3) All disaster privileges are time limited and shall automatically terminate at such time as the medical center's emergency plan is no longer in effect. The Chief of Staff or the Chief Executive Officer or their designees may also terminate disaster privileges at any time. The provisions of Article VII shall not apply to such termination.
- (4) All persons requesting or receiving disaster privileges shall be bound by the Medical Staff Bylaws, Rules and Regulations, and Medical Staff and medical center policies and procedures.

(5) Primary source verification of licensure occurs as soon as the immediate emergency situation is under control or within seventy-two (72) hours from the time the volunteer licensed independent practitioner presents him- or herself to the hospital, whichever comes first. If primary source verification of a volunteer licensed independent practitioner's licensure cannot be completed within seventy-two (72) hours of the practitioner's arrival due to extraordinary circumstances, the hospital documents all of the following:

- Reason(s) it could not be performed within seventy-two (72) hours of the practitioner's arrival.
- Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment and services.
- Evidence of the hospital's attempt to perform primary source verification as soon as possible.

If, due to extraordinary circumstances, primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within seventy-two (72) hours of the practitioner's arrival, it is performed as soon as possible. Note: Primary source verification of licensure is not required if the volunteer licensed independent practitioner has not provided care, treatment, or services under the disaster privileges.

(6) As soon as practicable, the Medical Staff Services personnel shall seek to collect and verify information concerning the background, education and training of each practitioner granted disaster privileges as provided in the volunteer practitioner's application for temporary privileges.

ARTICLE VI

CORRECTIVE ACTION

6.1 INVESTIGATION AND CORRECTIVE ACTION

6.1-1 CRITERIA FOR INITIATION OF INVESTIGATION

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members or others who exercise clinical privileges. When reliable information indicates a member may have exhibited acts, demeanor, or conduct, whether on or off the medical center premises, which is reasonably likely to be:

- (a) detrimental to patient safety or to the delivery of quality patient care services within the medical center;
- (b) unethical;
- (c) contrary to the Medical Staff Bylaws and Rules or Regulations; or
- (d) below applicable professional standards;

the Chief of Staff, a department chair, the Medical Staff Executive Committee (MSEC), or the Chief Executive Officer may initiate a request for an Investigation or action.

6.1-2 INITIATION OF INVESTIGATION

A request for action or for an Investigation under the auspices of the MSEC must be supported by reference to specific activities or conduct alleged. The MSEC shall determine how to proceed. Nothing in these provisions shall be construed to prevent the Chief of Staff or any other Medical Staff official from unilaterally initiating or conducting an investigation as may be appropriate pursuant to their responsibilities under the Medical Staff's Bylaws or policies.

6.1-3 INVESTIGATION

If the MSEC concludes that an Investigation is warranted, it may conduct the Investigation itself, or may assign the task to an appropriate Medical Staff department or standing or ad hoc committee of the Medical Staff. The member shall be notified that an Investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such interviews shall not constitute a "hearing" as that term is used in these Bylaws, nor shall the procedural rules with respect to hearing appeals apply. Despite the status of an Investigation, at all times, the MSEC shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

6.1-4 MSEC ACTION:

As soon as practicable after the conclusion of the Investigation, the MSEC shall take action, which may include, without limitation:

- (a) determining that no corrective action is warranted;
- (b) deferring action for a reasonable time where circumstances warrant;
- (c) issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude department heads from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file;
- (d) taking special measures to monitor the member's exercise of privileges on a nonrestrictive basis;
- (e) implementing a focused professional practice evaluation as per the Professional Practice Evaluation Policy;
- (f) recommending restrictions or special limitations regarding the exercise of clinical privileges including, but not necessarily limited to, requirements for co-admission, mandatory consultation, or restrictive proctoring;
- (g) recommending reduction, modification, suspension or revocation of clinical privileges;
- (h) recommending suspension, revocation or probation of Medical Staff membership;
- (i) referring the member to the Wellness Committee for evaluation and follow-up as appropriate; and
- (j) taking other actions deemed appropriate under the circumstances.

In all instances, the member shall be notified of the results of the investigation, either favorable or unfavorable, and adequate records shall be maintained in the credentials file.

If the MSEC makes a determination that there is a medical disciplinary action, it shall also determine whether the action is taken for any of the reasons requiring a report to the Medical Board of California pursuant to California Business and Professions Code Section 805.01. If the action is taken for any of these reasons, a report will be made as required.

6.1-5 GOVERNING BODY ACTION

- (a) The MSEC's action or recommendation following an Investigation as described in this policy shall be forwarded to the governing body.
- (b) If the MSEC has imposed or recommended corrective action as to which the affected practitioner may request a hearing pursuant to these Bylaws, the

governing body shall take no action on the matter until the practitioner has either waived or exhausted hearing rights as provided in these Bylaws.

- (c) If the practitioner invokes hearing and appeal rights pursuant to these Bylaws, the governing body shall proceed as described in these Bylaws.
- (d) If the MSEC has taken or recommended corrective action, and the practitioner has waived the right to a hearing under Article VII, and the governing body questions or disagrees with the decision of the MSEC, the matter shall be remanded to the MSEC for further consideration. If the decision of the governing body is to take corrective action which is more adverse than the action presented for the governing body's consideration, and if such additional adverse action would result in a report to the Medical Board of California or the National Practitioner Data Bank, the practitioner shall be given an opportunity for notice, hearing, and appeal before the governing body or a committee thereof pursuant to Article VII to challenge only the additional adverse action. The decision following the hearing shall be the final decision of the medical center.
- (e) If the MSEC decides not to conduct an Investigation or otherwise initiate corrective action proceedings as set forth above, the matter shall be subject to review by the governing body. The governing body may concur in the MSEC's decision or, if the governing body reasonably determines the MSEC's decision to be contrary to the weight of the evidence presented, the governing body may consult with the Chief of Staff and thereafter direct the MSEC to conduct an Investigation or otherwise initiate corrective action proceedings. In the event the MSEC fails to take action in response to such a directive from the governing body, the governing body may, after written notification to the MSEC, conduct an investigation or otherwise initiate corrective action proceedings on its own initiative. Any such proceedings shall afford the member the rights to which the member is entitled under California law. The decision following such proceedings shall be the final decision of the medical center.

6.2 SUMMARY RESTRICTION OR SUSPENSION

6.2-1 CRITERIA FOR INITIATION

A member's clinical privileges may be summarily suspended or restricted where the failure to take such action may result in an imminent danger to the health of any individual.

The following persons are authorized to impose a summary suspension or restriction: The Chief Executive Officer in consultation with the Chief of Staff, the Chief of Staff, the MSEC, or the Chair of the department in which the member holds privileges. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written confirmation to the member, the governing body, the MSEC and the Chief Executive Officer.

When none of the persons listed above is available to impose a summary suspension or restriction, the governing body or its designee may take such action if a failure to do so would be likely to result in an imminent danger to the health of any individual. Prior to exercising this authority, the governing body must make a reasonable attempt to contact

the Chief of Staff. Summary action by the governing body which has not been ratified by the Chief of Staff within two (2) working days, excluding weekends and holidays, after the suspension shall terminate automatically without prejudice to further summary action as warranted by the circumstances.

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 governing body, the MSEC and the Chief Executive Officer.

In addition, the affected medical staff member shall be provided with a written notice of the action which notice fully complies with the requirements of this Article and Article VII. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the department chair or by the chief of staff, considering where feasible, the wishes of the patient in the choice of a substitute member.

6.2-2 MSEC ACTION

As soon as practicable after such summary restriction or suspension has been imposed, a meeting of the MSEC shall be convened to review and consider the action. The member shall attend and make a statement concerning the relevant issues, on such terms and conditions as the MSEC may impose, although in no event shall any such meeting of the MSEC, with or without the member, constitute a "hearing" within the meaning of Article VII of these Bylaws, nor shall any procedural hearing rules apply. The MSEC may modify, continue, or terminate the summary restriction or suspension, and it shall furnish the member with notice of its decision.

6.2-3 PROCEDURAL RIGHTS

Unless the MSEC terminates the summary restriction or suspension within fourteen (14) days of its imposition, the member shall be entitled to the procedural rights afforded by Article VII.

6.3 AUTOMATIC SUSPENSION AND RESTRICTION

The actions below constitute grounds for automatic suspensions of the practitioner's medical staff membership, specific privileges, and/or all privileges. Automatic suspensions are not based on a medical disciplinary cause or reason and shall not entitle the practitioner to the hearing rights found in these bylaws. Except in the case of medical record suspensions, an automatic suspension will become effective by noon on the last working day prior to the applicable expiration date. Automatic suspensions will be lifted on the morning of the next working day that documentation/evidence of renewal has been received and verified.

6.3-1 FAILURE TO COMPLETE MEDICAL RECORDS

Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the MSEC in conjunction with Federal and State regulations and Joint Commission standards in order to insure continuity and quality of care of patients.

Practitioners who remain in delinquency status for thirty (30) days within a twelve (12) month rolling period shall be subject to provisions outlined in the Medical Staff Rules and Regulations.

6.3-2 ACTION BY STATE LICENSING AGENCY

- (a) Whenever a member's license or other legal credential authorizing practice in this state is:

Revoked, suspended, or expires, Medical Staff membership and clinical privileges shall be automatically revoked or suspended, as applicable, as of the date such action becomes effective and throughout its term; or, limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the member has been granted at the medical center which are within the scope of said limitation or restriction shall be automatically limited or restricted, as applicable, as of the date such action becomes effective and throughout its term.

- (b) Whenever a member is placed on probation by the applicable licensing or certifying authority, membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its terms.

- (c) A suspension, restriction, limitation, or imposition of probation on a practitioner's license or certification shall be grounds for an investigation pursuant to this Article.

6.3-3 FAILURE TO BE ADEQUATELY INSURED

If at any time a member's professional liability insurance coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect (in whole or in part), the member's affected clinical privileges shall be suspended automatically as of that date until adequate professional liability insurance coverage is restored, including coverage of any acts or potential liabilities that may have occurred or arisen during the period of any lapse in coverage. Failure to provide evidence of such coverage within ninety (90) days after the date the automatic suspension commences shall result in an automatic termination of the Medical Staff membership or privileges.

6.3-4 ACTION BY DEA

Whenever a member's Drug Enforcement Agency (DEA) certificate is:

- (a) revoked, limited (including failure to maintain full schedules: 2, 2N, 3, 3N, 4 and 5), expired, or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term; or
- (b) subject to probation, the member's right to prescribe medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

- (c) A suspension, restriction, limitation, or imposition of probation on a practitioner's license or certification shall be grounds for an investigation pursuant to this Article.

6.3-5 FAILURE TO PROVIDE REQUESTED INFORMATION OR TO ATTEND MEETINGS

- (a) Requested Information

Members are expected to cooperate with Medical Staff officers, committees and representatives in the discharge of their official functions. This includes responding promptly and appropriately to correspondence and providing information requested. Requested information includes, but is not limited to, submission to mental or physical examinations as requested by the Chief of Staff or MSEC to resolve issues of fitness to perform mental or physical functions associated with the member's privileges or related issues of reasonable accommodation; provision of current documentation of required professional licenses, professional liability coverage, DEA Certificates, Radiology/Fluoroscopy Certificates, annual tuberculin skin test results, board and/or agency certification to maintain specifically delineated privileges [neonatal resuscitation program (NRP); advanced cardiac life support (ACLS); advanced trauma life support (ATLS); pediatric advanced life support (PALS)]; provision of information regarding peer review actions affecting the member at another organization; and provision of information regarding actions against the practitioner's license or certification. Failure to respond promptly and appropriately to correspondence or to provide information requested by the deadline provided shall constitute grounds for administrative suspension until the member has complied to the satisfaction of the requesting party. Any such suspension or action shall remain in effect until the member is expressly notified that it is rescinded.

- (b) Special Attendance Requirement

Members are expected to appear at meetings regarding quality of care issues, utilization management issues, Medical Staff administrative issues, and other issues that may arise in the conduct of Medical Staff affairs. Failure of a member without good cause to appear when requested by a medical staff officer or committee shall result in the referral to the MSEC for action, which may include administrative suspension of all privileges. The administrative suspension shall remain in effect until the practitioner has satisfied the special attendance requirement.

- (c) Automatic Termination of Privileges and Membership

If a member is administratively suspended of all clinical privileges for a period of ninety (90) consecutive days as a result of a failure noted in Section 6.3 of these medical staff bylaws, his or her membership and privileges shall automatically terminate. Unless the hospital is required to report the termination to the Medical Board of California pursuant to Business and Professions Code Section 805 and/or to the National Practitioner Data Bank, the hearing and appeal rights in Article VII shall not apply.

6.3-6 FAILURE TO PAY FEES/ASSESSMENTS

Failure without good cause as determined by the MSEC, to pay fees or assessments shall be grounds for automatic suspension of a member's clinical privileges and if within three (3) months after written warning of the delinquency the member does not pay the required fees or assessments, the member's membership shall be automatically terminated.

6.3-7 EXCLUSION FROM FEDERAL HEALTH CARE PROGRAMS

- (a) Practitioners are not obligated to enter into contract with government-sponsored health care programs, or to provide care to beneficiaries of such programs (except while serving on emergency call), as a basic condition of Medical Staff membership. However, any practitioner who has been officially excluded from participating in such programs (an "excluded Practitioner"), under the authority of the United States Office of Inspector General "(OIG)", is automatically prohibited from providing professional services to, or ordering goods or services for, program beneficiaries. The practitioner is also automatically barred from serving on emergency call, based on the possibility that such service would necessitate the performance of prohibited activities.
- (b) A practitioner is obligated, pursuant to Section 2.3-1 (m) (7) of these Bylaws, to notify the Chief of Staff within ten (10) days after the practitioner learns that he or she is, or will be, excluded. Upon receipt of such notice, the Chief of Staff will convene a special meeting of the MSEC, as soon as possible, to determine how to proceed.
- (c) Exclusion from participation in federally funded health care programs shall constitute grounds for termination of Medical Staff membership and clinical privileges. However, the MSEC shall have the discretion to grant exceptions, subject to approval by the governing body, upon determining that: (i) the practitioner otherwise meets the Medical Staff's standards and qualifications for membership and clinical privileges relevant to the practitioner's specialty; and (ii) adequate arrangements are in place to assure that the practitioner will not intentionally or unintentionally engage in prohibited activities as described above; and (iii) the practitioner's inability to serve on emergency call or discharge other routine Medical Staff obligations which might involve prohibited activities, while remaining on the Medical Staff, would not be unfair to other practitioners who must discharge such obligations as a condition of Medical Staff Membership.

6.3-8 MSEC DELIBERATION AND ACTION

As soon as practicable after action is taken or warranted as described elsewhere in this Section 6.3 the MSEC shall review and consider the facts, and may take or recommend such additional action as it deems appropriate.

6.3-9 PROCEDURAL RIGHTS

There shall be no hearing rights under Article VII of these Bylaws for actions affecting a member's Medical Staff status or clinical privileges as provided in this Part 6.3. However, the member may be given an opportunity to be heard by the MSEC, which shall reverse any action that was taken automatically based on a mistake of fact. Additional actions taken by the MSEC that would require the hospital to file a report to

the Medical Board of California or the National Practitioner Data Bank shall be subject to hearing rights to the extent provided by Article VII.

6.4 INFORMAL PROCEEDINGS

Nothing in the Medical Staff Bylaws, Rules and Regulations, or other medical staff policies shall preclude collegial or informal efforts to address questions or concerns relating to an individual's practice and conduct at the medical center. The voluntary structuring of clinical privileges to achieve a clinical practice mutually acceptable to the individual, MSEC and the governing body is encouraged.

6.5 MEMBER OBLIGATIONS

Members shall immediately provide written notice to the Medical Staff Services Department of any actions or events described in Section 6.3. The member shall also promptly provide the Medical Staff Services Department with a written explanation of the basis for such actions, including copies of relevant documents.

Regardless of whether the member provides such notice to the Medical Staff Services Department, the limitations described in Section 6.3 shall take effect automatically as of noon on the last working day prior to the date of the underlying action or event. The MSEC may request the member to provide additional information concerning the above-described actions or events, and a failure of the member to provide such information may extend the special actions listed above, even though the underlying limitation may have been removed.

ARTICLE VII

HEARINGS AND APPELLATE REVIEWS

7.1 GENERAL PROVISIONS

7.1-1 INTENT

The intent of these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect practitioners (as described below) and at the same time to protect the peer review participants from liability. It is further the intent to establish flexible procedures that do not create burdens which will discourage the Medical Staff and governing body from carrying out peer review. Accordingly, discretion is granted to the medical staff and governing body to create a hearing process which provides for the least burdensome level of formality in the process and yet still provides a fair review and to interpret these Bylaws in that light. The Medical Staff, governing body, and their officers, committees and agents hereby constitute themselves as peer review bodies under the Federal Health Care Quality Improvement Act of 1986 and the California peer review hearing laws and claim all privileges and immunities afforded by the federal and state laws.

7.1-2 EXHAUSTION OF REMEDIES

If adverse action as described in these provisions is taken or recommended, the Practitioner must exhaust the remedies afforded by these bylaws before resorting to legal action.

7.1-3 INTRAORGANIZATIONAL REMEDIES

The hearing and appeal rights established in these Bylaws are strictly “judicial” rather than “legislative” in structure and function. The hearing committees have no authority to adopt or modify rules and standards or to decide questions about the merits or substantive validity of Bylaws, Rules or Policies. However, the governing body may, at its discretion, entertain challenges to the merits or substantive validity of Bylaws, Rules and Regulations or Policies and decide those questions. If the only issue a Practitioner is challenging is whether a Bylaw, Rule, Regulation or Policy is lawful or meritorious, the Practitioner is not entitled to a hearing or appellate review. In such cases, the Practitioner must submit challenges first to the governing body. The governing body shall consult with the Medical Staff Executive Committee (MSEC) before taking final action regarding the Bylaw, Rule, Regulation or Policy involved.

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 MSEC in all cases where the MSEC or authorized Medical Staff officers, members or committees took the action or rendered the decision which resulted in a hearing being requested. It refers to the governing body in all cases where the governing body or its authorized officers, directors or committees took the action or rendered the

decision which resulted in a hearing being requested. "Member," as used in this Article, includes current Medical Staff members, applicants, Practitioners with temporary privileges, as it may be applicable under the circumstances, unless otherwise stated.

- (b) "Practitioner", as used in this Article refers to the practitioner who may request or has requested a hearing pursuant to this Article.
- (c) "Day" means calendar day.

7.1-5 SUBSTANTIAL COMPLIANCE

Technical, insignificant, or non-prejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken or recommended by the body whose decision prompted the hearing.

7.2 GROUNDS FOR HEARING

- (a) Except as otherwise specified in applicable bylaws, rules, regulations or policies, any one of the following adverse actions or recommended actions is grounds for a hearing if, upon adoption, it would result in the hospital being required to file a report to the Medical Board of California pursuant to Business and Professions Code Section 805 and/or the National Practitioner Data Bank:
 - (1) denial of Medical Staff membership, reappointment and/or clinical privileges based on the practitioner's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care;
 - (2) involuntary revocation of Medical Staff membership based on the practitioner's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care;
 - (3) involuntary revocation or reduction of clinical privileges based on the practitioner's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care;
 - (4) involuntary restriction of clinical privileges (except for proctoring incidental to Provisional Status, new privileges, insufficient activity, or return from leave of absence) for more than fourteen (14) days based on the practitioner's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care;
 - (5) restrictions involuntarily imposed on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more for any twelve (12)-month period, based on the practitioner's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care;
 - (6) suspension of Medical Staff membership and/or clinical privileges for more than fourteen (14) days based on the practitioner's competence or

professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care; and

(7) any other involuntary disciplinary action or recommendation that must be reported, by law, to the Medical Board of California or the National Practitioner Data Bank.

(b) No actions or recommendations except those described above shall entitle the Practitioner to a hearing under these Bylaws.

7.3 REQUESTS FOR HEARING

7.3-1 NOTICE OF ACTION OR RECOMMENDATION

In all cases in which action has been taken or recommended as set forth in Section 7.2, the Practitioner shall be given prompt written notice of the action or recommendation including the following information:

- (a) a description of the action or recommendation;
- (b) a brief statement of the reasons for the action or recommendation;
- (c) a statement that the Practitioner may request a hearing;
- (d) a statement of the time limit within which a hearing may be requested;
- (e) a summary of the Practitioner's rights at a hearing; and
- (f) a statement as to whether the action or recommendation, if adopted, must be reported to the Medical Board of California and/or the National Practitioner Data Bank.

7.3-2 REQUEST FOR HEARING

- (a) The Practitioner shall have thirty (30) days following receipt of the notice of the action or recommendation within which to request a hearing. The request shall be in writing addressed to the Chief of Staff, and received by the Medical Staff Services Department within the deadline. A copy also shall be sent to the Chief Executive Officer.
- (b) If the Practitioner does not request a hearing within the time and in the manner described, the Practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. Said action shall thereupon become the final action or recommendation of the Medical Staff. The action or recommendation shall be presented for consideration by the governing body, which shall not be bound by it. If the governing body ratifies the action or recommendation, it shall thereupon become the final action of the medical center. However, if the governing body, after consulting with the Chief of Staff, is inclined to take action against the Practitioner that is more adverse than the action recommended by the Medical Staff, and if such additional adverse action would result in a report to the Medical Board of California or the National Practitioner Data Bank, the Practitioner shall be so notified and given an

opportunity for a hearing based on "an adverse action by the governing body," as provided herein. At the hearing, the Practitioner may only challenge the additional adverse action proposed by the Governing Body, and not that recommended or initiated by the MSEC.

7.4 HEARING PROCEDURE

7.4-1 HEARINGS PROMPTED BY GOVERNING BODY ACTION

If the hearing is based upon an adverse action by the governing body, the Chair of the governing body shall fulfill the functions assigned in this Article to the Chief of Staff. The Chair may modify the procedure as warranted under the circumstances, but the practitioner shall have all of the same rights to a fair hearing.

7.4-2 TIME AND PLACE FOR HEARING

Upon receipt of a request for hearing, the Chief of Staff shall schedule a hearing and, within thirty (30) days from the date received, give written notice to the Practitioner of the time, place and date of the hearing. The date of commencement of the hearing shall be not less than thirty (30) days nor more than sixty (60) days from the date the Chief of Staff received the request for a hearing. All attempts to complete the hearing within sixty (60) days shall be made, unless a longer timeframe is reasonable as agreed by the Practitioner and the MSEC, or as granted by the Hearing Officer pursuant to Section 7.4-9.

7.4-3 NOTICE OF CHARGES

Together with the Notice stating the place, time and date of the hearing, the Chief of Staff shall state clearly and concisely in writing the reasons for the adverse action taken or recommended (if not already provided), including a description of the acts or omissions with which the practitioner is charged and a list of the charts or cases in question, where applicable. The Notice of Reasons or Charges may be supplemented or amended at any time prior to the issuance of the Hearing Committee's decision, provided the Practitioner is afforded a fair and reasonable opportunity to respond.

7.4-4 HEARING COMMITTEE

- (a) When a hearing is requested, the Chief of Staff shall appoint a Hearing Committee which shall be composed of not less than three (3) members of the Active Medical Staff who shall gain no direct financial benefit from the outcome and who have not acted as accusers, investigators, fact-finders or initial decision-makers, and otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Hearing Committee. In the event that it is not feasible to appoint a Hearing Committee from the Active Medical Staff, the Chief of Staff may appoint members from other Medical Staff categories or practitioners who are not Medical Staff members. Such appointment shall include designation of the chair. When feasible, the Hearing Committee shall include at least one (1) member who has the same healing arts licensure and practices in the same specialty as the Practitioner involved. The Chief of Staff may consider appointing an alternate member(s), who shall participate in the entire hearing and deliberation process,

but shall not have a vote unless a Hearing Committee member is unable to participate through completion of the entire hearing procedure.

- (b) Alternatively, the Chief of Staff shall have the discretion to enter into an agreement with the Practitioner involved to hold the hearing before an arbitrator or arbitrators selected by a process mutually acceptable to the Practitioner and the MSEC. The arbitrator(s) shall have the same duties and authority described in these Bylaws that are delegated to the Hearing Officer and the Hearing Committee. Failure or refusal to exercise this discretion shall not constitute a breach of the Medical Staff's responsibility to provide a fair hearing.
- (c) The entire Hearing Committee must be present throughout the hearing. In unusual circumstances when a Hearing Committee member must be absent from any part of the proceedings, the hearing cannot proceed unless the Practitioner, the MSEC, and the Hearing Officer unanimously stipulate that the hearing can continue in the Hearing Committee member's absence. In such cases, the Committee member shall not be permitted to participate in the deliberations or the decision unless and until said member has read the entire transcript of the portion of the hearing from which the member was absent.
- (d) The Hearing Committee or the arbitrator (if one is used) shall have such powers as are necessary to discharge its responsibilities.

7.4-5 THE HEARING OFFICER

The Chief Executive Officer shall appoint a hearing officer to preside at the hearing. The hearing officer shall be an attorney-at-law, who is qualified to preside over a quasi-judicial hearing, but an attorney regularly utilized by the medical center or medical staff for legal advice regarding its affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall not be biased for or against any party, shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or the procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence that are raised prior to, during, or after the hearing. If at the hearing the parties are unaccompanied by attorneys, the hearing officer shall have the authority to interpose and rule on appropriate objections.

If the hearing officer determines that either party in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such action as the officer deems warranted by the circumstances, including, but not limited to, limiting the scope of examination and cross-examination and setting fair and reasonable time limits on either side's presentation of the case. If the hearing officer determines that the failure of a party to proceed in an efficient, expeditious, and fair manner is so obstructive that it jeopardizes the fairness of the hearing, then the hearing officer may terminate the hearing upon his or her own motion or on the motion of either party. Either party may appeal such termination to the governing body. The hearing officer should participate in the deliberations of the hearing committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

7.4-6 VOIR DIRE

Both parties shall have the right to a reasonable opportunity to voir dire the Hearing Committee members and the hearing officer, and the right to challenge the appointment of any member or the hearing officer. The hearing officer shall establish the procedure by which this right may be exercised, which may include reasonable requirements that voir dire questions be proposed in writing in advance of the hearing and that the questions are presented by the hearing officer. The hearing officer shall rule on any challenges in accordance with applicable legal principles defining standards of impartiality for hearing panels and hearing officers in proceedings of this type.

7.4-7 REPRESENTATION

Neither party may be represented in any phase of the hearing by an attorney-at-law unless the parties and the hearing officer agree to allow both parties to be represented by legal counsel.

In all instances, whether or not attorneys are allowed to represent the parties during the hearing, the MSEC shall be represented by a member of the Medical Staff who shall be responsible for representing the MSEC's interests in connection with the peer review matter and proceeding. This responsibility shall include the authority to make decisions regarding the detailed contents of the Notice of Reasons or Charges; to make decisions regarding the presentation of testimony and exhibits; to direct the activities of the MSEC's attorney, if any; to consult with specialists; and to amend the Notice of Reasons or Charges as the Medical Staff Representative deems warranted during the course of the proceedings, subject to the Practitioner's procedural rights. However, the MSEC's representative shall not have the authority to modify the nature of the MSEC's action or recommendation without the MSEC's approval.

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

- (a) If the practitioner wishes to be accompanied at the hearing by an attorney, he/she shall state the notice of such intent in the written Request for Hearing herein.
- (b) The MSEC representative shall not be accompanied by an attorney if the practitioner is not accompanied by an attorney. The foregoing shall not be deemed to deprive any party of its right to the assistance of legal counsel for the purpose of preparing for the hearing.
- (c) Attorneys for either party may accompany their clients in the hearing sessions in order to advise their clients, although any such attorney shall not examine witnesses, shall not address the Hearing Committee, and shall not make any oral statement whatsoever in the hearing.
- (d) Whether or not attorneys are present in the hearing pursuant to this Article, the practitioner and the MSEC may be represented at the hearing by a practitioner

licensed to practice medicine in the State of California who is not also an attorney at law or law school graduate.

- (e) The Hearing Officer shall not allow the presence of attorneys at the hearing to be disruptive or cause a delay in the hearing process.
- (f) The practitioner and the MSEC may stipulate to allow greater participation by attorneys in the hearing than this Article provides. Otherwise, the above provisions of this Article will control.

7.4-8 FAILURE TO APPEAR OR PROCEED

Failure without good cause of the practitioner to personally attend and proceed at a hearing in an efficient and orderly manner shall be deemed to constitute a waiver of any hearing rights and voluntary acceptance of the recommendation(s) or action(s) involved. The hearing officer shall determine good cause. The practitioner's voluntary acceptance of an action or recommendation pursuant to this provision shall be presented for consideration by the governing body, and the matter will be addressed in the same manner as a waiver of hearing rights.

7.4-9 POSTPONEMENTS AND EXTENSIONS

Once a timely request for a hearing has been made, postponements and extensions of the time beyond those referenced in this Article may be permitted at the hearing officer's discretion or upon agreement of both parties.

7.4-10 DISCOVERY

- (a) Rights of Inspection and Copying

The practitioner may inspect and copy, at the practitioner's expense, any documentary information relevant to the charges that the MSEC has in its possession or under its control. The MSEC may inspect and copy, at its expense, any documentary information relevant to the charges that are in the possession or under the control of the practitioner. Requests for discovery shall be met as soon as practicable. Failure to comply with reasonable discovery requests at least thirty (30) days prior to the hearing shall be good cause for a continuance of the hearing.

- (b) Limits on Discovery

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

- (c) Ruling on Discovery Disputes

In ruling on discovery disputes, the factors that may be considered include:

- (i) whether the information sought may be introduced to support or to defend against the charges;
- (ii) whether the information is “exculpatory” in that it would dispute or cast doubt upon the charges or “inculpatory” in that it would prove or help support the charges and/or recommendation;
- (iii) the burden imposed on the party in possession of the information sought, if access is granted; and
- (iv) any previous requests for access to information submitted or resisted by the parties to the same proceeding.

7.4-11 PREHEARING DOCUMENT EXCHANGE

The parties must exchange all exhibits that will be introduced at the hearing. The exhibits must be exchanged at least ten (10) days prior to the hearing. Failure to comply with this rule is good cause for the hearing officer to grant a continuance.

7.4-12 WITNESS LISTS

Not less than fifteen (15) days prior to the hearing, each party shall furnish to the other a written list of the names of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that party at the hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. Failure to provide the name of any witness at least ten (10) days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

7.4-13 PROCEDURAL DISPUTES

- (a) It shall be the duty of the parties to exercise reasonable diligence in notifying the hearing officer of any pending or anticipated procedural disputes as soon as possible in advance of the scheduled hearing, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing, but outside the presence of the Hearing Committee.
- (b) The parties shall be entitled to file motions or otherwise request rulings as deemed necessary to give full effect to rights established by the Bylaws and to resolve such procedural matters as the hearing officer determines may properly be resolved outside the presence of the full Hearing Committee. All such motions or requests, the arguments presented by both parties, and rulings thereon shall be reflected in the hearing record in a manner deemed appropriate by the hearing officer.

7.4-14 RECORD OF HEARING

A shorthand reporter shall be present to make a record of the hearing proceedings, and the pre-hearing proceedings if deemed appropriate by the

hearing officer. The cost of attendance of the shorthand reporter shall be borne by the medical center, but the cost of preparing a transcript, if any, or of a copy of the transcript that has already been prepared, shall be borne by the party requesting it. The hearing officer may, but shall not be required to, order that oral evidence shall be taken only under oath administered by a person lawfully authorized to administer such oath.

7.4-15 ATTENDANCE

Except as otherwise provided in these Bylaws and subject to reasonable restriction by the hearing officer, the following shall be permitted to attend the entire hearing in addition to the hearing officer, the court reporter, and the parties (with attorneys and/or other representatives, if allowed), the medical staff services personnel or designees, one or more key consultants for each party, and the Chief Executive Officer or designee. An individual shall not be excluded from attending any portion of the hearing solely by reason of the possibility or expectation that the individual will be a witness for one of the parties.

7.4-16 RIGHTS OF THE PARTICIPANTS

Within reasonable limitations, both parties may call and examine witnesses for relevant testimony; introduce relevant exhibits or other documents; cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues, and otherwise rebut evidence; receive all information made available to the Hearing Committee; and submit a written statement at the close of the hearing, as long as these rights are exercised in an efficient and expeditious manner. The practitioner may be called by the body whose decision prompted the hearing or the Hearing Committee and examined as if under cross-examination. The Hearing Committee may question witnesses or call additional witnesses if it deems such action appropriate. The hearing officer shall also have the discretion to ask questions of witnesses if the officer deems it appropriate for purposes of clarification or efficiency.

7.4-17 RULES OF EVIDENCE

Judicial rules of evidence and procedure relating to the conduct of a trial examination of witnesses and presentation of evidence shall not apply to a hearing conducted under these provisions. Any relevant evidence, including hearsay, may be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. In making rulings regarding the admissibility of evidence, the Hearing Officer shall endeavor to promote a less formal, rather than more formal, hearing process and also to promote the swiftest possible resolution of the matter, consistent with the standards of fairness set forth in these Bylaws.

7.4-18 BURDENS OF PRESENTING EVIDENCE AND PROOF

- (a) The body whose decision prompted the hearing shall have the initial duty to present evidence, which supports its recommendation or action.

- (b) An applicant for membership and/or privileges shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that the applicant is sufficiently qualified to be awarded such membership and/or privileges at this medical center. This burden requires the production of information, which allows for adequate evaluation and resolution of reasonable doubts concerning the practitioner's current qualifications. The applicant shall not be permitted to introduce information that was not produced upon the request of any committee or person on behalf of the Medical Staff during the application process, unless the member establishes that the information could not have been produced in the exercise of reasonable diligence. This provision shall not be construed to compel the Medical Staff to act on, or to afford a practitioner a hearing regarding, an incomplete application.
- (c) Except as provided in paragraph b above, the body whose decision prompted the hearing shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted. The term "reasonable and warranted" means within the range of reasonable and warranted alternatives open to the body whose decision prompted the hearing, as a matter of discretion, and not necessarily the only or best action or recommendation that could be formulated in the opinion of the Hearing Committee.

7.4-19 ADJOURNMENT AND CONCLUSION

The hearing officer may adjourn and reconvene the hearing at such times and intervals as may be reasonable and warranted, with due regard for the objective of reaching an expeditious conclusion to the hearing.

7.4-20 BASIS FOR DECISION

The decision of the Hearing Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence.

7.4-21 DECISION OF THE HEARING COMMITTEE

Within thirty (30) days after the final adjournment of the hearing, the Hearing Committee shall render a written decision. Final adjournment shall be when the Hearing Committee has concluded its deliberations. A copy of the decision shall be forwarded to the medical center Chief Executive Officer, the Chief of Staff who shall relay the decision to the MSEC, the governing body, and the practitioner. The report shall contain the Hearing Committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Both the practitioner and the body whose decision prompted the hearing shall be provided a written explanation of the procedure for appealing the decision. The decision of the Hearing Committee shall be considered final, subject only to such rights of appeal or review as described in these Bylaws.

7.5 APPEAL

7.5-1 TIME FOR APPEAL

Within ten (10) days after receipt of the decision of the Hearing Committee, either the practitioner or the MSEC may request an appellate review. A written request for such review shall be delivered to the medical center Chief Executive Officer and the other party in the hearing. If a request for appellate review is not received by the medical center Chief Executive Officer within such period, the decision of the Hearing Committee shall thereupon become final, except if modified or reversed by the governing body.

It shall be the obligation of the party requesting appellate review to produce the record of the Hearing Committee's proceedings. If the record is not produced within a reasonable period, as determined by the governing body or its authorized representative, appellate rights shall be deemed waived.

In the event of a waiver of appellate rights by a practitioner, if the governing body is inclined to take action which is more adverse than that taken or recommended by the MSEC, the practitioner shall be given an opportunity to be heard on only the more adverse action before a final decision is made. Said opportunity shall not involve additional evidentiary proceedings if the action under consideration by the governing body is based on the factual findings or conclusions of the Hearing Committee.

7.5-2 GROUNDS FOR APPEAL

A written request for an appeal shall include an identification of the grounds of appeal, and a clear and concise statement of the facts in support of the appeal.

7.5-3 TIME, PLACE AND NOTICE

The appeal board shall, within thirty (30) days after receipt of a request for appellate review, schedule a review date and cause each side to be given notice of time, place and date of the appellate review. The appellate review shall not commence less than thirty (30) or more than sixty (60) days from the date of notice; provided, however, that when a request for appellate review concerns a practitioner who is under suspension which is then in effect, the appellate review may commence as soon as the arrangements may reasonably be made. The time for appellate review may be extended by the appeal board for good cause.

7.5-4 APPEAL BOARD

The governing body may sit as the appeal board, or it may delegate that function to an appeal board, which shall be composed of not less than three (3) members of the governing body. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board so long as that person did not take part in a prior hearing on the action or recommendation being challenged. The appeal board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal.

7.5-5 APPEAL PROCEDURE

The proceedings by the appeal board shall be in the nature of an appellate review based upon the record of the proceedings before the Hearing Committee. However, the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Hearing Committee in the exercise of reasonable diligence, and subject to the same rights of cross-examination or confrontation that are provided at a hearing. The appeal board shall also have the discretion to remand the matter to the Hearing Committee for the taking of further evidence or for clarification or reconsideration of the Hearing Committee's decision. In such instances, the Hearing Committee shall report back to the appeal board within such reasonable time limits as the appeal board imposes. Each party shall have the right to be represented by legal counsel before the appeal board, to present a written argument to the appeal board, to personally appear and make oral argument and respond to questions in accordance with the procedure established by the appeal board. After the arguments have been submitted, the appeal board shall conduct its deliberations outside the presence of the parties and their representatives.

7.5-6 DECISION

Within thirty (30) days after the submission of arguments as provided above, the appeal board shall render a decision in writing and shall forward copies thereof to each side involved in the hearing. The appeal board may affirm, reverse or modify the decision of the Hearing Committee, and its decision shall constitute the final decision of the medical center. Any recommendation affirmed by the appeal board shall become effective immediately.

The appeal board shall give great weight to the Hearing Committee recommendation, and shall not act arbitrarily or capriciously. The appeal board may, however, exercise its independent judgment in determining whether a practitioner was afforded a fair hearing, whether the decision is reasonable and warranted, and whether any bylaw, rule or policy relied upon by the Hearing Committee is unreasonable or unwarranted. The decision shall specify the reasons for the action taken and provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any), and the decision reached, if such findings and conclusions differ from those of the Hearing Committee.

7.5-7 RIGHT TO ONE HEARING

No practitioner shall be entitled to more than one (1) evidentiary hearing and one (1) appellate review on any adverse action or recommendation.

7.6 EXCLUSIVE CONTRACTS AND HEARINGS

7.6-1 APPROPRIATENESS OF EXCLUSIVE CONTRACTS

Except as specified in this Section, the termination of privileges following the decision, after a notice and hearing period, to close a department/service pursuant to an exclusive contract or to transfer an exclusive contract shall not be subject to the procedural rights set forth in Article VII. If a practitioner whose privileges are terminated as a result of an exclusive contract also holds privileges that are not covered by an exclusive contract, those privileges shall remain granted and unchanged. Those specific privileges of a

member that are terminated because of institution of an exclusive contract must be stricken from the list of approved privileges maintained by the medical staff for that member.

7.7 REPORTING TO REGULATORY AGENCIES

The medical center and the Medical Staff shall report adverse actions to the Medical Board of California and the National Practitioner Data Bank in accordance to those agency standards. Any adverse report shall be reviewed by the Chief of Staff prior to submission.

ARTICLE VIII

OFFICERS

8.1 OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be:

- (a) Chief of Staff
- (b) Vice Chief of Staff
- (c) Immediate Past Chief of Staff

Only individuals meeting the qualifications and who are nominated and elected as expressly provided in these Bylaws shall be the officers of the medical staff with all powers and duties vested herein. The right of the medical staff to select and remove medical staff officers is inviolate and shall not be interfered with or restricted in any manner.

8.2 QUALIFICATIONS OF OFFICERS

Officers must be members of the Active Medical Staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. Active Medical Staff, of any discipline or specialty, are eligible for membership on the Medical Staff Executive Committee (MSEC).

8.3 ELECTION OF OFFICERS

- (a) Officers shall be elected at the annual (December) meeting of the Medical Staff. Only members of the Active Medical Staff shall be eligible to vote. The voting may be by voice, hand, or by secret ballot. A secret ballot vote shall be deemed in order if so requested by a member of the Active Staff in good standing. If three or more candidates are nominees for any one office, then successive balloting will be conducted with the name of the candidate receiving the fewest votes being eliminated from each successive slate until one candidate obtains a majority vote. The two candidates at-large positions on the MSEC receiving the highest number of votes shall be elected to occupy those posts.
- (b) The Nominating Committee shall consist of the Chief of Staff, the Vice Chief of Staff and last two (2) Past Chiefs of Staff. The Chair of the Nominating Committee will be the most senior in the past term of office. The Committee shall offer one (1) or more nominees for each office, the chair and vice chair for each department, and the members-at-large positions on the MSEC. These selections will be made in consultation with elected department leadership.
- (c) The slate of officers and at-large candidates offered by the Nominating Committee shall be presented at the November Medical Staff meeting, and by electronic notice. Other nominations from the floor will be entertained at the November meeting. Nominations may also be made by petition. The petition must be signed by five (5) active staff members and submitted to Medical Staff Services no later than five (5) days after the November meeting.

8.4 TERM OF OFFICE

All officers shall serve a two (2) year term beginning on the first day of the medical staff year (which is January 1st) and continuing until the end of the second year or until a successor is elected. Members-at-Large shall serve a one (1) year term.

8.5 VACANCIES IN OFFICE

The MSEC shall fill vacancies in office during the medical staff term, except for the Chief of Staff and, in the circumstances described in this paragraph, the Vice Chief of Staff. If there is a vacancy in the office of the Chief of Staff, the Vice Chief of Staff shall serve out the remaining term and shall immediately appoint an ad hoc nominating committee to decide promptly upon nominees for the office of Vice Chief of Staff. Such nominees shall be reported to the MSEC and to the medical staff. A special election to fill the position shall occur at the next regular staff meeting. If there is a vacancy in the office of Vice Chief of Staff that occurs for a reason other than that described above, that office need not be filled by election, but the MSEC shall appoint an interim officer to fill this office until election at the next annual meeting. A vacancy in the office of Immediate Past Chief of Staff shall be filled by a previous Chief of Staff as appointed by the MSEC.

8.6 REMOVAL OF OFFICERS

Removal of medical staff officers may be effected by two-thirds (2/3) vote of the members of the Active Medical Staff. The vote may take place at any regular or special meeting of the Active Medical Staff, upon notice as defined in Article XI. A two-thirds (2/3) vote of all Active Medical Staff is still required regardless of whether a quorum is present. A mail ballot may be approved at a regular or special meeting of the Active Medical Staff. Electronic and proxy voting are not acceptable for removal of officers.

8.7 DUTIES OF OFFICERS

8.7-1 CHIEF OF STAFF

The Chief of Staff shall serve as the chief administrative officer of the medical staff to:

- (a) interact with the administrator in all matters of mutual concern within the medical center;
- (b) represent the views and policies of the medical staff to the governing body at governing body meetings.
- (c) receive and interpret the policies of the governing body to the medical staff and report to the governing body on the performance and maintenance of quality with respect to the medical staff's responsibility to provide medical care;
- (d) call, preside at, and be responsible for the agenda of all general meetings of the medical staff;

- (e) be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the medical staff's compliance with procedural safeguards in all instances where an investigation which may lead to corrective action has been requested against a practitioner;
- (f) be the spokesperson for the medical staff in its external professional and public relations;
- (g) be responsible for the educational activities of the medical staff;
- (h) serve as chair of the MSEC;
- (i) serve as ex-officio member of all other medical staff committees without vote;
- (j) be a voting member of the governing body; and
- (k) appoint committee members to all standing, special, and multidisciplinary medical staff committees except the MSEC.

8.7-2 VICE CHIEF OF STAFF

The Vice Chief of Staff shall

- (a) assume all duties and authority of the chief of staff in the absence of the chief of staff;
- (b) be a member of the MSEC and of the joint conference committee,
- (c) attend and represent, at the direction of and in the absence of the chief of staff, the views and policies of the medical staff to the governing body at governing body meetings;
- (d) perform such other duties as the chief of staff may assign or as may be delegated by these bylaws, or by the MSEC;
- (e) automatically succeed the Chief of Staff when the latter is removed from office, resigns, or otherwise no longer remains in office for any reason.

8.7-3 IMMEDIATE PAST CHIEF OF STAFF

The Immediate Past Chief of Staff shall:

- (a) be a member of the MSEC;
- (b) be a member of the Nominating Committee; and
- (c) serve as Acting Chief of Staff in the absence of the Chief of Staff and Vice Chief of Staff.

ARTICLE IX

CLINICAL DEPARTMENTS

9.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND SERVICES

Each department shall be organized as a separate part of the medical staff and shall have a chair who shall be responsible for the overall supervision of the clinical work within that department and who shall have the authority, duties and responsibilities as specified in these Bylaws. Each department shall have a vice chair who shall assume the responsibilities of the chair in the event that the chair is unavailable. Each clinical service shall be directly responsible to the Department within which it functions.

9.2 QUALIFICATIONS, SELECTION AND TENURE OF DEPARTMENT CHAIRS

- (a) Each chair shall be a member of the Active Staff, qualified by training, experience and demonstrated ability for the position. The chair of each department will be certified by an appropriate specialty board, relevant to the Department so as to invest in the Chair sufficient knowledge about the care given within the department to discharge adequately the responsibilities inherent to a leadership role. Alternatively, competence comparable to board certification may be established by the department and through the credentialing process.
- (b) Each chair shall be elected for a two (2) year term. The selection of the chair will be in accordance with Article VIII, Section 8.3. Nominations may also be made by petition. The petition must be signed by five (5) active staff members of the department and submitted to Medical Staff Services no later than five (5) days after the candidates are announced. The election shall be at the last meeting of the year of the department by simple majority vote of all Active Staff members of the department in attendance, by mail or electronic ballot with a simple majority vote of Active Staff department members voting, and the duly elected chair shall assume the duties and responsibility as chair of the department on January 1st of the following year. In accordance with Article XIX of these bylaws, a Disclosure/Conflict of Interest statement will be collected from the candidate(s) at least twenty (20) days prior to the election.
- (c) Removal of a chair during a term of office may be effected by a two-thirds (2/3) majority vote of all Active Staff members of the department. The vote may take place at any regular or special meeting of the department, upon notice as defined in Article XII. A two-thirds (2/3) vote of all Active Staff department members is still required regardless of whether a quorum is present. A mail ballot may be approved at a regular or special meeting of the Active Staff department members. Electronic and proxy voting are not acceptable for removal of a department chair.
- (d) Vice chairs shall hold the same qualifications and be elected in the same manner as department chairs.
- (e) If there is a vacancy in the office of the chair during the term, the vice chair will serve out the remaining term. A vacancy in the office of vice chair will be

appointed by the Medical Staff Executive Committee (MSEC) to serve in an interim capacity until confirmed by special election of the department.

9.3 FUNCTIONS OF DEPARTMENT CHAIRS

Each chair shall:

- (a) establish, together with medical staff and administration, the type and scope of clinical and administrative services required to meet the needs of the patients in the medical center;
- (b) lead and be responsible for quality control activities within the department and the continuous assessment and improvement of the quality of care, treatment and services;
- (c) be a member of the MSEC, responsible for:
 - (i) the integration of the department into the primary functions of the medical center;
 - (ii) the coordination and integration of interdepartmental and intradepartmental services;
 - (iii) giving guidance to the overall medical policies of the medical center and making specific recommendations and suggestions regarding their own department in order to assure quality patient care;
 - (iv) assisting medical center administrators by recommending the sufficient numbers of qualified and competent persons to provide care, treatment and service in the department, and the qualifications and competence of departmental or service personnel who are not Licensed Independent Practitioners (LIP) and who provide patient care, treatment and services;
 - (v) recommending space and other resources needed by the department.
- (d) maintain continuing review of the professional performance of all practitioners with clinical privileges in that department and report regularly thereon to the MSEC;
- (e) be responsible for enforcement of the Medical Staff Bylaws, Rules and Regulations within that department, including but not limited to oversight of practitioners to ensure that practitioner functions within the scope of his/her privileges.
- (f) be responsible for appointment of proctors, initiation of corrective action and evaluation of clinical performance and ordering of consultations to be provided or sought when necessary;
- (g) be responsible for implementation within that department of actions taken by the MSEC and by the governing body;

- (h) transmit to the Credentials Committee recommendations regarding the criteria for clinical privileges that are relevant to the care provided in the department.
- (i) transmit to the Credentials Committee recommendations concerning the medical staff classification, the reappointment and the delineation of clinical privileges for all practitioners in that department;
- (j) be responsible for the orientation, teaching, education and research program in that department;
- (k) participate in every phase of administration of that department through cooperation with the nursing service and the medical center administration in matters affecting patient care, including personnel, supplies, special regulations, and techniques;
- (l) assist in the preparation of such annual reports, including budgetary planning, pertaining to that department as may be required by the MSEC, the Chief Executive Officer, or the governing body;
- (m) Assess and recommend off-site sources to the MSEC for needed patient care services not provided by the Department or the organization; and
- (n) other duties commensurate with the office as may from time to time be reasonably requested of by the Chief Executive Officer, the MSEC or the governing body.

9.4 FUNCTIONS AND QUALIFICATIONS OF MEDICAL DIRECTORS

The Medical Director of various services, as appointed by the medical center Administration, will be Active, Provisional or Administrative members of the Queen of the Valley Medical Center Medical Staff appointed through the processes detailed in Article IV of these Bylaws. The Medical Director of Anesthesiology Services shall be board certified in anesthesiology or be equally qualified by virtue of demonstrated training and/or experience. The Medical Director of Emergency Services shall be board certified in emergency medicine. Medical Directors shall collaborate with the Medical Staff through direction, supervision and communication via the Department Chair to whom the services reports. The Medical Director shall be responsible for:

- (a) implementing policies and procedures;
- (b) developing and recommending policies to the Medical Staff;
- (c) reviewing the quality and training of staff/personnel;
- (d) participating in the training and continuing education of personnel;
- (e) evaluating and making recommendations regarding items of capital purchase;
- (f) reviewing quality of patient care issues, reporting through the appropriate medical staff committee(s);

- (g) making decisions, in consultation with the physicians responsible for the patient, for the disposition of patient(s) when patient census exceeds optimal operational capacity;
- (h) monitoring and/or supervising medical activities in the Service, including appropriateness of care and level of care needed.

9.5 FUNCTIONS OF DEPARTMENTS

- (a) A primary responsibility delegated to each department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the department. Each clinical department shall establish its own criteria, consistent with the policies of the medical staff and of the governing body, for the granting of clinical privileges, the performance of specified services, and for the holding of office in the department.
- (b) Departments shall provide for medical evaluation and shall participate in a primary retrospective review of completed records of discharged patients and other pertinent departmental sources of medical information relating to patient care for the purpose of selecting cases for presentation that will contribute to the continuing education of every practitioner and to the process of developing criteria to assure quality patient care. Such reviews shall be ongoing and shall include the consideration of recent deaths, unimproved patients, patients with infections, complications, errors in diagnosis and treatment, and such other instances as are believed to be important, such as patients currently in the medical center with unsolved clinical problems.
- (c) Departments shall meet regularly to review and analyze on a peer-group basis the clinical work of the department.
- (d) A report shall be submitted at least quarterly to the MSEC detailing such departmental analysis of patient care.
- (e) Each department shall create, periodically review, and update privilege delineation form(s) pertaining to clinical privileges done within the medical center. Each member assigned to the department, including provisional members, shall be required to complete this form at time of reappointment, checking those procedures that the member feels qualified to do.

9.6 ASSIGNMENT TO DEPARTMENTS

- (a) The MSEC shall, after consideration of the recommendations of the clinical departments as transmitted through the Credentials Committee, make initial departmental assignments for all medical staff members with clinical privileges.

Each member of the medical staff shall be assigned to one department. The Credentials Committee shall act on the Department Chair's recommendation for such assignment after evaluation of the applicant's qualifications. The MSEC, after review of the Department Chair's recommendation and the Credentials Committee's report and subject to the approval of the governing body, shall make

the assignment. Each Active Staff member shall be allowed voting privileges and may hold office in the clinical department to which they are assigned.

- (b) A member of the staff may attend any department meetings. Attendance is not restricted to the department meetings in which the physician is assigned.

9.7 DESIGNATION OF DEPARTMENTS

The medical staff shall be divided into the following departments:

- (a) Department of Medicine; and
- (b) Department of Surgery

9.7-1 DEPARTMENT OF MEDICINE

The Department of Medicine shall include the specialty and sub-specialties of internal medicine, family medicine, emergency medicine, pediatrics and others as requested through the Credentials Committee.

9.7-2 DEPARTMENT OF SURGERY

The Department of Surgery will include those physicians in the specialty of surgery, and sub-specialties of surgery. Anesthesiology, podiatry, obstetrics/gynecology, radiology, dentistry and pathology and others as requested through the Credentials Committee will also be included.

9.8 DENTAL SERVICE

- (a) Dentistry and Oral Surgery will be the responsibility of the Department of Surgery.
- (b) Those practitioner members of the medical staff who by license limit their practice to Dentistry and/or Oral Surgery will have medical center, dental van and operating room privileges limited to procedures in and about the oral cavity and these privileges are never automatically granted or assumed, but are determined individually on the basis of training and experience in a manner conforming with these Bylaws and the Medical Staff Rules and Regulations and in a like manner, the privileges may be extended, limited, suspended or revoked.
- (c) Dental and Oral Surgery practitioners shall have the privileges of admitting and discharging patients for dental treatment with the concurrence of a physician member of the staff who has admitting privileges. It shall be the responsibility of the dentist and/or oral surgeon to obtain an adequate medical evaluation by an active medical staff physician on all cases admitted to the medical center. Said physician or designated alternate shall be responsible for the conduct of the medical care of the patient; the dentist and/or oral surgeon shall conduct the dental and/or oral surgical care of the patient. This is specifically intended to provide that every patient during any medical center stay shall have complete twenty-four (24) hour coverage for both medical and/or oral surgical problems.

- (d) Oral and maxillofacial surgeons who do not hold a license as a physician and surgeon, who hold a California dental license, who have successfully completed a postgraduate program in oral and maxillofacial surgery accredited by the American Board of Oral and Maxillofacial Surgery, and who the Medical Staff have found competent to do so, may perform a history and physical examination and determine the ability of their patient to undergo surgical procedures the oral and maxillofacial surgeon proposes to perform. For patients with existing medical conditions or abnormal findings beyond the surgical indications, a physician member of the Medical Staff must conduct or directly supervise the admitting history and physical examination, except the portion related to oral and maxillofacial surgery, and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the oral and maxillofacial surgeon's lawful scope of practice.

9.9 PODIATRY SERVICE

- (a) Podiatry will be the responsibility of the Department of Surgery.
- (b) Those practitioner members of the medical staff who by license limit their practice to Podiatry will have medical center and operating room privileges limited to procedures in and about the feet and these privileges are never automatically granted or assumed, but are determined individually on the basis of training and experience in a manner conforming with these Bylaws and the Medical Staff Rules and Regulations and in a like manner, the privileges may be extended, limited, suspended or revoked.
- (c) Podiatry practitioners shall have the privilege of admitting and discharging patients for podiatric treatment with the concurrence of a physician member of the staff who has admitting privileges. It shall be the responsibility of the podiatrist to obtain an adequate medical evaluation by an active medical staff physician on all cases admitted to the medical center. Said physician or the designated alternate shall be responsible for the conduct of the medical care of the patient; the podiatrist shall conduct the surgical care of the patient. This is specifically intended to imply that every patient, during any medical center stay shall have complete twenty-four (24) hour coverage for both medical and/or surgical problems.

9.10 MODIFICATIONS TO ORGANIZATIONAL STRUCTURE

When deemed appropriate, the MSEC may recommend to the Board of Trustees creation, elimination, subdivision or combination of departments and/or clinical services.

ARTICLE X

COMMITTEES

Functions covered by Medical Staff committees include, but are not necessarily limited to, executive review, credentialing, medical records, tissue review, utilization management, infection control, pharmacy and therapeutics, and assisting Medical Staff members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services. These functions may be performed by individual committees or, when appropriate, more than one function may be performed by a single committee. Reports of activities and recommendations relating to these functions shall be made, either directly or through the Clinical Departments, to the Medical Staff Executive Committee (MSEC) (which shall in turn report to the governing body) as frequently as necessary.

The committees described in these Bylaws shall be standing committees of the Medical Staff. Other standing committees may be created by the MSEC. Special or ad hoc committees may be created by appropriate officials, such as department chairs, to perform specified tasks consistent with these Bylaws.

Except as otherwise provided in these Bylaws, the chair of each standing committee, and all committee members, shall be appointed by and serve at the pleasure of the Chief of Staff.

10.1 MSEC COMMITTEE

10.1-1 COMPOSITION

The MSEC shall be a standing committee of the medical staff and shall consist of the Chief of Staff; Vice Chief of Staff; Immediate Past Chief of Staff; Chair and Vice Chair of the Department of Surgery; Chair and Vice Chair of the Department of Medicine; and up to four (4) members at large as selected in accordance with Article VIII, Section 8.3. All active medical staff members of any discipline or specialty are eligible to serve as members at large. The Chief of Staff, Vice Chief of Staff, Immediate Past Chief of Staff, Department Chairs and Vice Chairs shall serve a two-year term. The members at large shall serve a one-year term. The President of the medical center shall be an ex-officio member, without vote. Others may be invited as ex-officio non-voting members at the discretion of the Chief of Staff. An officer or department chair who has been removed during an active term in accordance with Articles VIII and/or IX of these Bylaws shall be automatically removed as a MSEC member. Other MSEC members may be removed by a two-thirds (2/3) vote of the MSEC.

10.1-2 DUTIES

The MSEC shall:

- (a) implement, enforce and safeguard the self-governance rights of the medical staff to the fullest extent permitted by laws, including but not limited to the following:

- (i) initiating, developing and adopting medical staff bylaws and rules and regulations, subject to the approval of the active medical staff and the medical center governing board;
 - (ii) assessing medical staff fees and utilizing the medical staff fees as appropriate for the purposes of the medical staff;
 - (iii) having the ability to retain and be represented by independent legal counsel at the expense of the medical staff, as provided for in Article XVIII of these Bylaws;
 - (iv) establishing, in medical staff bylaws, rules and regulations, criteria and standards for medical staff membership and privileges, and enforcing those criteria and standards;
 - (v) establishing in medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assessment, utilization review and other medical staff activities including, but not limited to, periodic meetings of the medical staff and its committees and departments as well as review and analysis of patient medical records;
 - (vi) taking such action as appropriate to enforce those bylaws regarding the prohibition against retaliation directed towards a member.
- (b) represent and to act on behalf of the medical staff, subject to such limitations as may be imposed by these Bylaws between meetings of the organized medical staff;
 - (c) coordinate the activities and general policies of the various departments;
 - (d) receive and act upon committee reports;
 - (e) implement policies of the medical staff not otherwise the responsibility of the departments;
 - (f) provide liaison between the medical staff, the Chief Executive Officer, and the governing body;
 - (g) recommend to the Chief Executive Officer action on matters of a medical-administrative nature including recommendations regarding the structure of the Medical Staff;
 - (h) make recommendations on medical center management matters, through the Chief Executive Officer, to the governing body;
 - (i) fulfill the medical staff's duty to the governing body for the medical care rendered to patients in the medical center including conducting review and generating recommendations regarding quality of care issues related to exclusive arrangements for physician and/or professional services, prior to any decision being made in the following situations:

- (i) the decision to execute an exclusive contract in a previously open department or service;
 - (ii) the decision to renew or modify an exclusive contract in a particular department or service;
 - (iii) the decision to terminate an exclusive contract in a particular department or service.
- (j) ensure that the medical staff is kept abreast of the accreditation program and informed of the accreditation status of the medical center;
- (k) provide for the preparation of all meeting programs, either directly or through delegation to a program committee or to other suitable agent;
- (l) review the credentials of all applicants and to make recommendations to the governing board for staff membership, assignments to departments and delineation of clinical privileges;
- (m) review periodically all information available regarding the performance and clinical competence of staff members and other practitioners with clinical privileges and as a result of such reviews to make recommendations for reappointments and renewal, changes in clinical privileges, or corrective action to the full extent of these Bylaws;
- (n) take all reasonable steps to ensure professionally 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;
- (o) be responsible for quality assessment, performance measurement and improvement activities;
- (p) establish appropriate criteria for cross-specialty privileges;
- (q) take reasonable steps to develop continuing education activities and programs for the medical staff; and
- (r) make reports at general staff meetings.

10.1-3 PROFESSIONAL LIABILITY INSURANCE

The MSEC from time to time shall specify reasonable limits for the requirement of professional liability insurance. The MSEC shall have the discretion to specify different limits for different departments or specialties; however, in no event shall the MSEC discriminate against an individual physician by requiring that such physician maintain higher limits than other physicians within their departments or specialties. This process is defined in the Medical Staff Rules and Regulations.

10.1-4 MEETINGS

The MSEC shall meet as often as necessary and maintain a permanent record of its proceedings and actions.

10.1-5 REVIEW OF MSEC DECISIONS AND ACTIONS BY THE MEDICAL STAFF

Except for actions or recommendations involving credentialing or peer review matters as specified in these Bylaws, the medical staff may, at any regular or special meeting, review any decision made or action taken by the MSEC, and modify or rescind such decision or action by a vote of greater than 50% of the Active staff members present and voting. If the medical staff votes to rescind the MSEC's action, the rescission shall not be retroactive and the MSEC's action will be deemed valid for the period it was in effect prior to the medical staff's vote. This paragraph shall not be interpreted as limiting the MSEC's existing authority as defined in these Bylaws. This paragraph is not intended to prevent medical staff members from communicating with the governing body.

10.2 CREDENTIALS COMMITTEE

10.2-1 COMPOSITION

The Credentials Committee shall consist of members of the Active staff selected by the Chief of Staff, with input from current members, on a basis that will insure representation of the major clinical specialties and the medical staff at large.

10.2-2 DUTIES

The duties of the Credentials Committee shall be:

- (a) to review the credentials of all applicants and to make recommendations for membership and delineation of clinical privileges in compliance with Articles IV and V of these Bylaws;
- (b) to make a report to the MSEC on each applicant for medical staff membership or clinical privileges, including specific consideration of the recommendations from the departments in which such applicant requests privileges;
- (c) to review periodically all information available regarding the competence of staff members and as a result of such reviews to make recommendations for granting of privileges, reappointments, and the assignment of practitioners to the various departments or services as provided in Articles IV and V of these Bylaws;
- (d) to review reports that are referred by the MSEC, Medical Staff Departments or the Chief of Staff.

10.2-3 MEETINGS

The Credentials Committee shall meet as often as necessary, maintain a permanent record of its proceedings and actions and shall report to the MSEC.

10.3 PEER REVIEW COMMITTEE

10.3-1 PURPOSE

This committee will attempt to assure the delivery of a high standard of medical care within the Medical Center. To this end, the committee will obtain data from all

appropriate sources within and outside the Medical Center in order to identify quality of care issues if such exist.

This committee shall also conduct a comprehensive review for justification of a sample of surgical and invasive procedures performed, whether tissue was removed or not, and for the acceptability of the procedure chosen. Special consideration shall be given to the agreement or significant disagreement of the preoperative and pathology diagnoses.

Summary reports of the peer review committee will be forwarded to the Departments, as well as to the MSEC.

10.3-2 COMPOSITION

The Committee will be comprised as to assure broad representation of the medical staff in all departments and representatives from the Performance Improvement Department and such other members of the medical staff and medical center services as the chief of staff wishes to appoint to the Committee depending on the Committee's needs.

10.3-3 MEETINGS

The Committee shall meet at least annually, or as often as necessary, and maintain a permanent record of proceedings and activities.

10.4 JOINT CONFERENCE COMMITTEE

10.4-1 COMPOSITION

The Joint Conference Committee shall be composed of three (3) members of the governing body and three (3) members of the Active medical staff in good standing, appointed by the MSEC. The Chief Executive Officer shall be a non-voting ex-officio member. The position of chair of the Committee shall alternate yearly between the governing body and the medical staff.

10.4-2 DUTIES

The Joint Conference Committee shall constitute a forum for the discussion of disputed matters of medical center and medical staff policy, practice, and planning, and a forum for interaction between the governing body and the medical staff on such matters as may be referred by the MSEC, the governing body, or by action of the medical staff per Section 10.1-5 of these bylaws. The Joint Conference Committee shall exercise other responsibilities set forth in these bylaws.

10.4-3 MEETINGS

The Joint Conference Committee shall meet at the discretion of the MSEC, the governing body, or by action of the medical staff per Section 10.1-5 of these bylaws. There is no minimum meeting requirement.

10.5 PERFORMANCE MONITORING COMMITTEE

10.5-1 COMPOSITION

- (a) The Chair of the Committee is appointed by the Chief of Staff.
- (b) Physician Members Physician members of the Committee may serve for one (1) or more years. The Chief of Staff shall ensure, by appointment, that there will be representatives of the Department of Medicine, Department of Surgery, and also members at large to bring the total physician membership to six (6) or more.
- (c) Non-physician Members Non-physician personnel will serve in a non-voting status. Representatives from Patient Care Services, Case Management, Medical Records, Nutrition Services, Laboratory Services, Infection Control, Pharmacy Services, and the Performance Improvement Department will serve on this Committee as a multidisciplinary advisory resource. Other members of the medical staff and medical center administrative services may attend from time to time as may be necessary.

10.5-2 DUTIES

This Committee shall be responsible for the following:

(a) **Function: Pharmacy & Therapeutics**

This Committee shall be responsible for the development and surveillance of drug utilization practices within the medical center in order to assure quality clinical results and a minimum potential for hazard. Additionally it shall perform the following specific functions:

- (1) assist in 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 medical center;
- (2) serve as an advisory group to the medical center, medical staff and the pharmacy on matters pertaining to the choice of available drugs;
- (3) make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;
- (4) develop and review periodically a formulary or drug list for use in the medical center;
- (5) prevent unnecessary duplication in stocking drugs, and drugs in combination having identical amounts of the same therapeutic ingredients;
- (6) evaluate clinical data concerning new drugs or preparations requested for use in the medical center;
- (7) establish standards concerning the use and control of investigational drugs and research in the use of recognized drugs. In this matter, the Committee shall coordinate with the St. Joseph Health Institutional Review Board or other qualified external Institutional Review Board;
- (8) review adverse drug reactions;
- (9) review medication errors; and

- (10) review Food and Drug Administration (FDA) black-box warnings and make recommendations regarding the use of those medications.

(b) Function: Infection Control

- (1) develop a medical center-wide infection control plan and maintain surveillance over the program;
- (2) develop a system for reporting, identifying and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data and follow-up activities;
- (3) develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;
- (4) develop written policies defining special indications for isolation requirements;
- (5) coordinate action on findings from the medical staff's review of the clinical use of antibiotics;
- (6) act on recommendations related to infection control received by the Chief of Staff, the MSEC and other committees;
- (7) review sensitivities of organisms specific to the facility; and
- (8) coordinate with public health agencies.

(c) Function: Utilization Review

- (1) review statistical data developed by the medical center and the Case Management Department;
- (2) review all denials by fiscal intermediaries or authorized monitoring organizations;
- (3) review requests for appeal of decisions of the Executive Director of Case Management, Physician Advisor or other actions of this Committee;
- (4) initiate retrospective reviews of problem areas which have been identified and to focus concurrent reviews where indicated; and
- (5) develop a Utilization Management Plan which shall be subject to annual review and amendment as may from time to time be required by regulatory agencies. All amendments thereto shall be deemed effective when approved by the MSEC and the governing body.

(d) Function: Blood Usage and Medical Records

The Performance Monitoring Committee shall receive report, on at least a quarterly basis, regarding review and findings relative to the use of blood and blood components, and evaluation of the medical record for both quality of care

and of the record itself to assure adequate documentation of required components.

(e) Other Functions

This committee shall periodically evaluate and make recommendations to the MSEC regarding the following services: 1) electrocardiographic testing; 2) pulmonary function testing; 3) intermittent positive pressure breathing apparatus; 4) cardiac monitoring capability; and 5) suction.

10.5-3 MEETINGS

The Performance Monitoring Committee shall meet at least annually, or as often as necessary, and report to the MSEC regarding its activities.

10.6 BIOETHICS COMMITTEE

10.6-1 COMPOSITION

Members of the Bioethics Committee shall be appointed by the Chief of Staff based on their particular interest in bioethical issues and may include other health care professionals.

10.6-2 DUTIES

The duties of the Bioethics Committee shall be:

- (a) to serve as a resource for the medical staff, nursing and allied health staff, patients and/or families, in dealing with ethical questions related to hospitalization and treatment;
- (b) to serve as an advisory body for professional staffs and administration on the formulation of policies and/or guidelines dealing with ethical issues in health care;
- (c) to support the medical center Bioethics Council in the development of educational programs for medical, nursing, allied health and administrative departments in the areas of ethics and health care philosophy of the medical center;
- (d) to support the medical center Bioethics Council in providing opportunities for all health care professionals and for the community to become sensitive to and knowledgeable about ethical issues in medicine and the life sciences.

10.6-3 MEETINGS

Meetings shall be held as necessary but at least annually, or as often as necessary.

10.7 WELLNESS COMMITTEE

10.7-1 COMPOSITION

In order to improve the quality of care and promote the competence of the medical staff, the MSEC shall establish a Wellness Committee comprised of no less than three (3)

active members of the medical staff, a majority of which, including the chair, shall be physicians. Except for initial appointments, each member should serve a term of three (3) years, and the terms shall be staggered as deemed appropriate by the MSEC to achieve continuity. The Chair of the Committee will be appointed by the Chief of Staff. Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assessment committees while serving on this committee.

10.7-2 DUTIES

- (a) to accept, and maintain confidentiality of, reports related to the health, well-being, or impairment of medical staff members and to investigate such reports, as it deems appropriate;
- (b) to educate the medical staff and medical center staff about illness and impairment recognition issues specific to physicians;
- (c) to accept self-referrals from practitioners seeking assistance and referrals from members of the medical staff and/or medical center staff;
- (d) to refer an affected practitioner to the appropriate professional resource for diagnosis and treatment of the condition or concern;
- (e) to maintain confidentiality of the practitioner seeking referral or referred for assistance, except as limited by law, ethical obligation or when the safety of a patient is threatened;
- (f) to monitor the affected practitioner and safety of patients until rehabilitation or disciplinary process is complete and periodically thereafter, if required; and
- (g) to report to the Chief of Staff instances in which a practitioner is providing unsafe treatment or fails to complete the required rehabilitation program.

10.7-3 MEETINGS

The Committee will meet at the discretion of the chair. There is no minimum meeting requirement. The committee will maintain only such record of its proceedings as it deems advisable. Reports of these functions must be made at least quarterly to the MSEC and the Board of Trustees.

10.8 EDUCATION COMMITTEE

10.8-1 COMPOSITION

The Education Committee shall be a standing committee made up of members of the medical staff representing specialties of the medical staff; Quality Improvement; Nursing; Administration and Pharmacy.

10.8-2 DUTIES

The Education Committee will oversee the educational activities of the medical staff when appropriate.

The Education Committee shall perform the following duties:

- (a) to assess the educational needs of the Medical Staff and formulate appropriate activities to respond to those needs;
- (b) to formulate and recommend to the MSEC applicable policies and forms.

10.8-3 MEETINGS

The Committee shall meet on an ad hoc basis as often as necessary. It shall maintain a record of its proceedings and report its activities and recommendations to the MSEC.

10.9 BYLAWS COMMITTEE

10.9-1 COMPOSITION

The members of the Committee will be appointed by the Chief of Staff.

10.9-2 DUTIES

The Committee will review the Bylaws and be responsible for making recommendations relating to revisions to and updating of the Bylaws, Rules and Regulations of the Medical Staff at least annually. The committee will act on request of the MSEC, or independently in response to governmental regulations or applicable accreditation standards.

10.9-3 MEETINGS

The Committee shall meet as often as necessary, without a minimum meeting requirement.

10.10 CANCER COMMITTEE

10.10-1 COMPOSITION

This Committee shall conform to the requirements of the American College of Surgeons, Commission on Cancer as regards the formation of the Cancer Committee. The Cancer Committee is a multidisciplinary standing committee of the medical staff, composed of physician and non-physician members from specialties involved in the care of patients with cancer.

Membership shall include at least one (1) physician member from the required specialties: diagnostic radiology, pathology, general surgery, medical oncology, and radiation oncology. The committee shall also consist of at least one (1) non-physician member from the cancer program administration, oncology nursing, social services, cancer registry, quality improvement, and palliative care.

Additional members may include physicians or non-physicians representing family medicine, internal medicine, and the major cancer sites (breast, prostate, lung and colon/rectum), hospice/home care, pain management, clinical research, nutrition, pharmacy services, spiritual care, rehabilitation, Community Outreach and the American Cancer Society.

The Cancer Committee chair is a physician who may also fulfill the role of one of the required physician specialties. The cancer liaison physician must be a member of the Cancer Committee and may also fulfill the role of one of the required physician specialties.

The chair, vice-chair and physician members of the Cancer Committee will be appointed by the Chief of Staff.

10.10-2 DUTIES

The Cancer Committee acts as a policy-advisory administrative (leadership) body whose purpose is to decrease the morbidity and mortality of patients with cancer in Queen of the Valley Medical Center and within the community. It is responsible for planning, initiating, stimulating and assessing all cancer related activities in the hospital.

The committee shall:

- (a) Perform all of the duties and responsibilities as outlined in the Cancer Program Standards of the American College of Surgeons, Commission on Cancer;
- (b) Develop and evaluate annual goals for the endeavors related to cancer care;
- (c) Establish and monitor multidisciplinary cancer conferences (tumor board);
- (d) Monitor and evaluate patient care outcomes and disseminate the results to medical staff and administration;
- (e) Monitor the quality of the Cancer Registry Database; and
- (f) Monitor compliance to the Commission on Cancer's Cancer Program Standards.

10.10-3 MEETINGS

The Committee shall meet at least annually, or as often as necessary.

10.11 CRITICAL CARE COMMITTEE

10.11-1 COMPOSITION

The Critical Care Committee shall be a standing committee of the Medical Staff and consist of Active Staff members appointed annually by the Chief of Staff and selected on a basis that will ensure representation of the major clinical specialties who utilize the Intensive Care Unit. The Medical Director of the Intensive Care Unit and the Medical Director of Respiratory Care Services will be voting members of this committee. Medical center representatives from the Intensive Care Unit, the Step-Down Unit, Respiratory Care and Renal Care shall participate in meetings as non-voting members, as assigned by the Vice President of Patient Care Services.

10.11-2 DUTIES

The Critical Care Committee shall perform functions consistent with the requirements of law and regulation. The Committee shall:

- (a) Review all policies and procedures that pertain to critical care for appropriateness;
- (b) Review and make recommendations regarding equipment acquisition and use;

- (c) Participate in the assessment, recommendation and implementation of needed continuing education of the Medical Staff, Intensive Care Unit, Respiratory Care and Renal Care staff as from time to time may be appropriate.
- (d) Implement and provide ongoing assessment of a continuing interdisciplinary performance improvement program as a part of the Queen of the Valley Medical Center's quality assessment program. Performance improvement activities will be reported to the appropriate medical staff quality assessment committee(s).
- (e) Review renal care activities and complications.
- (f) Provide oversight of the cardiopulmonary resuscitation training program.
- (g) Determine what emergency equipment and supplies should be available in all areas of the hospital.

10.11-3 MEDICAL DIRECTOR/QUALIFICATIONS & RESPONSIBILITIES

- (a) The Medical Director of the Intensive Care Unit will be an Active member of the Queen of the Valley Medical Center Medical Staff and be board certified in critical care medicine or be equally qualified by virtue of demonstrated training and/or experience. The Medical Director shall collaborate with the Medical Staff through direction, supervision and communication via the Critical Care Committee. The Medical Director shall be responsible for:
 - 1) implementing policies and procedures;
 - 2) developing and recommending policies to the Committee;
 - 3) reviewing of the quality and training of critical care staff/personnel;
 - 4) participating in the training and continuing education of critical care personnel;
 - 5) evaluating and making recommendations regarding items of capital purchase;
 - 6) reviewing of quality of patient care issues related to critical care, reporting through the applicable medical staff peer review committee;
 - 7) making decisions, in consultation with the physician responsible for the patient, for the disposition of patient(s) when patient census exceeds optimal operational capacity;
 - 8) monitoring and/or supervising medical activities in the Intensive Care Unit, including appropriateness of care and level of care needed; and
 - 9) reporting to the Physician Advisor for Case Management as requested, giving summary of the utilization of the Intensive Care Unit and of the individual cases reviewed as appropriate.
- (b) The Medical Director of Respiratory Care Services will be an Active member of Queen of the Valley Medical Center Medical Staff and be board certified in pulmonary medicine, internal medicine, anesthesiology, or be equally qualified by virtue of demonstrated training and/or experience. The Medical Director shall collaborate with the Medical Staff through direction, supervision and communication via the Critical Care Committee. The Medical Director shall be responsible for:
 - 1) implementing policies and procedures;

- 2) developing and recommending policies to the Critical Care Committee;
- 3) reviewing the quality and training of respiratory care services personnel;
- 4) participating in the training and continuing education of respiratory care services personnel;
- 5) evaluating and making recommendations to the Critical Care Committee regarding items of capital purchase;
- 6) reviewing quality of care issues relating to respiratory care and report through the applicable medical staff peer review committee; and
- 7) reviewing all abnormal lab results generated by the Blood Gas and Pulmonary Function Laboratories.

10.11-4 MEETINGS

The Critical Care Committee shall meet at least annually, or as often as necessary. It shall report to the MSEC with secondary reporting responsibility to the Departments of Medicine and Surgery.

10.12 INTERDISCIPLINARY PRACTICES COMMITTEE

10.12-1 COMPOSITION

The Interdisciplinary Practices Committee (IDPC) shall include, as a minimum, the following voting members:

- (a) the Chief Executive Officer or designee;
- (b) the Vice President of Patient Care Services;
- (c) the Immediate Past Chief of Staff;
- (d) an equal number of physicians appointed by the Chief of Staff and nurses appointed by the Vice President of Patient Care Services; and
- (e) representatives of licensed or certified health professionals other than registered nurses who are not members of the medical staff and who are granted clinical privileges or practice prerogatives.

10.12-2 DUTIES

The IDPC shall perform functions consistent with the requirements of law and regulation. The Committee is responsible for monitoring the activities of credentialed personnel who are not medical staff members.

Because of the responsibility of the medical staff for the actions of this Committee and because this Committee may at any time not have a majority of its members represented by the Medical Staff, all actions of this committee shall be reviewed and approved or disapproved by the MSEC and governing body before such actions become effective.

10.12-3 MEETINGS

The IDPC shall meet at least annually, or as often as necessary.

10.13 TRAUMA COMMITTEE

10.13-1 COMPOSITION

The Trauma Committee shall be a multidisciplinary committee and shall have broad representation from the medical staff.

10.13-2 DUTIES

The Trauma Committee shall review the processes relating to the care of trauma and Emergency Medical System patients and make recommendations for improving patient safety and quality of care.

10.13-3 MEETINGS

Committee shall meet at least annually, or as often as necessary.

10.14 MEDICAL STAFF QUALITY COUNCIL

10.14-1 COMPOSITION

The Medical Staff Quality Council shall consist of at least six (6) physician members, appointed by the Chief of Staff, representing each clinical department insofar as possible, and representatives from medical center Administration, the Executive Director for Performance Improvement/Risk Management or his/her designee, and the Vice-President for Patient Care Services or his/her designee. The Chair of the Committee shall be appointed by the Chief of Staff.

10.14-2 DUTIES

The Medical Staff Quality Council shall perform the following duties:

- (a) recommend for approval of the MSEC and the governing body plans for maintaining quality patient care, patient satisfaction, and patient safety within the medical center. These may include mechanisms to:
 - 1) establish systems to identify potential problems in patient care;
 - 2) set priorities for action on problem correction;
 - 3) refer priority problems for assessment and corrective action to appropriate departments or committees;
 - 4) monitor the results of quality assessment and improvement activities throughout the medical center; and
 - 5) coordinate quality assessment and improvement activities.
- (b) submit regular confidential reports to the MSEC on the quality of medical care provided and on quality of care activities conducted.

10.14-3 MEETINGS

Committee shall meet at least annually, or as often as necessary.

10.15 OBSTETRICS/NEWBORN CARE COMMITTEE

10.15-1 COMPOSITION

The Obstetrics/Newborn Care Committee shall consist of physicians appointed by the Chief of Staff, representing the specialties of obstetrics and pediatrics, as well as representatives from nursing and administration.

10.15-2 DUTIES

The Obstetrics/Newborn Care Committee shall perform the following duties:

- (a) review policies and procedures that pertain to Maternal Services for appropriateness;
- (b) review and make recommendations regarding equipment acquisition and use; and
- (c) participate in performance improvement activities.

10.15-3 MEETINGS

Committee shall meet at least annually, or as often as necessary.

10.16 COMMITTEE REPORTING GUIDELINES

The medical staff may develop appropriate committees to direct or monitor and review and analyze services on a regular basis. These may include, but may not be limited to the following.

10.16-1 COMMITTEES REPORTING TO MSEC

The Committees reporting directly to the MSEC will be:

- Bioethics Committee
- Bylaws Committee
- Credentials Committee
- Critical Care Committee
- Education Committee
- Interdisciplinary Practices Committee
- Medical Staff Quality Council
- Nominating Committee
- Peer Review Committee
- Performance Monitoring Committee
- Wellness Committee

10.16-2 COMMITTEES REPORTING TO DEPARTMENT OF MEDICINE:

- Critical Care Committee (informational)
- Peer Review Committee (informational)

10.16-3 COMMITTEES REPORTING TO DEPARTMENT OF SURGERY:

Cancer Committee
Critical Care Committee (informational)
Obstetrics/Newborn Care Committee
Peer Review Committee (informational)
Trauma Committee

ARTICLE XI

MEDICAL STAFF MEETINGS

11.1 REGULAR MEETINGS

The Annual Staff Meeting will be the December meeting. At the Annual Staff meeting, the officers for the ensuing term will be elected. At least one (1) meeting of the entire Active Medical Staff shall be held annually. The Staff, however, may choose to meet as often as they desire.

Notice of all regular meetings shall be given to the membership at least ten (10) days prior to the meeting, stating the date, place and time as determined by the Medical Staff Executive Committee (MSEC). If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail, with postage thereon prepaid, addressed to the member at the appropriate address as it appears in the records of the Medical Staff Services Department. The attendance of such member at a meeting shall constitute a waiver of the notice of such meeting.

11.2 SPECIAL MEETINGS

- (a) The Chief of Staff or the MSEC may call a special meeting of the Medical Staff at any time. The Chief of Staff shall call a special meeting within thirty (30) days after receipt of a written request for same signed by not less than one-fourth (1/4) of the Active Staff and stating the purpose of such meeting. The MSEC shall designate the time and place of any specified meeting.
- (b) Written or printed notice stating the place, day, and hour of any special meeting of the Medical Staff shall be delivered, either personally, by mail or electronically, to each member of the Active Staff not less than ten (10) days before the date of such meeting, or by the direction of the Chief of Staff. 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 the appropriate address as it appears on the records of the medical center. The attendance of a member of the medical staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

11.3 QUORUM

The presence of the Chief of Staff and/or Vice Chief of Staff, and at least one (1) active staff physician from each of the two (2) clinical departments at any regular or special meeting shall constitute a quorum, unless otherwise so stated in these Bylaws.

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws.

11.4 PROCEDURE

Strict parliamentary procedures are not necessary for conducting a medical staff meeting. However, the *Sturgis Standard Code of Parliamentary Procedure* may be utilized as standard conduct at the discretion of the chair or upon request by any member of the medical staff present at the meeting.

ARTICLE XII

COMMITTEE AND DEPARTMENT MEETINGS

12.1 REGULAR MEETINGS

Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments shall hold regular meetings at least annually, or as often as needed.

12.2 SPECIAL MEETINGS

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

12.3 COMMITTEE ACTION

Committee action may be conducted by a telephone conference during which all committee members in attendance must have the technological ability to hear and be heard. Such telephone conference shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Valid action may be taken without a meeting by a committee if it is acknowledged in writing setting forth the action so taken which is approved by at least a majority of the members entitled to vote.

12.4 NOTICE OF MEETINGS

Written, electronic or oral notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the committee or department not less than seven (7) 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, with postage thereon prepaid, addressed to the member at the address as it appears on the records of the Medical Staff Services Department. The attendance of such a member at a meeting shall constitute a waiver of notice of such meeting.

12.5 QUORUM

The presence of the department chair or vice-chair and at least three (3) active members of that department shall constitute a quorum at any department meeting.

The presence of the committee chair or vice-chair and at least one (1) active member of that committee shall constitute a quorum at any committee meeting, unless otherwise specified in these bylaws.

12.6 MANNER OF ACTION

The action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of a committee or department. Members may be present physically, by telephone or by real time interactive electronic communication where each attending member has the ability to hear and be heard.

Action may be taken without a meeting by consent of a majority of the members entitled to vote. Written consent shall be obtained as soon as practicable.

12.7 EXECUTIVE SESSION

Executive session is a meeting of a medical staff committee, department, or of the medical staff as a whole, which only voting medical staff members may attend, unless others are expressly requested by the chair of the committee to attend. Executive session may be called by the committee chair at the request of any medical staff committee member, and shall be called by the committee chair pursuant to a duly adopted motion. Executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality.

12.8 RIGHTS OF EX OFFICIO MEMBERS

Persons serving under these Bylaws as ex officio members of a committee shall have all rights and privileges of regular members except that they shall not be counted in determining the existence of a quorum, nor shall they have a vote, unless otherwise specified in these bylaws. The Chair of the committee or department has the right to determine in all circumstances who may remain in an executive session.

12.9 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. The Chair shall be responsible for the content and accuracy of minutes offered for approval.

12.10 PROCEDURE

Strict parliamentary procedures are not necessary for conducting a medical staff meeting. However, the Sturgis Standard Code of Parliamentary Procedure may be utilized as standard conduct at the discretion of the chair or upon request by any member of the medical staff present at the meeting.

ARTICLE XIII

CONFIDENTIALITY, IMMUNITY AND RELEASES

13.1 AUTHORIZATION AND CONDITIONS

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

- (a) authorizes representatives of the medical center and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability; qualifications; training; experience; character; conduct and judgment; ethics; ability and willingness to comply with the Medical Staff Bylaws, Rules and Regulations, and policies and procedures; and ability to work with others;
- (b) authorizes persons and organizations to provide information concerning such practitioner to the Medical Staff;
- (c) agrees to be bound by the Medical Staff Bylaws, Rules and Regulations, and policies and procedures and to waive all legal claims against any representative of the Medical Staff or the medical center who acts in accordance with the provisions of the Medical Staff Bylaws, Rules and Regulations, and policies and procedures; and
- (d) acknowledges that the provisions of the Medical Staff Bylaws, Rules and Regulations, and policies and procedures, and including this Article, are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges at this medical center.

13.2 CONFIDENTIALITY OF INFORMATION

13.2-1 GENERAL

Medical Staff, department, service, or committee minutes, files, and records, including information regarding any member or applicant to this Medical Staff 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, pursuant to officially adopted policies of the Medical Staff or, where no officially adopted policy exists, only with the express approval of the Chief of Staff, the Medical Staff Executive Committee (MSEC), or their designees. All subpoenas for confidential credentialing and/or peer review records and/or information will be forwarded to the Medical Staff Services Department who will consult with legal counsel before determining how to reply. Specific policies regarding confidentiality include the following:

- (a) Members shall have a right to review portions of their own credentials files after requesting such from the Chief of Staff. The Chief of Staff or his/her designee shall be present during the scheduled review of the file. The member may only view those documents submitted by him/her or addressed to him or her. All other documents shall be summarized in advance of the scheduled review, and the member shall be permitted to review the summary;

- (b) Members shall have the right to review their quality assessment file after requesting such from the Chief of Staff. The Chief of Staff or his/her designee shall be present during the scheduled review of the file.

A copy of the file shall be made, excluding any names or information that identifies the persons who initiated Quality Assessment notices or Statements of Concern. In addition, physician reviewers' names will be removed from screening and proctor sheets. The original quality assessment file will remain in the Performance Improvement Office. The entire copied quality assessment file will be returned to the Performance Improvement Office and will be destroyed.

13.2-2 BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff departments, services, or committees, except in conjunction with medical staff or medical center operations, other hospitals' operations, 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 medical center. If it is determined that such a breach has occurred, the MSEC 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 medical center shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties as a representative of the Medical Staff or medical center.

13.3-2 FOR PROVIDING INFORMATION

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

13.4 ACTIVITIES AND INFORMATION COVERED

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) peer review organizations, Medical Board of California and similar reports.

13.5 RELEASES

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

Failure to provide a release by the deadline requested is grounds for corrective action, including, but not limited to, automatic suspension. Such action shall not give rise to the hearing rights pursuant to Article VII.

ARTICLE XIV

RULES AND REGULATIONS AND POLICIES

The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the governing body. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the medical center. Such Rules and Regulations shall be a part of the Bylaws. Rules, regulations, policies and amendments may be adopted or repealed by a simple majority vote of those members of the Active Medical Staff who are voting on the issue at hand. Exact wording of the proposed changes will be made available to all Active Staff members at least one (1) week in advance of the vote. The vote may take place at any regular or special meeting of the active medical staff or may be conducted by electronic, mail and/or written ballots. Such changes shall become effective when approved by the governing body. The Rules and Regulations will be reviewed at least annually.

Each department of the Medical Staff may develop their own Rules and Regulations, which shall be subject to the approval of the Medical Staff Executive Committee (MSEC) and to the approval of the governing body. These departmental Rules and Regulations may be adopted, amended or repealed by simple majority vote of those members of the Active Medical Staff in the department who are voting on the issue at hand. The vote may take place at any regular or special meeting of the department or may be conducted by electronic, mail and/or written ballots.

Subject to approval of the MSEC and the Governing Body, each Medical Staff Department, Service and Committee may promulgate its own policies and procedures, which may establish principles, protocols, standing orders, guidelines, or other instruments relevant to its assigned functions. Such policies and procedures shall be consistent with, and have the same force and effect as, the Medical Staff Bylaws, Rules and Regulations. In the event of a conflict, the Medical Staff Bylaws, Rules and Regulations shall take precedence.

The Medical Staff Services Department may formulate and adopt Medical Staff Policies and procedures as it may deem necessary which are not required to be included in the bylaws, rules and regulations or policies of the medical staff so long as there is no accreditation requirement for such policy and so long as the policy does not fundamentally alter, modify, or change the nature and intent of the processes or procedures described in the bylaws, rules and regulations of the medical staff.

ARTICLE XV

AMENDMENT OF THE BYLAWS

- 15.1** A proposed amendment shall be referred to the Bylaws Committee. To be adopted, an amendment shall require a simple majority vote of those members of the Active medical staff who are voting on the issue at hand. Exact wording of the amendment will be made available to all Active Staff members at least one (1) week in advance of the vote. The vote may take place at any regular or special meeting of the active medical staff or may be conducted by electronic, mail and/or written ballots. All such amendments shall become effective upon approval of the governing body which approval shall not be withheld unreasonably.
- 15.2** Upon the request of the Chief of Staff, the Medical Staff Executive Committee (MSEC), the Bylaws Committee, or upon timely written petition signed by at least ten percent (10%) of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these Bylaws. Such action shall require a simple majority vote as described above.
- 15.3** The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws. These bylaws may not be unilaterally amended or repealed by the medical staff or governing body. No medical staff governing document and no medical center corporate bylaws or other medical center governing document shall include any provision purporting to allow unilateral amendment of the medical staff bylaws or other medical staff governing document.
- 15.4** These Bylaws, and privileges of individual members of the Medical Staff accorded under these Bylaws, will be binding upon the Medical Staff and the Board of Trustees of any successor in interest in this medical center, except where hospital Medical Staffs are being combined.
- 15.5** The Bylaws will be reviewed at least annually.

ARTICLE XVI

MEDICAL STAFF FUNDS

Medical staff funds shall be under the sole control of the Queen of the Valley Medical Center Medical Staff. Management of such funds is outlined in the Medical Staff Funds Policy maintained in the Medical Staff Services Department.

16.1 FEES

The Medical Staff Executive Committee (MSEC) shall determine the amount and how the fees are to be utilized, as appropriate for the purposes of the Medical Staff.

ARTICLE XVII

RETALIATION PROHIBITED

Neither the medical staff, its members, committees or department heads, the governing body, its chief administrative officer, or any other employee or agent of the medical center or medical staff, may engage in any punitive or retaliatory action against any member of the medical staff because that member claims a right or privilege afforded by, or seeks implementation of any provision of, these medical staff bylaws.

The medical staff recognizes and embraces that it is public policy of the State of California that a physician and surgeon be encouraged to advocate for medically appropriate health care for his or her patients. Advocating for medically appropriate health care includes, but is not limited to, the ability of a physician to protest a decision, policy, or practice that the physician, consistent with that degree of learning and skill ordinarily possessed by reputable physicians practicing according to the applicable legal standard of care, reasonably believes impairs the physician's ability to provide medically appropriate health care to his or her patients. Advocacy for medically appropriate health care is protected under these Bylaws only if it is performed in a manner that does not violate the Medical Staff Bylaws, Rules and Regulations, or policies and procedures, and is not disruptive to medical staff or medical center operations.

No person, including but not limited to the medical staff, the medical center, its employees, agents, director or owners, shall retaliate against or penalize any member for such advocacy or prohibit, restrict or in any way discourage such advocacy, nor shall any person prohibit, restrict, or in any way discourage a member from communicating to a patient information in furtherance of medically appropriate health care, provided, however, that the manner in which the medical staff member advocates for medically appropriate care does not violate the Medical Staff Bylaws, Rules and Regulations, or policies and procedures, and/or is not disruptive to medical staff or medical center operations.

This section does not preclude corrective and/or disciplinary action as authorized by these medical staff bylaws.

ARTICLE XVIII

LEGAL COUNSEL

Should the need arise, and upon authorization of the Medical Staff Executive Committee (MSEC) acting on behalf of the Medical Staff, the Medical Staff may retain and be represented by independent legal counsel at the Medical Staff's expense.

ARTICLE XIX

DISCLOSURE OF INTEREST

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

The MSEC shall evaluate the significance of such disclosures and discuss any conflicts with the nominee. If a nominee with a conflict of interest remains on the ballot, the nature of their conflict shall be disclosed in writing and circulated with the ballot. If an officer, department chair, or MSEC member discovers a potential conflict of interest during his or her term of office or appointment, he or she shall disclose the conflict to the MSEC and shall abstain from any votes affecting the matter related to the conflict.

All medical staff committees that conduct peer review, quality oversight or credentialing/privileging functions will also have a disclosure of interest process. Committee members will submit written disclosures, as noted above. The disclosure statements will be collected on an annual basis and reviewed by the applicable committee.

Physicians are expected to voluntarily recuse themselves from voting on any issue they believe a potential conflict of interest may exist.

If a committee member believes another member should not vote on a particular matter because of a possible conflict of interest, a motion should be made to discuss the voting rights of the members present. Physicians will have an opportunity to present their views to the other committee members. If a physician does not voluntarily recuse himself/herself from voting, the Committee Chair may choose to decide the voting rights of the member in question by a majority vote of the committee members present.

ARTICLE XX

ADOPTION, AMENDMENT, OR REPEAL

These Bylaws, together with the appended Rules and Regulations or policies that address procedural details shall be adopted by the Active Medical Staff, shall replace any previous Bylaws, Rules and Regulations, and shall become effective when approved by the governing body of the medical center.

Amended Bylaws ADOPTED BY the Active Medical Staff of Queen of the Valley Medical Center on January 20, 2017.



Chief of Staff



Vice Chief of Staff

APPROVED BY the Board of Trustees of Queen of the Valley Medical Center on March 31, 2017.



Board of Trustees