

**REDWOOD MEMORIAL HOSPITAL**

**MEDICAL STAFF**

**BYLAWS**

**REVISED:**

Medical Staff: 7/17/2019

MEC: 8/19/2019

Board of Trustees: 8/28/2019

**REDWOOD MEMORIAL HOSPITAL  
MEDICAL STAFF BYLAWS – 8/29/2019**

**TABLE OF CONTENTS**

<b>ARTICLE I - PURPOSES AND TERMS</b>	<b>1</b>
1.1 PURPOSES OF THE BYLAWS	1
1.2 DEFINITIONS	1
1.2-1 ADMINISTRATOR	1
1.2-2 ALLIED HEALTH PROFESSIONAL (AHP) STAFF	1
1.2-3 AUTHORIZED REPRESENTATIVE OR HOSPITAL'S AUTHORIZED REPRESENTATIVE	1
1.2-4 BOARD OF TRUSTEES	1
1.2-5 CHIEF OF STAFF	1
1.2-6 CLINICAL PRIVILEGES OR PRIVILEGES	1
1.2-7 DEPENDENT PRACTITIONER	2
1.2-8 EX OFFICIO	2
1.2-9 FEDERAL HEALTH CARE PROGRAM	2
1.2-10 FOCUSED REVIEW OF PRACTITIONER PERFORMANCE	2
1.2-11 HOSPITAL	2
1.2-12 INELIGIBLE PERSON	2
1.2-13 IN GOOD STANDING	2
1.2-14 INVESTIGATION	2
1.2-15 LIMITED LICENSED PRACTITIONER	2
1.2-16 MEDICAL EXECUTIVE COMMITTEE (MEC)	3
1.2-17 MEDICAL STAFF	3
1.2-18 MEDICAL STAFF YEAR	3
1.2-19 MEMBER	3
1.2-20 MONTHLY	3
1.2-21 PHYSICIAN	3
1.2-22 PRACTITIONER	3
1.2-23 PRIVILEGES	3
1.3 NAME	3
<b>ARTICLE II - MEMBERSHIP</b>	<b>4</b>
2.1 NATURE OF MEMBERSHIP	4
2.2 QUALIFICATIONS FOR MEMBERSHIP	4
2.2-1 GENERAL QUALIFICATIONS	4
2.2-2 PARTICULAR QUALIFICATIONS	5
2.3 EFFECT OF OTHER AFFILIATIONS	5
2.4 NONDISCRIMINATION	5
2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP	6
2.6 BEHAVIOR	8
2.7 HARASSMENT PROHIBITED	8
<b>ARTICLE III - CATEGORIES OF MEMBERSHIP</b>	<b>9</b>
3.1 CATEGORIES	9
3.2 ACTIVE STAFF	9
3.2-1 QUALIFICATIONS	9
3.2-2 PREROGATIVES	9
3.2-3 RELINQUISHMENT OF ACTIVE STAFF STATUS	10
3.3 ASSOCIATE STAFF	10

3.3-1	QUALIFICATIONS.....	10
3.3-2	PREROGATIVES .....	10
3.3-3	RELINQUISHMENT OF ASSOCIATE STAFF STATUS .....	10
3.4	PROVISIONAL STAFF .....	11
3.4-1	QUALIFICATIONS.....	11
3.4-2	PREROGATIVES .....	11
3.4-3	OBSERVATION OF PROVISIONAL STAFF MEMBER.....	11
3.4-4	TERM OF PROVISIONAL STAFF STATUS .....	11
3.4-5	ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS .....	12
3.5	AFFILIATE, HONORARY, AND RETIRED STAFF .....	12
3.5-1	QUALIFICATIONS – AFFILIATE STAFF .....	12
3.5-2	PREROGATIVES – AFFILIATE STAFF .....	12
3.5-3	QUALIFICATIONS – HONORARY AND RETIRED STAFF.....	13
3.5-4	PREROGATIVES – HONORARY AND RETIRED STAFF .....	13
3.6	TEMPORARY STAFF.....	13
3.6-1	QUALIFICATIONS.....	13
3.6-2	PREROGATIVES .....	13
3.6-3	APPOINTMENT .....	13
3.6-4	TERM.....	14
3.7	ADMINISTRATIVE STAFF .....	14
3.7-1	QUALIFICATIONS.....	14
3.7-2	PREROGATIVES .....	14
3.8	LIMITATION OF PREROGATIVES .....	15
3.9	GENERAL EXCEPTIONS TO PREROGATIVES .....	15
3.10	MODIFICATION OF MEMBERSHIP .....	15
<b>ARTICLE IV - APPOINTMENT AND REAPPOINTMENT .....</b>		<b>16</b>
4.1	GENERAL.....	16
4.2	BURDEN OF PRODUCING INFORMATION.....	16
4.3	APPOINTMENT AUTHORITY .....	16
4.4	DURATION OF APPOINTMENT AND REAPPOINTMENT .....	16
4.5	APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT .....	17
4.5-1	PRE-APPLICATION SCREENING FORM.....	17
4.5-2	FORMAL APPLICATION .....	17
4.5-3	INCOMPLETE APPLICATION .....	19
4.5-4	EFFECT OF APPLICATION.....	19
4.5-5	VERIFICATION OF INFORMATION .....	20
4.5-6	DELEGATED AND/OR PROXY CREDENTIALING .....	21
4.5-7	DEPARTMENT ACTION .....	21
4.5-8	MEDICAL EXECUTIVE COMMITTEE ACTION .....	22
4.5-9	EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION .....	22
4.5-10	ACTION ON THE APPLICATION .....	22
4.5-11	NOTICE OF FINAL DECISION .....	24
4.5-12	REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION .....	24
4.5-13	TIMELY PROCESSING OF APPLICATIONS .....	24
4.6	REAPPOINTMENT AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES .....	25
4.6-1	APPLICATION.....	25
4.6-2	EFFECT OF APPLICATION .....	25
4.6-3	STANDARDS AND PROCEDURE FOR REVIEW .....	25
4.6-4	REAPPOINTMENT PERIOD .....	25
4.6-5	FAILURE TO FILE REAPPOINTMENT APPLICATION .....	26

4.6-6	CONSECUTIVE ONE YEAR REAPPOINTMENTS .....	26
4.6-7	IMPACT OF MEDICAL RECORD SUSPENSIONS .....	26
4.7	LEAVE OF ABSENCE.....	26
4.7-1	LEAVE STATUS .....	26
4.7-2	TERMINATION OF LEAVE .....	26
4.7-3	FAILURE TO REQUEST REINSTATEMENT .....	27
4.7-4	MEDICAL LEAVE OF ABSENCE .....	27
4.8	NOTIFICATION AND UPDATE TO THE MEDICAL STAFF .....	27
4.9	RESIGNATION .....	28
<b>ARTICLE V - CLINICAL PRIVILEGES .....</b>		<b>29</b>
5.1	EXERCISE OF PRIVILEGES .....	29
5.2	DELINEATION OF PRIVILEGES IN GENERAL .....	29
5.2-1	REQUESTS .....	29
5.2-2	BASIS FOR PRIVILEGES DETERMINATION .....	29
5.3	PROCTORING.....	29
5.3-1	GENERAL PROVISIONS.....	29
5.3-2	FAILURE TO OBTAIN CERTIFICATION .....	30
5.3-3	MEDICAL STAFF ADVANCEMENT .....	30
5.4	CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS .....	30
5.4-1	ADMISSIONS.....	30
5.4-2	SURGERY.....	31
5.4-3	MEDICAL APPRAISAL.....	31
5.4-4	CARE DISPUTES BETWEEN PHYSICIANS AND DENTISTS, ORAL SURGEONS OR PODIATRISTS.....	31
5.5	TEMPORARY CLINICAL PRIVILEGES.....	31
5.5-1	REQUIREMENT OF NEED AND DEFINITION OF CIRCUMSTANCES .....	31
5.6	EMERGENCY PRIVILEGES .....	33
5.7	DISASTER PRIVILEGES .....	33
5.8	TRANSPORT AND ORGAN HARVEST TEAM PRIVILEGES .....	35
5.9	CLINICAL PRIVILEGES FOR NEW PROCEDURES .....	35
5.10	MEDICAL PRIVILEGES THAT CROSS SPECIALTY LINES.....	36
5.11	MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT .....	37
5.12	LAPSE OF APPLICATION .....	37
5.13	DOCUMENTATION REQUIREMENTS .....	37
5.13-1	FULL H&P.....	37
5.13-2	ABBREVIATED H&P.....	37
5.13-3	UPDATE NOTE .....	38
5.13-4	H&P REQUIREMENTS.....	38
5.13-5	ORAL AND MAXILLOFACIAL SURGEONS .....	39
5.13-6	DENTISTS & PODIATRISTS .....	39
5.13-7	LICENSED DEPENDENT PRACTITIONERS.....	40
5.13-8	PROGRESS RECORD.....	40
5.13-7	OPERATIVE REPORTS .....	40
<b>ARTICLE VI - CORRECTIVE ACTION .....</b>		<b>41</b>
6.1	CORRECTIVE ACTION .....	41
6.1-1	CRITERIA FOR INITIATION .....	41
6.1-2	INITIATION .....	41
6.1-3	INVESTIGATION .....	41
6.1-4	MEDICAL EXECUTIVE COMMITTEE ACTION.....	42

6.1-5	SUBSEQUENT ACTION.....	43
6.1-6	INITIATION BY BOARD OF TRUSTEES.....	43
6.2	SUMMARY RESTRICTION OR SUSPENSION.....	43
6.2-1	CRITERIA FOR INITIATIONS.....	43
6.2-2	WRITTEN NOTICE OF SUMMARY SUSPENSION .....	44
6.2-3	MEDICAL EXECUTIVE COMMITTEE ACTION.....	44
6.2-4	PROCEDURAL RIGHTS.....	44
6.2-5	INITIATION BY BOARD OF TRUSTEES.....	44
6.3	AUTOMATIC SUSPENSION OR LIMITATION.....	45
6.3-1	LICENSURE .....	45
6.3-2	CONTROLLED SUBSTANCES .....	45
6.3-3	MEDICAL RECORDS .....	46
6.3-4	FAILURE TO PAY DUES / ASSESSMENTS .....	46
6.3-5	PROFESSIONAL LIABILITY INSURANCE .....	46
6.3-6	FAILURE TO RESPOND OR APPEAR .....	46
6.3-7	CRIMINAL ACTIVITY.....	46
6.3-8	MEDICAL EXECUTIVE COMMITTEE DELIBERATION AND ACTION .....	47

## **ARTICLE VII - HEARINGS AND APPELLATE REVIEWS .....** 48

7.1	GENERAL PROVISIONS.....	48
7.1-1	EXHAUSTION OF REMEDIES .....	48
7.1-2	APPLICATION OF ARTICLE.....	48
7.1-3	TIMELY COMPLETION OF PROCESS .....	48
7.1-4	FINAL ACTION.....	48
7.2	GROUND FOR HEARING .....	48
7.3	REQUESTS FOR HEARING.....	49
7.3-1	NOTICE OF ACTION OR PROPOSED ACTION .....	49
7.3-2	REQUEST FOR HEARING.....	49
7.3-3	TIME AND PLACE FOR HEARING .....	49
7.3-4	NOTICE OF HEARING.....	49
7.3-5	JUDICIAL REVIEW COMMITTEE .....	50
7.3-6	FAILURE TO APPEAR OR PROCEED .....	50
7.3-7	POSTPONEMENTS AND EXTENSIONS .....	50
7.4	HEARING PROCEDURE .....	50
7.4-1	PRE-HEARING PROCEDURE .....	50
7.4-2	REPRESENTATION .....	51
7.4-3	THE HEARING OFFICER.....	52
7.4-4	RECORD OF THE HEARING.....	52
7.4-5	RIGHTS OF THE PARTIES .....	52
7.4-6	MISCELLANEOUS RULES .....	52
7.4-7	BURDENS OF PRESENTING EVIDENCE AND PROOF.....	53
7.4-8	ADJOURNMENT AND CONCLUSION .....	53
7.4-9	BASIS FOR DECISION .....	53
7.4-10	DECISION OF THE JUDICIAL REVIEW COMMITTEE .....	54
7.5	APPEAL.....	54
7.5-1	TIME FOR APPEAL.....	54
7.5-2	GROUND FOR APPEAL.....	54
7.5-3	TIME, PLACE AND NOTICE .....	54
7.5-4	APPEAL BOARD .....	55
7.5-5	APPEAL PROCEDURE .....	55
7.5-6	DECISION.....	55
7.5-7	RIGHT TO ONE HEARING .....	56
7.6	MANDATORY REPORTING .....	56

<b>ARTICLE VIII - OFFICERS</b>	57
8.1 OFFICERS OF THE MEDICAL STAFF	57
8.1-1 IDENTIFICATION	57
8.1-2 QUALIFICATIONS	57
8.1-3 NOMINATIONS	57
8.1-4 ELECTIONS	57
8.1-5 TERM OF ELECTED OFFICE	58
8.1-6 RECALL OF OFFICERS	58
8.1-7 VACANCIES IN ELECTED OFFICE	58
8.2 DUTIES OF OFFICERS	58
8.2-1 CHIEF OF STAFF	58
8.2-2 VICE CHIEF OF STAFF	59
8.2-3 IMMEDIATE PAST CHIEF OF STAFF	59
8.2-4 SECRETARY-TREASURER	59
8.2-5 QUALITY IMPROVEMENT CHAIR	60
8.2-6 IMMEDIATE PAST QUALITY IMPROVEMENT CHAIR	60
<b>ARTICLE IX - CLINICAL DEPARTMENT</b>	61
9.1 ORGANIZATION OF CLINICAL DEPARTMENTS	61
9.2 CURRENT DEPARTMENTS	61
9.3 ASSIGNMENT TO DEPARTMENTS	61
9.4 FUNCTIONS OF DEPARTMENTS	62
9.5 DEPARTMENT CHAIRS	62
9.5-1 QUALIFICATIONS	62
9.5-2 SELECTION	63
9.5-3 TERM OF OFFICE	63
9.5-4 REMOVAL	63
9.5-5 DUTIES	63
<b>ARTICLE X - COMMITTEES</b>	65
10.1 DESIGNATION	65
10.2 GENERAL PROVISIONS	66
10.2-1 TERMS OF COMMITTEE MEMBERS	66
10.2-2 REMOVAL	66
10.2-3 VACANCIES	66
10.2-4 EXECUTIVE SESSION	66
10.2-5 ADDITION, DELETION OR MODIFICATION OF STANDING COMMITTEES OF THE MEDICAL STAFF	66
10.3 STANDING MEDICAL STAFF COMMITTEES	66
10.3-1 MEDICAL STAFF ADMINISTRATIVE COMMITTEES	67
10.3-2 MEDICAL STAFF QUALITY ASSESSMENT AND LEADERSHIP COMMITTEES	67
10.4 MEETING QUORUM/REPORTS	67
10.5 MEDICAL EXECUTIVE COMMITTEE	67
10.5-1 COMPOSITION	67
10.5-2 DUTIES	67
10.5-3 MEETINGS	69
10.6 PHYSICIAN WELL-BEING COMMITTEE	69
10.6-1 COMPOSITION	69
10.6-2 DUTIES	69
10.6-3 MEETINGS	70
10.7 INTERDISCIPLINARY PRACTICE COMMITTEE (IDPC)	70

10.7-1	COMPOSITION .....	70
10.7-2	DUTIES .....	70
10.7-3	MEETINGS.....	71
10.8	JOINT CONFERENCE COMMITTEE.....	71
10.8-1	COMPOSITION .....	71
10.8-2	DUTIES .....	71
10.8-3	MEETINGS.....	71
10.9	SURGERY AND MEDICINE SERVICE COMMITTEES.....	72
10.9-1	COMPOSITION .....	72
10.9-2	DUTIES AND OBLIGATIONS .....	72
10.9-3	MEETINGS.....	73
10.10	QUALITY IMPROVEMENT/PHARMACY & THERAPEUTICS/ INFECTION PREVENTION COMMITTEE .....	74
10.10-1	COMPOSITION .....	74
10.10-2	DUTIES .....	74
10.10-3	MEETINGS AND REPORTING .....	76
10.11	UTILIZATION REVIEW COMMITTEE .....	76
10.11-1	COMPOSITION .....	76
10.11-2	DUTIES .....	77
10.11-3	MEETINGS.....	77

#### **ARTICLE XI - MEETINGS .....** 78

11.1	MEETINGS .....	78
11.1-1	GENERAL MEDICAL STAFF .....	78
11.1-2	REGULAR MEETINGS .....	78
11.1-3	AGENDA.....	78
11.1-4	SPECIAL MEETINGS .....	78
11.2	COMMITTEE AND SERVICE GROUP METINGS.....	79
11.2-1	REGULAR MEETINGS .....	79
11.2-2	SPECIAL MEETINGS .....	78
11.3	QUORUM.....	79
11.3-1	GENERAL MEDICAL STAFF MEETINGS .....	79
11.3-2	DEPARTMENT AND COMMITTEE MEETINGS .....	79
11.4	VOTING AND MANNER OF ACTION .....	80
11.4-1	VOTING .....	80
11.4-2	MANNER OF ACTION.....	80
11.5	MINUTES.....	80
11.6	ATTENDANCE REQUIREMENTS.....	81
11.6-1	REGULAR ATTENDANCE.....	81
11.6-2	MANDATORY ATTENDANCE .....	81
11.7	CONDUCT OF MEETINGS.....	81

#### **ARTICLE XII - CONFIDENTIALITY, IMMUNITY AND RELEASES .....** 82

12.1	AUTHORIZATION AND CONDITIONS .....	82
12.2	CONFIDENTIALITY OF INFORMATION.....	82
12.2-1	GENERAL .....	82
12.2-2	BREACH OF CONFIDENTIALITY .....	82
12.2-3	PROTECTED HEALTH INFORMATION.....	82
12.3	IMMUNITY FROM LIABILITY .....	83
12.3-1	FOR ACTION TAKEN .....	83
12.3-2	FOR PROVIDING INFORMATION .....	83
12.4	ACTIVITIES AND INFORMATION COVERED .....	83
12.5	RELEASES .....	84

12.6	INDEMNIFICATION .....	84
<b>ARTICLE XIII - GENERAL PROVISIONS .....</b>		<b>85</b>
13.1	ADOPTION AND AMENDMENTS TO THE GENERAL RULES AND REGULATIONS OF THE MEDICAL STAFF .....	85
13.2	DUES OR ASSESSMENTS .....	86
13.3	AUTHORITY TO ACT .....	86
13.4	DIVISION OF FEES .....	86
13.5	NOTICES .....	86
13.6	DISCLOSURE OF INTEREST AND CONFLICT OF INTEREST .....	86
	13.6-1 DISCLOSURE OF INTEREST .....	86
	13.6-2 CONFLICT OF INTEREST .....	87
13.7	NOMINATION OF MEDICAL STAFF REPRESENTATIVES .....	88
13.8	MEDICAL STAFF CREDENTIAL FILES.....	88
	13.8-1 INSERTION OF LETTER OF REPRIMAND D .....	88
	13.8-2 OPPORTUNITY TO CORRECTION / DELETION OF INFORMATION CONTAINED IN A LETTER OF REPRIMAND AND/OR MAKE AN ADDITION OF INFORMATION TO THE CREDENTIAL FILE .....	88
	13.8-3 CONFIDENTIALITY .....	89
13.9	MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING .....	90
13.10	FORMS.....	90
<b>ARTICLE XIV - ADOPTION AND AMENDMENT OF BYLAWS .....</b>		<b>91</b>
14.1	PROCEDURE .....	91
14.2	REVIEW.....	91
	14.2-1 ACTION OF BYLAWS CHANGE .....	91
14.3	APPROVAL.....	91
14.4	EXCLUSIVITY.....	91
14.5	AFFILIATIONS.....	92
14.6	CONSTRUCTION OF TERMS AND HEADINGS .....	92
<b>APPROVALS BY MEDICAL STAFF AND BOARD OF TRUSTEES .....</b>		<b>93</b>



# REDWOOD MEMORIAL HOSPITAL MEDICAL STAFF BYLAWS

## ARTICLE I PURPOSES AND TERMS

### 1.1 PURPOSES OF THE BYLAWS

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

### 1.2 DEFINITIONS

- 1.2-1 ADMINISTRATOR means the person appointed by the Board of Trustees to serve in an administrative capacity.
- 1.2-2 ALLIED HEALTH PRACTITIONER (AHP) STAFF means the organization of those limited licensed practitioners and dependent practitioners who are not members of the Medical Staff but either hold clinical privileges or provide patient care services pursuant to a job description. At a minimum AHPs from the following disciplines requiring privileging through Medical Staff include:
  - 1) Advanced Practice Registered Nurses (Nurse Practitioners, CRNAs, Certified Nurse Midwives and Clinical Nurse Specialists providing direct patient care),
  - 2) Physician Assistants
  - 3) Registered Nurse First Assistants (RNFAs) or others who provide a surgical level of care. A surgical level of care is defined as incising, closing, ligating or actively retracting live tissue. All others are usually processed through the HR process.
- 1.2-3 AUTHORIZED REPRESENTATIVE or HOSPITAL'S AUTHORIZED REPRESENTATIVE means the individual designated by the Hospital and approved by the MEC to provide information to and request information from the National Practitioner Data Bank according to the terms of these Bylaws.
- 1.2-4 BOARD OF TRUSTEES means the Board of Trustees of the Hospital.
- 1.2-5 CHIEF OF STAFF means the Chief Officer of the Medical Staff elected by members of the Medical Staff.
- 1.2-6 CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to members of the Medical Staff and Credentialed Allied Health Professionals to provide patient care and includes unrestricted access to those Hospital

resources (including equipment, facilities and Hospital personnel) which are necessary to effectively exercise those privileges.

- 1.2-7 **DEPENDENT PRACTITIONER** means an appropriately licensed or certified health care practitioner whose licensure or certification does not permit, and/or the Hospital does not authorize, the independent exercise of clinical privileges. Dependent practitioners may only provide patient care services pursuant to individually designed job description. Dependent practitioners may become members of the Allied Health Professional Staff at the Hospital.
- 1.2-8 **EX OFFICIO** means by virtue of an office or position held. Ex officio members on committees have no voting rights unless otherwise specified in these Bylaws.
- 1.2-9 **FEDERAL HEALTH CARE PROGRAM** means any plan or program that provides health benefits whether directly, through insurance or otherwise, which is funded directly in whole or in part by the United States government or a state health program (with the exception of the Federal Employees Health Benefits program). Examples of federal health care programs include, but are not limited to: are Medicare, Medicaid (MediCal), Blue Cross Federal Employees Program (FEP) /Tricare /CHAMPUS and veterans' programs.
- 1.2-10 **FOCUSED REVIEW OF PRACTITIONER PERFORMANCE** means the focus review process which involves monitoring, analyzing and understanding those special circumstances of a practitioner's performance, as defined by the organized Medical Staff and which require further evaluation.
- 1.2-11 **HOSPITAL** means Redwood Memorial Hospital.
- 1.2-12 **INELIGIBLE PERSON** means any person who:
  - (a) Is currently excluded, suspended, debarred, or ineligible to participate in any federal health care program, or
  - (b) Has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in a federal health care program after a period of exclusion, suspension, debarment, or ineligibility.
- 1.2-13 **IN GOOD STANDING** means a member is currently not under suspension or serving with any limitation of voting or other prerogatives imposed by operation of the Bylaws, Rules and Regulations or policies of the Medical Staff.
- 1.2-14 **INVESTIGATION** means a process specifically instigated by the MEC to determine the validity, if any, to a concern or complaint raised against a member of the Medical Staff.
- 1.2-15 **LIMITED LICENSED PRACTITIONER** means a practitioner whose licensure or certification permits, and the Hospital authorizes, the independent

provision of patient care services without direction or supervision and within the scope of individually delineated clinical privileges. Limited licensed practitioners may qualify to become members of the Medical Staff or may qualify to become members of the Allied Health Professional Staff.

- 1.2-16 MEC means the Executive Committee of the Medical Staff which shall constitute the governing body of the Medical Staff as described in these Bylaws. It is noted that the MEC at this Hospital serves as the Credentials Committee. Throughout these Bylaws, MEC/Credentials Committee will be abbreviated MEC.
  - 1.2-17 MEDICAL STAFF or STAFF means those physicians (MD or DO or their equivalent as defined in Section 2.2-2(a)), doctors of dental surgery or medicine, and podiatrists who have been granted recognition as members of the Medical Staff pursuant to the terms of these Bylaws.
  - 1.2-18 MEDICAL STAFF YEAR means the calendar year.
  - 1.2-19 MEMBER means, unless otherwise expressly limited, any physician (MD or DO or their equivalent as defined in Section 2.2-2(a)), doctors of dental surgery or medicine, and podiatrists, holding a current license to practice within the scope of that license who is a member of the Medical Staff.
  - 1.2-20 MONTHLY means a minimum of ten (10) meetings per year.
  - 1.2-21 PHYSICIAN means an individual with an MD or DO degree or the equivalent degree (i.e., foreign) as recognized by the Medical Board of California (MBC) or the Board of Osteopathic Examiners (BOE), who is licensed by either the MBC or the BOE.
  - 1.2-22 PRACTITIONER means those individuals who are members of either the Medical or Allied Health Professional Staff of Redwood Memorial Hospital.
  - 1.2-23 PRIVILEGES means the permission granted to a Medical Staff member or Allied Health Professional Staff member to render specific patient services.
- 1.3 THE NAME of this organization is the Medical Staff of Redwood Memorial Hospital.

## ARTICLE II MEMBERSHIP

### 2.1 NATURE OF MEMBERSHIP

No physician, dentist, or podiatrist, including those in a medical administrative position by virtue of a contract with the Hospital, shall admit or provide medical or health-related services to patients in the Hospital unless the physician is a member of the Medical Staff or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws. Appointment to the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws. Democratic principles shall prevail in Medical Staff functions at Redwood Memorial Hospital. The civil rights of every Medical Staff member and applicant shall be retained.

### 2.2 QUALIFICATIONS FOR MEMBERSHIP

#### 2.2-1 GENERAL QUALIFICATIONS

Only currently licensed physicians, dentists, or podiatrists shall be deemed to possess basic qualifications for membership in the Medical Staff, and who

- (a) document their (1) current licensure, (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and (5) current adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;
- (b) are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care, (3) to keep as confidential, as required by law, all information or records received in the physician-patient relationship, and (4) to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff;
- (c) maintain in force professional liability insurance covering the exercise of all requested privileges, in not less than amounts that may be determined from time to time by a joint resolution of the MEC and the Board of Trustees. Professional liability insurance must be held with an insurance carrier approved by the State Insurance Commissioner to conduct business in the State of California, or the practitioner may demonstrate membership in a physician's cooperative with the same minimum amounts of coverage as determined by the MEC and Board of Trustees;
  - (1) Each member of the Medical Staff, or applicant thereto, shall certify in writing at the time of application, and provide ongoing documentation as required by the MEC, that he or she possess professional liability insurance in the amount determined appropriate by the Medical Staff and Board of Trustees, including either prior acts (nose coverage) or an extended reporting enhancement (tail coverage). Such certification shall include the name of the carrier, the period of coverage, assurance

that the coverage can be reduced or canceled only after notification to the Hospital and, if requested by the MEC, a certified or photo copy of the face sheet of his/her policy evidencing such coverage, or the entire policy if requested.

- (d) are eligible to participate in federal and state healthcare programs. The practitioner may not currently be an ineligible person and shall not become an ineligible person during any term of membership.

## 2.2-2 PARTICULAR QUALIFICATIONS

- (a) **Physicians.** An applicant for physician membership on the Medical Staff, except for the honorary staff, must hold an MD or DO degree or their equivalent and a valid and unsuspended license to practice medicine issued by the Medical Board of California or the Board of Osteopathic Examiners of the State of California. For the purpose of this section, "or their equivalent" shall mean any degree (i.e., foreign) recognized by the Medical Board of California or the Board of Osteopathic Examiners. The MEC retains the prerogative to recommend an applicant to the Board.
- (b) Limited License Practitioners.
  - (1) **Dentists.** An applicant for dental membership on the Medical Staff, except for the honorary staff, must hold a DDS or equivalent degree and a valid and unsuspended certificate to practice dentistry issued by the Board of Dental Examiners of California.
  - (2) **Podiatrists.** An applicant for podiatric membership on the Medical Staff, except for the honorary staff, must hold a DPM degree and a valid and unsuspended certificate to practice podiatry issued by the Medical Board of California.

## 2.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to Medical Staff membership merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at another health care facility. Medical Staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, IPA, PPO, PHO, Hospital-Sponsored Foundation, or other organization or in contracts with a third party which contracts with this Hospital.

## 2.4 NONDISCRIMINATION

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

## 2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for the honorary and retired staff, the ongoing responsibilities of each credentialed member of the Medical Staff include:

- (a) providing patients with the quality of care meeting the professional standards of the Medical Staff of this Hospital;
- (b) abiding by the Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital policies;
- (c) discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments;
- (d) preparing and completing in timely a fashion medical records for all the patients for whom the member provides care in the Hospital;
- (e) abiding by the lawful ethical principles of the practitioner's applicable professional association;
- (f) aiding in any Medical Staff approved educational programs for medical students, interns, resident physicians, resident dentists, staff physicians and dentists, nurses and other personnel;
- (g) working cooperatively with colleagues, nurses, Hospital administration and others so as not to adversely affect patient care;
- (h) making appropriate arrangements for coverage of his/her patients, by practitioner privileged in the same or similar specialty, including patients who may come to the Hospital for emergency services;
- (i) refusing to engage in improper inducements for patient referral;
- (j) participating in continuing education programs as determined by the Medical Staff;
- (k) participating in voluntary emergency service coverage or consultation panels as may be determined by the Medical Staff;
- (l) discharging such other staff obligations as may be lawfully established from time to time by the Medical Staff or MEC;
- (m) providing information to and/or testifying on behalf of the Medical Staff or an accused practitioner regarding any matter under an investigation pursuant to paragraph 6.1-3, and those which are the subject of a hearing pursuant to Article VII;
- (n) refraining from behaviors that a reasonable physician would consider inappropriate or not acceptable and could be grounds for discipline;
- (o) abiding by all applicable laws and regulations of governmental agencies and complying with applicable standards of The Joint Commission;

- (p) actively participating in and regularly cooperating with the Medical Staff in assisting the Hospital to fulfill its obligations related to patient care, including, but not limited to, performance improvement, focused review of practitioner performance, utilization management, quality evaluation, and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time;
- (q) recognizing the importance of communicating with appropriate officers and/or Department Chairs when he/she obtains credible information indicating that a fellow Medical Staff member may have engaged in unprofessional or unethical conduct or may have a health condition which poses a significant risk to the well-being or care of patients and then cooperating as reasonably necessary toward the appropriate resolution of any such matter;
- (r) residing in the access area required of his/her category;
- (s) responding within thirty (30) days unless stated otherwise to all notices or requests made by a peer review body of the Medical Staff. Such requests may include requests for information, clarification of information or a request for personal appearance by the practitioner at a specific peer review meeting;
- (t) refraining from any harassment or discrimination against any person;
- (u) refraining from delegating the responsibility for diagnosis or care of hospitalized patients to a Practitioner or AHP who is not qualified to undertake this responsibility or who is not adequately supervised;
- (v) seeking consultation whenever warranted by the patient's condition or when required by these Bylaws and Rules and Regulations.
- (w) providing information from his/her office records or from outside sources, as requested, as necessary, to facilitate the care of or review of the care of specific patients;
- (x) accepting responsibility for participating in Medical Staff proctoring in accordance with Medical Staff requirements.
- (y) continuously informing the Medical Staff of any significant changes in the information required on appointment and reappointment forms; and
- (z) continuously meeting the qualifications for membership as set forth in these Bylaws.
- (aa) participating in any medical Staff approved educational programs for medical students, interns, resident physicians, and Nurse Practitioners or Physician Assistants, although members who choose not to participate in professional graduate education programs shall not be subject to denial or limitation of privileges for that reason.

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

## 2.6 BEHAVIOR

Members of the Medical Staff and others holding clinical privileges shall demonstrate a willingness and capability:

- (a) to work with and relate to other staff members, members of other health disciplines, Hospital management and employees, visitors and the community in general in a cooperative, professional, non-disruptive manner that is essential for maintaining a Hospital environment appropriate to quality and efficient patient care; and,
- (b) to discharge the basic obligations of Medical Staff membership and specific obligations appropriate to staff membership category.

Failure of a member to demonstrate behavior as described in Section 2.6(a) may result in responsive action by the Medical Staff which may include, but is not limited to, disciplinary action as described in Article VII.

## 2.7 HARASSMENT PROHIBITED

Harassment by a Medical Staff member of any individual will not be tolerated.

“Sexual harassment” is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters).

Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment or (3) is directed to a patient.

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



## ARTICLE III CATEGORIES OF MEMBERSHIP

### 3.1 CATEGORIES

The categories of the Medical Staff shall include the following: Active, Associate, Provisional, Honorary, Retired, Affiliate, Temporary, and Administrative. At appointment and each time of reappointment, the member's staff category shall be determined.

### 3.2 ACTIVE STAFF

#### 3.2-1 QUALIFICATIONS

The Active staff shall consist of members who:

- (a) meet the general qualifications for membership set forth in Section 2.2;
- (b) have offices or residences which, in the opinion of the MEC, are located close enough to the Hospital to provide appropriate continuity of quality care;
- (c) are involved in at least twenty (20) direct patient care activities per two (2) year period in facilities licensed by the Hospital. These patient care activities may consist of admissions, assisting at surgeries, consultations, and/or other direct contact patient care procedures, although exceptions to this requirement may be made for good cause by the MEC;
- (d) except for good cause, as determined by the Medical Executive Committee, have satisfactorily completed their designated term in the Provisional Staff category.

#### 3.2-2 PREROGATIVES

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

- (a) admit patients and exercise such clinical privileges as are granted pursuant to Article V;
- (b) attend and vote on matters presented at general and special meetings of the Medical Staff and of the department and committees to which the member is duly appointed; and
- (c) hold staff or department office and serve as a voting member of committees to which the member is duly appointed or elected by the Medical Staff or duly authorized representative thereof, so long as the activities required by the position fall within the member's scope of practice as authorized by law.

#### 3.2-3 RELINQUISHMENT OF ACTIVE STAFF STATUS

The failure of an Active Staff member to meet the requirements of Section 3.2-1(a-c) shall be deemed a voluntary relinquishment of Active Staff status and the member

shall automatically be transferred to the appropriate staff category, if any, for which the member is eligible. In the event that the member is not eligible for any other category, his/her Medical Staff membership shall automatically terminate. No such transfer or termination shall be subject to the provisions of Article VII.

### 3.3 ASSOCIATE STAFF

#### 3.3-1 QUALIFICATIONS

The Associate Medical Staff shall consist of members who:

- (a) meet the general qualifications set forth in Section 3.2-1(a-b);
- (b) are involved in at least one (1) but not more than nineteen (19) direct patient care activities per two (2) year period in facilities licensed by the Hospital. These patient care activities may consist of admissions, assisting at surgeries, consultations, and/or other patient care procedures, although exception to this requirement may be made for good cause by the MEC;
- (c) are members in good standing of the Active Medical Staff of another California licensed Hospital, although exceptions to this requirement may be made by the MEC for good cause; and
- (d) have satisfactorily completed appointment in the provisional category.

#### 3.3-2 PREROGATIVES

Except as otherwise provided, the Associate Medical Staff member shall be entitled to:

- (a) admit patients to the Hospital with the limitations of Section 3.3-1(b) and exercise such clinical privileges as are granted pursuant to Article V; and
- (b) attend in a non-voting capacity meetings of the Medical Staff and the department of which the individual is a member, and medical staff committees of which the individual is a member, including open committee meetings and educational programs.

Associate staff members shall not be eligible to hold office in the Medical Staff.

#### 3.3-3 RELINQUISHMENT OF ASSOCIATE STAFF STATUS

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

## 3.4 PROVISIONAL STAFF

### 3.4-1 QUALIFICATIONS

The Provisional Staff shall consist of members who:

- (a) meet the general qualifications for Medical Staff membership set forth in Sections 3.2-1(a) and (b) or 3.3-1(a)-(d); and
- (b) immediately prior to their application and appointment were not members (or were no longer members) in good standing of this Medical Staff.

### 3.4-2 PREROGATIVES

The Provisional Staff member shall be entitled to:

- (a) admit patients and exercise such clinical privileges as are granted pursuant to Article V; and
- (b) attend meetings of the Medical Staff and the department of which that person is a member, including open committee meetings and educational programs;
- (c) membership category designation of Provisional/Active or Provisional/Associate during the provisional period.

Provisional staff members shall not be eligible to hold office in the Medical Staff organization, but may serve upon committees.

### 3.4-3 OBSERVATION OF PROVISIONAL STAFF MEMBER

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

### 3.4-4 TERM OF PROVISIONAL STAFF STATUS

A member shall remain in the provisional staff for a period of six (6) months, unless that status is extended by the MEC for an additional six (6) month-period upon a determination of good cause, which determination shall not be subject to review pursuant to Articles VI or VII.

### 3.4-5 ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS

- (a) If the Provisional Staff member has substantially completed proctoring requirements and satisfactorily demonstrated the ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued Medical Staff membership, the member shall be eligible for placement in the Active, Associate, or Affiliate staff as appropriate, upon recommendation of the MEC and Board of Trustees. At the discretion of the MEC, failure to complete one or more procedure-specific proctoring requirements shall not of itself preclude advancement to another staff category provided that all basic proctoring requirements have been successfully completed pursuant to current Medical Staff proctoring policies.
- (b) Failure to satisfactorily conclude Provisional Staff status because of failure to complete proctoring requirements shall be governed by the provisions of Section 5.3-3.

## 3.5 AFFILIATE, HONORARY, AND RETIRED STAFF

### 3.5-1 QUALIFICATIONS – AFFILIATE STAFF

The Affiliate Staff shall consist of members who:

- (a) do not meet the criteria for Active or Associate Staff member;
- (b) meet the general Medical Staff membership qualification set forth in Section 3.2-1 (a); with the exception of item 2.2-1, (c), an Affiliate Staff member will not need to meet the location requirements as specified in this section; and,
- (c) desire Medical Staff membership without holding clinical privileges to treat patients, for the purpose of referring and observing the care rendered to his/her patients by other Medical Staff members with clinical privileges.

### 3.5-2 PREROGATIVES

The Affiliate Staff member:

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

### 3.5-3 QUALIFICATIONS - HONORARY AND RETIRED STAFF

#### (a) THE HONORARY STAFF

The Honorary staff shall consist of physicians, dentists, or podiatrists, who do not actively practice at the Hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the Hospital, and who continue to exemplify high standards of professional and ethical conduct.

#### (b) THE RETIRED STAFF

The Retired staff shall consist of members who have retired from active practice and, at the time of their retirement, were members in good standing of the Active Medical Staff for a period of at least one (1) continuous year, and who continue to adhere to appropriate professional and ethical standards.

### 3.5-4 PREROGATIVES

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

## 3.6 TEMPORARY STAFF

### 3.6-1 QUALIFICATIONS

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

### 3.6-2 PREROGATIVES

Temporary Medical Staff members shall be entitled to attend all meetings of committees to which they have been appointed for the limited purpose of carrying out quality assessment and improvement functions. They shall have no privileges to perform clinical services in the Hospital. They may not admit patients to the Hospital, or hold office in the Medical Staff organization. They may, however, serve on designated committees with or without vote at the discretion of the MEC. Finally, they may attend Medical Staff meetings outside of their committees, upon invitation.

### 3.6-3 APPOINTMENT

Recommendation for appointment to the Temporary Medical Staff for the purpose of quality assessment and peer review shall be made by the Chief of Staff or designee and approved by the Chief Executive Officer or designee acting on behalf of the Board of Trustees.

### 3.6-4 TERM

Membership on the temporary Medical Staff shall be time limited and the exact duration of membership shall be specified at the time of appointment to the temporary Medical Staff.

## 3.7 ADMINISTRATIVE STAFF

### 3.7-1 QUALIFICATIONS

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

The Administrative Staff shall consist of members who:

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

### 3.7-2 PREROGATIVES

The Administrative Staff may be allowed to:

- (a) Attend meetings of the Medical Staff and various departments, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except to the extent the right to vote is specified at the time of appointment.
- (b) Administrative Staff members shall not be eligible to hold office in the Medical Staff organization, admit patients or exercise clinical privileges.

## 3.8 TELEMEDICINE STAFF

### 3.8-1 QUALIFICATIONS

The Telemedicine Staff shall consist of physicians who:

- (a) Meet the qualifications for credentialing as noted in section 2 of these Bylaws;

- (b) Provide only Telemedicine services to patients at the Hospital;

### 3.8-2 PREROGATIVES

The Telemedicine Staff providers:

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

### 3.9 LIMITATION OF PREROGATIVES

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

### 3.10 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership on the Medical Staff, limited license members:

- (a) shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the chair of the meeting, subject to final decision by the MEC; and
- (b) shall exercise clinical privileges only within the scope of their licensure and as set forth in Section 5.4.

### 3.11 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the MEC or pursuant to a request by a member under Section 4.6-1(b), or upon direction of the Board of Trustees as set forth in Section 6.1-6, the MEC may recommend a change in the Medical Staff category of a member consistent with the requirements of the Bylaws.

## ARTICLE IV APPOINTMENT AND REAPPOINTMENT (Including Telemedicine Services)

### 4.1 GENERAL

No person (including persons engaged by the Hospital in administratively responsible positions) shall exercise clinical privileges in the Hospital unless and until that person applies for and receives appointment to the Medical Staff or is otherwise granted privileges as set forth in these Bylaws. By applying to the Medical Staff for appointment or reappointment (or, in the case of members of the honorary staff, by accepting an appointment to that category), the applicant acknowledges responsibility to first review these Bylaws and Medical Staff Rules, Regulations and Medical Staff and Hospital policies, and agrees that throughout any period of membership that he/she will comply with the responsibilities of Medical Staff membership and with the Bylaws, Rules and Regulations and policies of the Medical Staff and Hospital as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws.

### 4.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement, or transfer, the applicant shall have the burden of producing sufficient information of clinical and professional performance for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to produce any required or reasonably requested information shall render the application incomplete and it shall not be acted upon. To the extent consistent with law, this burden may include submission to a complete medical (which may include blood or other chemical analysis) or psychological examination, at the applicant's expense, if deemed appropriate by the MEC which may select the examining physician. This same burden of producing clinical, medical, and psychological information rests with any practitioner required to produce information as part of an authorized Medical Staff peer review activity.. Failure of a practitioner to produce required information related to an authorized Medical Staff peer review, quality assessment, performance improvement, or credentialing activity in a timely manner shall result in automatic suspension of all clinical privileges until such time as the required information has been provided.

### 4.3 APPOINTMENT AUTHORITY

Appointments, denials and revocations of appointments to the Medical Staff shall be made as set forth in these Bylaws, but only after there has been a recommendation from the Medical Staff, or as set forth in Section 6.1-6.

### 4.4 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these Bylaws, initial appointments to the Medical Staff shall be for a period of two (2) years. Reappointments shall be for a period of up to two (2) Medical Staff years.



## 4.5 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

### 4.5-1 PRE-APPLICATION SCREENING FORM

Practitioners seeking initial appointment to the Medical Staff must complete a request for application form. This document shall seek to establish the practitioner's eligibility to apply for membership by verifying the potential applicants:

- (a) Current California licensure
- (b) Ability to participate in Federally funded health care programs
- (c) Evidence of satisfactory completion of an ACGME or AOA accredited postgraduate training program (for all physician applicants)
- (d) Evidence of recent clinical activity in their specialty as required by the credentialing criteria of Redwood Memorial Hospital
- (e) Evidence of professional liability insurance in the amount currently required of clinical practitioners exercising clinical privileges of their specialty
- (f) Evidence that their office and/or home are located close enough to the Hospital to provide appropriate patient care.

Those practitioners who fail to meet the threshold criteria for consideration for appointment and the granting of privileges shall not receive a formal application to the Medical Staff. This does not constitute a rejection for membership and/or privileges as the consequence of a medical disciplinary reason or cause. Such an action by the Medical Staff of Redwood Memorial Hospital does not entitle a practitioner to hearing rights pursuant to Article VII.

### 4.5-2 FORMAL APPLICATION

A formal application to the Medical Staff shall be developed by the MEC. This form is to be completed by initial applicants for Medical Staff membership and/or privileges, and by those individuals seeking reappointment to the Medical Staff and/or renewal or revision of clinical privileges. The Medical Staff application form is a peer review evaluation document, an official record of the MEC, and is afforded all protections pursuant to California Evidence Code Section 1157. This form shall require detailed information which shall include, but not be limited to, information concerning:

- (a) the applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA registration, special certifications, where appropriate and as specified in Medical Staff policy, and continuing medical education information related to the clinical privileges to be exercised by the applicant;
- (b) medical education and postgraduate training, including the name of each institution, degrees granted, programs completed, dates attended and names of practitioners responsible for the applicant's performance;
- (c) specialty or subspecialty board certification, recertification and eligibility;

- (d) three (3) peer references familiar with the applicant's professional competence and ethical character; (Note: one peer reference must be from someone in the same professional discipline.)
  - (1) At a minimum, the reference must include assessment of the following six (6) elements:
    - ~~1.~~ i. Medical/clinical knowledge
    - ~~2.~~ ii. Technical and clinical skills
    - ~~3.~~ iii. Clinical judgment
    - ~~4.~~ iv. Interpersonal skills
    - ~~5.~~ v. Communication skills
    - ~~6.~~ vi. Professionalism
- (e) requests for membership categories, department, and clinical privileges;
- (f) past or pending professional disciplinary action, voluntary or involuntary denial, revocation, suspension, reduction or relinquishment of Medical Staff membership or privileges and/or any licensure or registration, or sanctions of same and/or any other related matters;
- (g) health impairments, if any, affecting the applicant's ability in terms of skill, attitude or judgment to perform professional and Medical Staff duties fully and including information regarding the ability to perform all procedures and other privileges requested with or without reasonable accommodations, according to accepted standards of professional performance without posing a threat to patients, including proof of recent TB screening;
- (h) final judgments or settlements made against the applicant in professional liability cases, and any filed and served cases pending;
- (i) professional liability coverage for the clinical privileges sought to be exercised. This information shall include the name of the insurance company, the amount and classification of such coverage, and verification that said insurance coverage covers the clinical privileges requested. All policies for professional liability coverage must contain an agreement by which the policy or coverage shall not be cancelled, reduced or modified without at least fifteen (15) days' direct notice to the Hospital, which agreement shall also cover any cancellation for nonpayment of insurance premium. The applicant shall execute the appropriate releases with the insurer to effectuate such notice to the Hospital; as well as, each member or applicant shall promptly report in writing to the MEC, any actual or proposed reductions, restrictions, cancellation or termination of the required professional liability coverage, or change in insurance carrier; and, in the event of a failure to maintain such professional liability insurance as required above, a practitioner's clinical privileges shall be automatically suspended and shall remain suspended until the practitioner shall provide to the MEC

evidence of coverage or insurance as required herein. Failure to provide such coverage within ninety (90) days after the date of suspension, shall be deemed to be a voluntary withdrawal from the Medical Staff.

- (j) any prior or pending government agency or third party proceeding or litigation challenging or sanctioning the practitioner's admission, treatment, discharge, billing, collection, or utilization practices, including but not limited to Medicare and Medicaid fraud and abuse proceedings, convictions, and or settlements;
- (k) information as to whether the applicant has ever been charged or convicted of a felony or whether any such action is pending;
- (l) complete chronological listing of the applicant's professional and educational appointments, employment, or positions;
- (m) information on the citizenship or visa status of the applicant;
- (n) the applicant's signature;
- (o) additional information as requested by the MEC or Board of Trustees may require.
- (p) attestation of Continuing Medical Education (CME) obtained in the last 2 years. (Note: A minimum of 50 hours is required by the California Medical Board for licensing every 2 years.)

Each application for initial appointment to the Medical Staff shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. When an applicant requests an application form, that person shall be given a copy of these Bylaws, the Medical Staff Rules and Regulations, and, as deemed appropriate by the MEC, copies or summaries of any other applicable Medical Staff policies relating to clinical practice in the Hospital.

#### 4.5-3 INCOMPLETE APPLICATION

The MEC shall return incomplete applications to the applicant for correction before consideration. If items as required in 4.5-2 (a-o) are not addressed, the application may be considered incomplete.

#### 4.5-4 EFFECT OF APPLICATION

In addition to the matters set forth in Section 4.1-2, by applying for appointment to the Medical Staff each applicant:

- (a) signifies willingness to appear for interviews in regard to the application;
- (b) authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;

- (c) consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;
- (d) releases from any liability, to the fullest extent provided by law, all persons for their acts performed in connection with investigating and evaluating the applicant;
- (e) releases from any liability, to the fullest extent provided by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;
- (f) consents to the disclosure to other Hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the Hospital or Medical Staff may have, and releases the Medical Staff and Hospital from liability for so doing to the fullest extent permitted by law;
- (g) acknowledges responsibility for timely payment of required Medical Staff dues or other fees;
- (h) agrees to provide for continuous quality care for patients;
- (i) pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing for the continuous care of the applicant's patients, seeking consultation whenever necessary, refraining from failing to disclose to patients when another surgeon will be performing the surgery, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners; and
- (j) pledges to be bound by the Medical Staff Bylaws, Rules and Regulations, and Hospital and Medical Staff policies.
- (k) acknowledges that any misrepresentation or misstatement in, or omission from, the application, whether intentional or not, may result in no further processing of the application. If appointment or reappointment has been granted prior to discovery of such misrepresentation, misstatement or omission, such discovery may result in automatic relinquishment of all clinical privileges and Medical Staff appointment. In either situation, there shall be no entitlement to any hearing or appeal;
- (l) acknowledges that the hearing and appeal procedures set forth in this policy shall be the sole and exclusive remedy with respect to any professional review action taken at this Hospital; and
- (m) certifies that he or she will report any changes in the information submitted on the application form, which may subsequently occur, to the MEC.

#### 4.5-5 VERIFICATION OF INFORMATION

The applicant shall deliver a completed, signed, and dated application and supporting documents to the Medical Staff Office and an advance payment of Medical Staff dues or fees, if any is required. The administrator shall be notified of

the application. The application and all supporting materials then available shall be transmitted to the chair of each department in which the applicant seeks privileges and to the MEC. The MEC, and the administrator (when requested to assist by the MEC) shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The Hospital's authorized representative shall query the National Practitioner Data Bank, conduct a routine criminal background check regarding the applicant or member, and submit any resulting information to the MEC for inclusion in the applicant's or member's credentials file. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain any reasonably requested information. Once verified, a completed application will be forwarded to the designated Department and to the MEC for review. No application will be considered complete without a verified NPDB report

#### 4.5-6 DELEGATED AND/OR PROXY CREDENTIALING

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

#### 4.5-7 DEPARTMENT ACTION

After receipt of the application, the chair of each department to which the application is submitted shall review the application and supporting documentation, and may conduct a personal interview with the applicant at the chair's or committee's discretion. The chair or appropriate committee shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges granted, and the re-applicant's participation in relevant continuing education. The department shall transmit to the MEC a written report and recommendation as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges

to be granted, and any special conditions to be attached. The chair may also request that the MEC defer action on the application.

#### 4.5-8 MEDICAL EXECUTIVE COMMITTEE ACTION

At its next regular meeting after receipt of the chairperson of the department's report and recommendation, or as soon thereafter as is practicable, the MEC shall consider the report and any other relevant information. The MEC may request additional information, return the matter to the department for further investigation, and/or elect to interview the applicant. The MEC shall immediately forward its recommendation in written form to the Board of Trustees. In the case of an expedited credentialing request, the MEC will forward its recommendation to the CEO (or designee) as the direct representative of the Board of Trustees. The recommendation must include membership category, department, clinical privileges granted, as well as any special conditions related to or required of or by the practitioner. The MEC may also defer action on the application. The reasons for each recommendation shall be stated.

#### 4.5-9 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

- (a) Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, it shall be immediately forwarded, together with supporting documentation, to the Board of Trustees or, in cases eligible for expedited processing, applicable committee duly appointed by the Board to handle expedited credentialing.
- (b) Adverse Recommendation: When a final recommendation of the MEC is adverse to the applicant for reasons related to the applicant's professional competence or conduct, the Board of Trustees and the applicant shall be promptly informed by written notice. The applicant shall then be entitled to procedural rights as provided in Article VII.
- (c) When the MEC recommends denial of appointment or denial of a requested privilege for reasons other than the applicant's professional competence or conduct, the Board of Trustees and the applicant shall be promptly informed by written notice, but the procedural rights provided in Article VII shall not apply.

#### 4.5-10 ACTION ON THE APPLICATION

The Board of Trustees or, in cases eligible for expedited processing, to the CEO (or designee), may accept the recommendation of the MEC or may refer the matter back to the MEC for further consideration, stating the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. The following procedures shall apply with respect to action on the application:

- (a) If the MEC issues a favorable recommendation, the Board of Trustees or its duly appointed committee in cases eligible for expedited processing shall affirm the recommendation of the MEC if the MEC's decision is supported by substantial evidence.

- (1) If the Board of Trustees concurs in that recommendation, the decision of the Board shall be deemed final action.
  - (2) If the tentative final action of the Board of Trustees is unfavorable, the administrator 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 procedural rights are waived by the applicant, the decision of the Board of Trustees shall be deemed final action.
- (b) In the event the recommendation of the MEC, or any significant part of it, is unfavorable to the applicant the procedural rights set forth in Article VII shall apply.
- (1) If procedural rights are waived by the applicant, the recommendations of the MEC shall be forwarded to the Board of Trustees for final action, which shall affirm the recommendation of the MEC if the MEC's decision is supported by substantial evidence.
  - (2) If the applicant requests a hearing following the adverse MEC recommendation pursuant to Section 4.5-7(b) or an adverse Board of Trustees tentative final action pursuant to 4.5-7(a) (2), the Board of Trustees shall take final action only after the applicant has exhausted all procedural rights as established by Article VII. After exhaustion of the procedures set forth in Article VII, the board shall make a final decision and shall affirm the decision of the judicial review committee if the judicial review committee's decision is supported by substantial evidence, following a fair procedure. The Board's decision shall be in writing and shall specify the reasons for the action taken.
- (c) In cases eligible for expedited processing, if the duly appointed committee of the Board concurs in that recommendation, the positive decision shall be ratified by the Board of Trustees at its next regularly scheduled meeting. The ratification by the Board shall be deemed final. If the committee's decision is adverse to the applicant, or the Board fails to ratify the committee's decision, the matter shall be referred back to the MEC for evaluation.

Applicants are ineligible for expedited processing if, at the time of appointment, any of the following has occurred: the applicant submits an incomplete application or the MEC makes a final recommendation that is adverse or with limitation.

Applicants presenting with the following situations are evaluated on a case by case basis, usually resulting in ineligibility for the expedited process:

- (1) There is a current challenge or previously successful challenge to licensure
- (2) The applicant has received an involuntary termination of medical staff membership at another organization

- (3) The applicant has received involuntary limitation, reduction, denial, or loss of medical privileges
- (4) There has been a final judgment adverse to the applicant in a professional liability action
- (5) There is an unusual pattern or excessive number of professional liability actions.

#### 4.5-11 NOTICE OF FINAL DECISION

- (a) Notice of the final decision shall be given to the Chief of Staff, the MEC, the chair of each department concerned, the applicant, and the administrator.
- (b) A decision and notice to appoint or reappoint shall include, if applicable:
  - (1) the staff category to which the applicant is appointed;
  - (2) the department to which that person is assigned;
  - (3) the clinical privileges granted;
  - (4) any special conditions attached to the appointment; and
  - (5) the timeframe of the appointment, not to exceed 2 years.
- (c) Upon such approval by the Board of Trustees, a separate credential file will be maintained for each Medical Staff member and all credentialed staff.

#### 4.5-12 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 two (2) years. 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.

#### 4.5-13 TIMELY PROCESSING OF APPLICATIONS

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

- (a) evaluation, review, and verification of application and all supporting documents by the Medical Staff office: thirty (30) days from receipt of all necessary documentation;
- (b) review and recommendation by the chairperson of the relevant department(s): thirty (30) days after receipt of all necessary documentation from the Medical Staff Office;



- (c) review and recommendation by the MEC: thirty (30) days after receipt of all necessary documentation from the department(s) chairperson(s); and
- (d) final action: 180 days after receipt of all necessary documentation by the Medical Staff Office, thirty (30) days in expedited cases, or seven (7) days after conclusion of hearings.

#### 4.6 REAPPOINTMENT AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

##### 4.6-1 APPLICATION

- (a) At least six (6) months prior to the expiration date of the current staff appointment (except for temporary appointments), a reapplication form developed by the MEC shall be mailed or delivered to the member. If a completed application for reappointment is not received at least 150 days prior to the expiration date, written notice shall be promptly sent to the applicant advising that the application has not been received. At least 120 days prior to the expiration date, each Medical Staff member shall submit to the MEC the completed application form for renewal of appointment to the staff for the coming year, and for renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 4.5-2, as well as other relevant matters. Upon receipt of the application, the information shall be processed as set forth commencing at Section 4.5-4.
- (b) A Medical Staff member who seeks a change in Medical Staff status or modification of clinical privileges may submit such a request at any time upon a form developed by the MEC, except that such application may not be filed within ninety (90) days of the time a similar request has been denied.

##### 4.6-2 EFFECT OF APPLICATION

The effect of an application for reappointment or modification of staff status or privileges is the same as that set forth in Section 4.5-4.

##### 4.6-3 STANDARDS AND PROCEDURE FOR REVIEW

When a staff member submits the first application for reappointment, and every two years thereafter, or when the member submits an application for modification of staff status or clinical privileges, the member shall be subject to an in-depth review generally following the procedures set forth in Sections 4.5-2 through 4.5-12.

##### 4.6-4 REAPPOINTMENT PERIOD.

The standard reappointment period will be two (2) years. No extensions can be granted. A reappointment period may be for less than two (2), if a concern exists related to the practitioner's performance.

- (a) If a reappointment application cannot be processed by the expiration date, not due to the applicant's failure to respond in a timely fashion, "Temporary

Privileges for important patient care” may be approved by the Chief of Staff and granted by the CEO (or designee), acting on behalf of the Board of Trustees. The member shall continue to be subject to the reapplication review process as outlined in Sections 4.5-2 through 4.5-10.

#### 4.6-5 FAILURE TO FILE REAPPOINTMENT APPLICATION

Failure to file a completed application for reappointment at least 120 days before expiration of the members current appointment and/or provide required documentation shall result in the automatic expiration of Medical Staff membership and/or privileges at the end of the current staff appointment. In the event membership and/or privileges expire as set forth herein, the procedures set forth in Article VII shall not apply.

#### 4.6-6 CONSECUTIVE ONE YEAR REAPPOINTMENTS

A processing fee of \$250 will be charged to physicians and allied health professionals who receive consecutive one-year reappointments. This fee will be due at the time of the next reappointment. Non-payment of the processing fee renders the application incomplete and will result in resignation of Medical Staff membership at the end of the Medical Staff year as outlined in Section 4.6-5 above.

#### 4.6-7 IMPACT OF MEDICAL RECORD SUSPENSIONS

Any physician or allied health professional with greater than five (5) suspensions, and/or a total of greater than thirty (30) cumulative days of suspensions, and/or greater than ten (10) consecutive days of suspension, within a one year period, will receive a one year reappointment.

### 4.7 LEAVE OF ABSENCE

#### 4.7-1 LEAVE STATUS

At the discretion of the MEC, a Medical Staff member may obtain a voluntary leave of absence from the staff upon submitting a written request to the MEC stating the approximate period of leave desired, which may not exceed two (2) years, or the term of appointment, whichever is less. During the period of the leave, the member shall not exercise clinical privileges at the Hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the Medical Staff. Before any voluntary leave of absence may begin, all medical records must be completed and dues and/or assessments must be current and paid.

#### 4.7-2 TERMINATION OF LEAVE

At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff member may request reinstatement of privileges by submitting a written notice to that effect to the MEC. The staff member shall submit a summary of relevant activities during the leave, if the MEC so requests. The MEC shall make a recommendation concerning the reinstatement of the member's

privileges and prerogatives, and the procedure provided in Sections 4.1 through 4.5-12 shall be followed.

#### 4.7-3 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A practitioner whose membership is automatically terminated may appeal to the MEC by submitting a statement of explanation, in writing. The MEC will determine if the failure to request reinstatement was excusable.

- (a) If excusable, the practitioner will be required to comply with Section 4.7-2 of these bylaws.
- (b) If felt not to be excusable, the practitioner will be required to apply to the Medical Staff as an initial applicant.

#### 4.7-4 MEDICAL LEAVE OF ABSENCE

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

### 4.8 NOTIFICATION AND UPDATE TO THE MEDICAL STAFF

Each applicant member and Allied Health practitioner agrees to notify the Medical Staff promptly of the occurrence of any event representing a change or modification of information required as a condition of appointment and/or reappointment as described in Article IV. Such information includes but is not limited to:

#### Immediate Notification Required:

- (a) Receipt of written notice of any adverse action by the Medical Board of California taken or pending, including but not limited to an accusation filed, temporary restraining order, or imposition of any interim suspension, probation, or limitations affecting the practitioner's license to practice medicine or the practitioner's designated profession.
- (b) Any material reduction in professional liability coverage, including changes in the scope of coverage.
- (c) Conviction of any crime excluding minor traffic violations.
- (d) Receipt of any proposed or actual exclusion or adverse action under Medicare or Medicaid programs or any other federally funded or state health care programs including, but not limited to, fraud and abuse proceedings or convictions.

#### Notification Required within 14 days:

- (a) Any action taken by any health care organization which has resulted in the filing of a Section 805 report with the Medical Board of California or a report with the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank.
- (b) The denial, revocation, suspension, reduction, limitation, probation or voluntary relinquishment by resignation, of Medical Staff membership or clinical privileges at any health care organization
- (c) Receipt of notice of any legal action related to a claim for malpractice or professional liability, whether filed or served, including requests for arbitration.

#### 4.9 RESIGNATION

A Medical Staff member may resign upon submitting a written request to the MEC. The member remains responsible for fulfilling all the responsibilities of Medical Staff membership, including the responsibilities described under Section 2.5, until the effective date of the resignation.

## ARTICLE V CLINICAL PRIVILEGES

### 5.1 EXERCISE OF PRIVILEGES

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

### 5.2 DELINEATION OF PRIVILEGES IN GENERAL

#### 5.2-1 REQUESTS

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

#### 5.2-2 BASIS FOR PRIVILEGES DETERMINATION

Requests for clinical privileges shall be evaluated on the basis of the member's education, training, experience, current demonstrated professional competence and judgment, clinical performance, current health status, and the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges.

### 5.3 PROCTORING

#### 5.3-1 GENERAL PROVISIONS

initial appointees to the Medical Staff and all members granted new clinical privileges shall be subject to a period of proctoring. Each appointee or recipient of new clinical privileges shall be assigned to a department where performance on an appropriate number of cases as established by the MEC, or the department as designee of the MEC, shall be observed by the proctors designated by the MEC during the period of proctoring to determine qualification to continue to exercise the clinical privileges granted in that department. The exercise of clinical privileges in any other department shall also be subject to direct observation by that department's chair or the chair's designee. The member shall remain subject to such proctoring until the MEC has been furnished with:

- (a) a report signed by the chair of the department to which the member is assigned describing the types and numbers of cases observed and the

evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made; and

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

### 5.3-2 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 clinical privileges fails to furnish such certification within the time allowed by the department those specific clinical privileges shall automatically terminate, and the member shall be entitled to a hearing, upon request, pursuant to Article VII.

- (a) Failure to obtain certification due to low volume (not an indicator of competence), the termination will be automatic and the practitioner will not be entitled to fair hearing rights.
- (b) If the failure to obtain certification is due to poor performance, then termination of those privileges will result in fair hearing rights, as detailed in Article VII.

### 5.3-3 MEDICAL STAFF ADVANCEMENT

- (a) If a practitioner fails to complete proctoring requirements because of quality of care concerns or any medical disciplinary cause or reason, the failure will constitute a termination of the clinical privileges in question and the provisions of Article VII shall apply.
- (b) At the discretion of the MEC, a practitioner may be advanced from the provisional category to another category of membership when the practitioner has successfully completed all basic proctoring requirements pursuant to current Medical Staff proctoring policies even if one or more privilege-specific special proctoring requirements have not been completed. Advancement shall be recommended by the MEC to the Board of Trustees who retains accountability for the final decision.

## 5.4 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

### 5.4-1 ADMISSIONS

- (a) When dentists, oral surgeons, or podiatrists, who are members of the Medical Staff, admit patients, a physician member of the Medical Staff must conduct or directly supervise the admitting history and physical examination, including the H&P update, if necessary (except the portion related to dentistry or podiatry), and assume responsibility for the care of the patient's

medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice.

#### 5.4-2 SURGERY

Surgical procedures performed by dentists, oral surgeons, and podiatrists shall be under the overall supervision of the Chair of the Surgery Department or the chair's designee.

#### 5.4-3 MEDICAL APPRAISAL

All patients admitted for care in the Hospital by a dentist, oral surgeon, or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and the dentist, oral surgeon, or podiatrists shall seek consultation with a physician member to determine the patient's medical status and need for medical evaluation whenever the patient's clinical status indicates the presence of a medical problem.

#### 5.4-4 CARE DISPUTES BETWEEN PHYSICIANS AND DENTISTS, ORAL SURGEONS, OR PODIATRISTS

Any dispute between a dentist or podiatrist and a physician member regarding proposed treatment shall be promptly resolved by the appropriate Chair of the Department.

### 5.5 TEMPORARY CLINICAL PRIVILEGES

Temporary privileges may only be granted on a case-by-case basis when:

- (a) there is need to fulfill an important patient care treatment or service that mandates an immediate authorization to practice for a limited period of time, or
- (b) when a new applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and the Board of Trustees.
- (c) If a reappointment application cannot be processed by the expiration date, not due to the applicant's failure to respond in a timely fashion; "Temporary Privileges for important patient care" may be approved by the Chief of Staff and granted by the CEO (or designee), acting on behalf of the Board of Trustees. (See Section 4.6-4) Once the reappointment process is complete, a new two year cycle will begin with the date when the MEC and Board of Trustees take action on the complete application. (See Section 5.5-1 (a) (1)).

#### 5.5-1 REQUIREMENT OF NEED AND DEFINITION OF CIRCUMSTANCES

- (a) Requirement of Need
  - (1) Pending Completion of the Credentialing Process: Temporary privileges may be granted for a specified period, not to exceed

one hundred twenty (120) days, to an initial applicant for Medical Staff membership whose services are required to maintain or enhance the quality of care of the Hospital, pending final review and approval. In this instance, Temporary Privileges may be approved by the Chief of Staff and granted by the CEO (or designee), acting on behalf of the Board of Trustees. (See Sections 4.6-4 & 5.5).

- (2) Care of a Specific Patient: Temporary privileges may be granted for a specified period, not to exceed sixty (60) days, to a physician, dentist, or podiatrist for the care of a specific patient. No individual shall have such privileges renewed on more than two (2) occasions per calendar year.
- (3) Locum Tenens: Temporary privileges may be granted for a specified period not to exceed ninety (90) days, to a person serving as a locum tenens for a current member of the Medical Staff. No individual shall have such temporary privileges for more than 120 consecutive days per calendar year. Such person may attend only patients of the member for whom he/she is providing coverage. The practitioner serving as a Locum Tenens must have the same qualifications and privileges as the person for whom he/she is providing coverage.

(b) Application and Review

- (1) Upon receipt of a completed application and supporting documentation from a physician, dentist, oral surgeon, or podiatrist authorized to practice in California, the Chief Executive Officer on the recommendation of both the applicable department chair and the Chief of Staff, may grant temporary privileges to a member who appears to have qualifications, ability and judgment consistent with Section 2.2-1, but only:
  - i.. with respect to applications by a locum tenens, or to fulfill an important patient care need, after verification of current licensure and current competence; or
  - ii. with respect to a new applicant with an application without issues awaiting review and approval of the MEC and the Board of Trustees in compliance with the requirements in Section 5.5-3. Temporary Privileges may be approved by the Chief of Staff and granted by the CEO (or designee), acting on behalf of the Board of Trustees.

(c) General Conditions

- (1) Temporary privileges shall be exercised under the supervision of the chairperson of each department to which the applicant has been assigned. The applicant shall ensure that the chairperson, or the chairperson's designee, is kept closely informed as to the applicant's activities within the Hospital.



- (2) All temporary privileges are time limited and shall automatically terminate at the end of the designated period. The provisions of Article VII shall not apply to such termination.
- (3) Requirements for proctoring shall be imposed on individuals granted temporary privileges per Section 4.6-1.
- (4) All persons requesting or receiving temporary privileges shall be bound by the Bylaws and Rules and Regulations and policies of the Medical Staff.

## 5.6 EMERGENCY PRIVILEGES

- (a) In the case of an emergency involving a particular patient, any member of the Medical Staff with clinical privileges, to the degree permitted by the scope of the applicant's license and regardless of the department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of the patient or to save the patient from serious harm provided that the care provided is within the scope of the individual's license. The member shall make every reasonable effort to communicate promptly with the Department Chair concerning the need for emergency care and assistance by members of the Medical Staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the Department Chair with respect to further care of the patient at the Hospital.
- (b) In the event of an emergency under subsection (a) above, any person shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to qualified members of the Medical Staff when it becomes reasonably available.
- (c) Emergency privileges under subsection (a) shall not be used to force members to serve on emergency department call panels providing service for which they do not hold delineated clinical privileges.

## 5.7 DISASTER PRIVILEGES

For the purposes of this Section, a "disaster" is defined as any officially declared emergency, whether it is local, state, or national. In the case of a disaster, any Practitioner who presents himself/herself to the Hospital as a volunteer shall be directed to the Medical Director of the Emergency Department and the administrator on duty. Disaster privileges may only be granted to a licensed independent practitioner (LIP) when the following two criteria have been met:

- (a) The organization's emergency management plan has been formally activated; and,
- (b) The organization is unable to meet immediate patient needs.

Granting of disaster privileges must be authorized by the Chief of Staff or authorized designee. Disaster privileges will be granted on a case by case basis.

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

- (a) A current picture identification card that clearly identifies the individual's professional designation.
- (b) Current and valid license to practice in California or other state license with primary source verification of that license.
- (c) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organization or group(s).
- (d) Identification indicating that the individual has been granted authority to render patient care, treatment or services in disaster circumstances (such as authority having been granted by a federal, state, or municipal entity).
- (e) Identification by a current member of the organization or medical staff who possesses personal knowledge regarding the individual's ability to act as a LIP during a disaster;

And each of the following:

- (a) Name of the current malpractice carrier or, if available, a copy of current Malpractice Certificate.
- (b) List of current Hospital affiliations where the practitioner holds Active Staff privileges.
- (c) All necessary information required to conduct a NPDB query and complete the Temporary Disaster Privileges Request Form.

Current professional licensure of those providing care under disaster privileges is verified from the primary source as soon as the immediate situation is under control and completed within 72 hours, unless extraordinary circumstances prohibit verification, in which case the following is documented:

- (a) The reasons verification could not be performed within 72 hours.
- (b) Evidence of demonstrated ability to continue to provide adequate care, treatment and services.
- (c) An attempt to rectify the situation as soon as possible.

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

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

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

- (a) Direct observation
- (b) Clinical review of care documented in the patient's medical record.

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

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

## 5.8 TRANSPORT AND ORGAN HARVEST TEAM PRIVILEGES

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

## 5.9 CLINICAL PRIVILEGES FOR NEW PROCEDURES

Whenever a Medical Staff member requests clinical privileges to perform a procedure or service not currently being performed at the Hospital (or a significant new technique to perform an existing procedure), the request will not be processed until:

- (a) a determination has been made regarding whether the technique/procedure or service will be offered by the Hospital, and
- (b) threshold criteria have been established defining the qualifications that an individual must possess to be eligible to request the clinical privileges in question.

The MEC shall make a preliminary recommendation as to whether the new technique/procedure or service should be offered to patients, considering such factors as the Hospital's capabilities, including support services, space and equipment to perform the technique/procedure or service. After reviewing the

recommendations of the MEC, the Board of Trustees or its designee shall determine whether the new technique/procedure or service shall be offered.

If the technique/procedure or service is to be offered, the MEC shall develop threshold credentialing criteria. In developing such criteria, the MEC shall conduct research, may consult with experts, including those on the Hospital's Medical Staff and those outside the Hospital, and develop recommendations regarding:

- (a) the minimum education, training, and experience necessary to perform the technique/procedure or service,
- (b) the extent of monitoring and supervision that should be required if privileges are granted, and
- (c) the criteria and/or indications for when the technique/procedure or service is appropriate.

The MEC shall forward its recommendations to the Board of Trustees for final action.

Once the threshold qualifications are approved, specific requests from eligible Medical Staff members may be processed.

#### 5.10 MEDICAL PRIVILEGES THAT CROSS SPECIALTY LINES

Whenever a Medical Staff member requests clinical privileges that traditionally at this Hospital have been exercised only by individuals from another specialty, the request will not be processed until the steps outlined in this section have been completed and a determination has been made regarding the staff member's eligibility to request the clinical privileges in question.

The MEC shall conduct research and may consult with experts, including those on the Hospital's Medical Staff (appropriate department or department chairpersons or individuals on the Medical Staff with special interest and/or expertise in the privileges in question) or those outside the Hospital, including but not limited to, other Hospitals, residency training programs, and specialty societies.

The MEC shall then develop recommendations regarding:

- (a) the minimum education, training, and experience necessary to perform the clinical privileges in question, and
- (b) the extent of monitoring and supervision that should be required.

These recommendations may or may not permit individuals from different specialties to request the privileges at issue. The MEC shall forward its recommendation to the Board of Trustees for final action.

Once threshold qualifications are approved, specific requests from eligible Medical Staff members may be processed.

## 5.11 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

On its own or pursuant to a request under Section 4.6-1(b), the MEC may recommend a change in the clinical privileges or department assignment(s) of a member. The MEC may also recommend that the granting of additional privileges to a current Medical Staff member be made subject to monitoring in accordance with procedures similar to those outlined in Section 5.3-1.

## 5.12 LAPSE OF APPLICATION

If a Medical Staff member requesting a modification of clinical privileges or department assignments fails to furnish within thirty (30) the information reasonably necessary to evaluate the request, the application shall automatically lapse, and the applicant shall not be entitled to a hearing as set forth in Article VII.

## 5.13 DOCUMENTATION REQUIREMENTS

The H&P must be physically present prior to the procedure, either on the paper record or in the electronic medical record (EMR). When the H&P examination report is not present before any elective procedure, the procedure will not proceed until the appropriate H&P documentation is present. If this does not occur, the procedure will be cancelled.

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

### 5.13-1 FULL H&P

A full H&P is defined as an H&P that contains the following data elements:

- (a) A chief complaint, reason for admission
- (b) Details of the present illness
- (c) Past medical and surgical history, including medications and allergies
- (d) Relevant past psycho-social history (appropriate to the patient's age)
- (e) Relevant past family history
- (f) A physical examination inventoried by body systems. (Unless relevant to the chief complaint or necessary to establish diagnosis, a pelvic and/or rectal exam need not be performed. )
- (g) A statement on the conclusions or impressions drawn from the H&P
- (h) A statement on the course of action planned for the patient for that episode of care.

### 5.13-2 ABBREVIATED H&P

An abbreviated H&P is defined as an H&P that contains the following data elements:

- (a) A chief complaint

- (b) Details of present illness
- (c) Relevant past medical and surgical history, pertinent to the procedure being performed, including medications and allergies
- (d) Relevant past psycho-social history, pertinent to the procedure being performed
- (e) A relevant physical examination of those body systems pertinent to the procedure performed, but including at a minimum an appropriate assessment of the patient's cardio-respiratory status
- (f) A statement on the conclusions or impressions drawn from the H&P examination
- (g) A statement on the course of action planned for the patient for that episode of care

#### 5.13-3 UPDATE NOTE

A update note is defined as a statement entered into the patient's medical record that the H&P was reviewed and that:

- (a) There are no significant changes to the findings contained in the H&P since the time it was performed, or
- (b) There are significant changes and such changes are subsequently documented in the patient's medical record.

While it is recommended that the update note be documented on or appended to the H&P, documentation may be entered anywhere in the medical record. For patients undergoing outpatient procedures, in addition to the update note, it is required that the patient must be re-examined with attestation of the re-examination and documentation of changes, if applicable.

#### 5.13-4 H&P REQUIREMENTS

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

PATIENT TYPE	H&P REQUIREMENTS
Inpatient Admission Except OB Admissions for Vaginal Delivery	A full H&P is required. The H&P must be completed no more than 30 days prior to or within 24 hours after admission. If the H&P is performed within 30 days prior to admission, an update note must be entered into the record within 24 hours after admission.
Inpatient Procedure	A full H&P is required. If the procedure is performed more than 24 hours after admission, then the admission H&P is considered the procedure H&P. No update is needed since the physician progress notes constitute an "updating" of the patient's condition.  If the procedure is to be performed within the first 24 hours of admission, but an admission H&P has not been done, then an H&P must be completed

	<p>on the day of and prior to the start of the procedure after the patient is admitted. In an emergent situation, the H&amp;P should be completed as soon as possible after the procedure.</p> <p>If the procedure is to be performed within the first 24 hours of admission, and an H&amp;P was done prior to admission, then an update note must be entered into the record on the day of and prior to the start of the procedure after the patient is admitted. In an emergent situation, the update note should be completed as soon as possible after the procedure.</p>
Outpatient Procedure	<p>A full or abbreviated H&amp;P is required. The H&amp;P must be completed no more than 30 days prior to or on the day of and prior to the start of the procedure after the patient is admitted.</p> <p>If the H&amp;P was performed within 30 days prior to the procedure, an update note and attestation of re-examination must be entered into the record on the day of and prior to the start of the procedure after the patient is admitted.</p>
OB Admissions for Vaginal Deliveries	<p>A full H&amp;P, abbreviated H&amp;P, or the patient's prenatal record is required. The H&amp;P must be completed no more than 30 days prior to admission or within 24 hours after admission.</p> <p>If the H&amp;P is performed within 30 days prior to admission, an update note must be entered into the record within 24 hours after admission.</p> <p>If the patient's prenatal record is used in lieu of an H&amp;P, the last entry on the prenatal record must be within 30 days of admission and an update note must be entered into the record within 24 hours after admission. The prenatal record must be legible and transferred to the hospital before admission. Otherwise, an H&amp;P must be done.</p> <p>Completion of the newborn record shall constitute an adequate medical history and physical assessment for newborns.</p>

#### 5.13-5 ORAL and MAXILLOFACIAL SURGEONS

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

#### 5.13-6 DENTISTS & PODIATRISTS

Doctors of dentistry or podiatry are responsible for that part of the patient's history and physical examination that relate, respectively, to dentistry and podiatry, whether or not they are granted clinical privileges to take a complete history and perform a complete examination.

Doctors of dentistry or podiatry may perform a complete H&P if they possess the clinical privileges to do so. However, Dentists and Podiatrists are not typically granted privileges to perform H&Ps. If the Dentist or Podiatrist does not possess such privileges, then a qualified physician must perform the H&P

#### 5.13-7 LICENSED DEPENDENT PRACTITIONERS

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

#### 5.13-8 PROGRESS RECORD

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.

Progress notes shall be written at least daily on all acute –care patients.

#### 5.13-9 OPERATIVE REPORTS

(a) Dictated Operative Report:

CMS/TJC (combined) requirements for an operative report include:

- (1) primary surgeon and assistants and a description of their respective tasks
- (2) pre- and post-operative diagnoses
- (3) procedure performed
- (4) type of anesthesia administered
- (5) complications, if any
- (6) description of the techniques, findings and tissues removed or altered
- (7) any prosthetic devices, grafts, tissues, transplants or devices implanted
- (8) estimated blood loss (TJC)

(b) Hand Written Operative Note:

When the operative report is not immediately available, TJC requires a hand written, legible Operative Note with the following elements:

- (1) primary surgeon and assistants
- (2) procedure performed
- (3) findings of the procedure
- (4) estimated blood loss
- (5) specimens removed
- (6) post-operative diagnosis

The Operative Note must be completed prior to transfer to the next level of care.



## ARTICLE VI CORRECTIVE ACTION

### 6.1 CORRECTIVE ACTION

#### 6.1-1 CRITERIA FOR INITIATION

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (2) unethical, unprofessional, or illegal; (3) contrary to the Medical Staff Bylaws, Rules or Regulations, or Medical Staff or administrative policy and procedure; or (4) below applicable professional standards, a request for an investigation or action against such member may be initiated by the Chief of Staff, a department chair, or the MEC.

#### 6.1-2 INITIATION

A request for an investigation must be in writing, submitted to the MEC, and supported by reference to specific activities or conduct alleged. If the MEC initiates the request, it shall make an appropriate recordation of the reasons. The MEC shall determine how to proceed. The Chief of Staff may act on behalf of the MEC to initiate an investigation, subject to subsequent review and approval by that Committee. In addition, the Chief of Staff or any other Medical Staff official may, instead of initiating an investigation, initiate or conduct such reviews as may be appropriate to his/her responsibilities under the Medical Staff Bylaws, Rules and Regulations, or Policies.

#### 6.1-3 INVESTIGATION

An investigation under these Bylaws ("Investigation") means an investigation ordered by the MEC, or by the Chief of Staff on its behalf, based upon information indicating that a Member has exhibited acts, demeanor or conduct as described above in Section 6.1-1. An investigation does not include the usual activities of departments and other committees of the Medical Staff, including the usual quality assessment and improvement activities undertaken by the Medical Staff in compliance with the licensing and certification requirements for health facilities set forth in Title 22 of the California Code of Regulations, or preliminary deliberations or inquiries of the MEC or its representatives to determine whether to initiate an Investigation. If the MEC concludes an investigation is warranted, it shall direct an investigation to be undertaken. The MEC may conduct the investigation itself, or may assign the task to an appropriate Medical Staff officer, Medical Staff department, or standing or ad hoc committee of the Medical Staff. The parties conducting the Investigation shall not include partners, associates or relatives of the individual being investigated or any individual who is in direct economic competition or who, has a conflict of interest with the individual being investigated. The MEC in its discretion may appoint practitioners who are not members of the Medical Staff as temporary members of the Medical Staff for the sole purpose of serving on a standing or ad hoc committee, and not for the purpose of granting these practitioners temporary clinical privileges under Section 5.5, should circumstances warrant. If the investigation is delegated to an officer of committee other than the MEC, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the MEC as soon as practicable. The report may include recommendations for

appropriate corrective action. The member shall be notified in a timely manner that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a "hearing" as that term is used in Article VII, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the MEC 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 MEDICAL EXECUTIVE COMMITTEE ACTION

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

- (a) determining no corrective action be taken and, if the MEC determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's file;
- (b) deferring action for a reasonable time where circumstances warrant;
- (c) issuing letters of admonition, censure, reprimand, or warning. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file. Nothing herein shall be deemed to preclude a department chair, committee chairperson, or the MEC from issuing informal written or oral warnings outside of the corrective action process as described in these Bylaws;
- (d) taking special measures to monitor the Member's exercise of privileges on a non-restrictive basis;
- (e) recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admission, mandatory consultation, or restrictive proctoring;
- (f) recommending reduction, modification, suspension or revocation of clinical privileges, such actions may be time limited;
- (g) recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care, such actions may be time limited;
- (h) imposing a suspension or restriction of clinical privileges and/or Medical Staff membership for a duration of twenty-nine (29) days or less, after giving the member an opportunity to be heard by the MEC;
- (i) summarily suspending or restricting Medical Staff membership and/or clinical privileges.
- (j) taking other actions deemed appropriate under the circumstances.

#### 6.1-5 SUBSEQUENT ACTION

- (a) If corrective action as set forth in Section 7.2 (a)-(k) is recommended by the MEC, that recommendation shall be transmitted to the Board of Trustees.
- (b)
  - (1) If the MEC has imposed or recommended corrective action as to which the affected Practitioner may request a hearing, the Board of Trustees shall take no action on the matter until the Practitioner has either waived or exhausted his hearing rights.
  - (2) If the Practitioner invokes his hearing and appeal rights, the Board of Trustees shall proceed as described in Article VII.
  - (3) If the MEC has taken or recommended corrective action and the practitioner has no rights of hearing or appeal, or has waived such rights, and the Board of Trustees questions or disagrees with the action of the MEC, the matter may be remanded back to the MEC for further consideration.

#### 6.1-6 INITIATION BY BOARD OF TRUSTEES

If the MEC fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Board of Trustees may direct the MEC to initiate investigation or disciplinary action, but only after consultation with the MEC. The Board's request for Medical Staff action shall be in writing and shall set forth the basis for the request. If the MEC fails to take appropriate action in response to that Board of Trustees direction, the Board of Trustees may initiate corrective action after written notice to the MEC, but this corrective action must comply with Articles VI and VII of these Medical Staff Bylaws. As a follow up, either the MEC or the Board of Trustees may request a meeting of the Joint Conference Committee.

### 6.2 SUMMARY RESTRICTION OR SUSPENSION

#### 6.2-1 CRITERIA FOR INITIATION

Whenever a member's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient, prospective patient, or other person, the Hospital CEO in consultation with the Chief of Staff, the Chief of Staff, the MEC, or the head of the department or designee in which the member holds privileges may summarily restrict or suspend the Medical Staff membership or clinical privileges of such member. When none of the persons listed above is available to impose a summary suspension or restriction, the Board of Trustees 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 or safety of any individual, including current or future Hospital patients. Prior to exercising this authority, the Board of Trustees must make a reasonable attempt to contact the Chief of Staff. Summary action by the Board of Trustees 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 Board of Trustees, the MEC and the administrator. In addition, the affected Medical Staff member shall be provided with a written notice of the action which notice fully complies with the requirements of Section 6.2-2 below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the department chair or by the Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute member.

#### 6.2-2 WRITTEN NOTICE OF SUMMARY SUSPENSION

Within three (3) working days of imposition of a summary suspension, the affected Medical Staff member shall be provided with written notice of such suspension. This initial written notice shall include a statement of facts demonstrating that the suspension was necessary because failure to suspend or restrict the practitioner's privileges summarily could reasonably result in an imminent danger to the health of an individual. The statement of facts provided in this initial notice shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for, but is in addition to, the notice required under Section 7.3-1 (which applies in all cases where the MEC does not immediately terminate the summary suspension). The notice under Section 7.3-1 may supplement the initial notice provided under this section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

#### 6.2-3 MEDICAL EXECUTIVE COMMITTEE ACTION

Within ten (10) days after such summary restriction or suspension has been imposed, a meeting of the MEC shall be convened to review and consider the action. Upon request, the member may attend and make a statement concerning the issues under review, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the member, constitute a "hearing" within the meaning of Article VII, nor shall any procedural rules apply. The MEC may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the member with notice of its decision within two working days of the meeting.

#### 6.2-4 PROCEDURAL RIGHTS

Unless the MEC promptly terminates the summary restriction or suspension, the member shall be entitled to the procedural rights afforded by Article VII.

#### 6.2-5 INITIATION BY BOARD OF TRUSTEES

If the Chief of Staff, members of the MEC and the head of the department in which the member holds privileges are not available to summarily restrict or suspend the member's membership or clinical privileges, the Board of Trustees may immediately suspend a member's privileges if a failure to suspend those privileges is likely to result in an imminent danger to the health of any person, provided that the Board of Trustees

made reasonable attempts to contact the Chief of Staff, members of the MEC and the head of the department before the suspension.

Such a suspension is subject to ratification by the MEC. If the MEC does not ratify such a summary suspension within two working days, excluding weekends and holidays, the summary suspension shall terminate automatically. If the MEC does ratify the summary suspension, all other provisions under Section 6.2 of these Bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the MEC for purposes of compliance with notice and hearing requirements.

### 6.3 AUTOMATIC SUSPENSION OR LIMITATION

An Automatic Suspension or Automatic Limitation of the practitioner's privileges will occur under any of the following conditions. The practitioner is not entitled to the fair hearing process for an Automatic Suspension or Automatic Limitation of privileges.

#### 6.3-1 LICENSURE

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

#### 6.3-2 CONTROLLED SUBSTANCES

- (a) Whenever a member's DEA certificate is revoked, limited, or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.
- (b) Probation: Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

### 6.3-3 MEDICAL RECORDS

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

### 6.3-4 FAILURE TO PAY DUES/ASSESSMENTS

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

### 6.3-5 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance, if any is required, shall be grounds for automatic suspension of a member's clinical privileges, and if within thirty (30) days after written warnings of the delinquency the member does not provide evidence of required professional liability insurance, the member's membership shall be automatically terminated.

### 6.3-6 FAILURE TO RESPOND OR APPEAR

Members are expected to cooperate with Medical Staff committees and representatives in the discharge of their official functions. This includes responding promptly and appropriately to correspondence, providing requested information, and appearing at appropriately announced 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. It also includes submitting to mental or physical examinations, as requested by the Chief of Staff or the MEC, for the purpose of resolving issues of fitness to perform mental or physical functions associated with the practitioner's privileges or related issues of reasonable accommodation. Failure to comply shall constitute grounds for the Chief of Staff or a department chair to suspend the member's clinical privileges or take other appropriate action until a response is provided which is satisfactory to the requesting party. Any such suspension or action shall remain in effect until the member is expressly notified that it is rescinded.

### 6.3-7 CRIMINAL ACTIVITY

Conviction of any felony, including those related to violence or abuse, or of any misdemeanor involving violations of law pertaining to controlled substances, illegal

drugs, Medicare, Medicaid, or insurance fraud or abuse, or a plea of guilty or nolo contendere to charges pertaining to the same shall result in automatic relinquishment of Medical Staff membership and privileges.

#### 6.3-8 MEDICAL EXECUTIVE COMMITTEE DELIBERATION AND ACTION

As soon as practicable after action is taken or warranted as described elsewhere in this Article, with the exception of routine suspensions for failure to complete medical records, the MEC shall review and consider the facts, and may take or recommend such additional action as it deems appropriate.

## ARTICLE VII HEARINGS AND APPELLATE REVIEWS

### 7.1 GENERAL PROVISIONS

#### 7.1-1 EXHAUSTION OF REMEDIES

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

#### 7.1-2 APPLICATION OF ARTICLE

For purposes of this Article, the term “member” may include “applicant,” as it may be applicable under the circumstances, unless otherwise stated. In addition to Medical Staff members and applicants, clinical psychologists who are providing or applying to provide professional services in the Hospital, but are not members of the Medical Staff, are entitled to the hearing rights specified in this article.

#### 7.1-3 TIMELY COMPLETION OF PROCESS

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

#### 7.1-4 FINAL ACTION

Recommended adverse actions described in Section 7.2 shall become final only after the hearing and appellate rights set forth in these Bylaws have either been exhausted or waived, and only upon being adopted as final actions by the Board of Trustees.

### 7.2 GROUNDS FOR HEARING

When Corrective Action is applied as specified in Article VI of these bylaws, the member/practitioner shall be entitled to the “Fair Hearing Process” for the conditions listed below:

- (a) denial of Medical Staff membership;
- (b) denial of Medical Staff reappointment;
- (c) suspension of staff membership for greater than twenty-nine (29) days;
- (d) revocation of Medical Staff membership;
- (e) denial of requested clinical privileges;
- (f) involuntary reduction of current clinical privileges;
- (g) suspension of clinical privileges for greater than 29 days;
- (h) termination of all clinical privileges; or
- (i) involuntary imposition of significant consultation or monitoring requirements (excluding monitoring incidental to provisional status and Section 5.3).



(j) Per California Business and Professions Code Section 805:

(1) change in membership status, and/or

(2) denial of requested advancement in staff membership status, or category, are not reportable and are not a reason to require a fair hearing.

### 7.3 REQUESTS FOR HEARING

#### 7.3-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which action has been taken or a recommendation made as set forth in Section 7.2, the Chief of Staff or designee on behalf of the MEC shall give the member prompt written notice of (1) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the Medical Board of California and/or to the National Practitioner Data Bank if required; (2) the reasons for the proposed action including the acts or omissions with which the member is charged; (3) the right to request a hearing pursuant to Section 7.3-2, and that such hearing must be requested within thirty (30) days; and (4) a summary of the rights granted in the hearing pursuant to the Medical Staff Bylaws.

#### 7.3-2 REQUEST FOR HEARING

The member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the MEC with a copy to the Board of Trustees. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing or other challenge of any kind and accepted the recommendation or action involved.

#### 7.3-3 TIME AND PLACE FOR HEARING

Upon receipt of a request for hearing, the MEC shall schedule a hearing and within fifteen (15) days give notice to the member of the time, place and date of the hearing. Unless extended by the judicial review committee, the date of the commencement of the hearing shall be not less than thirty (30) days from the date of notice, nor more than sixty (60) days from the date of receipt of the request by the MEC for a hearing; provided, however, that when the request is received from a member who is under summary suspension the hearing shall be held as soon as the arrangements may reasonably be made, so long as the member has at least thirty (30) days from the date of notice to prepare for the hearing or waives this right.

#### 7.3-4 NOTICE OF HEARING

Together with the notice stating the place, time and date of the hearing, which date shall not be less than thirty (30) days after the date of the notice unless waived by a member under summary suspension, the Chief of Staff or designee on behalf of the MEC shall provide the reasons for the recommended action, including the acts or omissions with which the member is charged, a list of the charts in question, where applicable, and a list of the witnesses (if any) expected to testify at the hearing on behalf of the MEC. The content of this list is subject to update pursuant to Section 7.4-1.

### 7.3-5 JUDICIAL REVIEW COMMITTEE

When a hearing is requested, the MEC shall appoint a judicial review committee. The judicial review committee shall be composed of not less than five (5) members of the Medical Staff. The judicial review committee members shall gain no direct financial benefit from the outcome, and shall not have acted as accusers, investigators, fact finders, initial decision makers or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the judicial review committee. In the event that it is not feasible to appoint a judicial review committee from the Active Medical Staff, the MEC may appoint members from other staff categories or practitioners who are not members of the Medical Staff. Such appointment shall include designation of the chair. Membership on a judicial review committee shall consist of one (1) member who shall have the same healing arts licensure as the accused, and where feasible, include an individual practicing the same specialty as the member. All other members shall have MD or DO degrees or their equivalent as defined in Section 2.2-2(a).

### 7.3-6 FAILURE TO APPEAR OR PROCEED

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

### 7.3-7 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the hearing officer on a showing of good cause, or upon agreement of the parties.

## 7.4 HEARING PROCEDURE

### 7.4-1 PRE-HEARING PROCEDURE

- (a) If either side to the hearing requests in writing a list of witnesses, within fifteen (15) days of such request, and in no event less than ten (10) days before commencement of the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. The member shall have the right to inspect and copy documents or other evidence upon which the charges are based, as well as all other evidence relevant to the charges. The member shall also have the right to receive at least thirty (30) days prior to the hearing a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the member to prepare a defense, including all evidence which was considered by the MEC in determining whether to proceed with the adverse action, and any exculpatory evidence in the possession of the Hospital or Medical Staff. The member and the MEC shall have the right to receive all evidence which will be made available to the Judicial Review Committee. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least ten

days before the commencement of the hearing shall constitute good cause for a continuance.

- (b) The MEC shall have the right to inspect and copy at its expense any documents or other evidence relevant to the charges which the member possesses or controls as soon as practicable after receiving the request.
- (c) The failure by either party to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the member under review.
- (d) The hearing officer shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the hearing officer shall consider:
  - (1) whether the information sought may be introduced to support or defend the charges;
  - (2) the exculpatory or inculpatory nature of the information sought, if any;
  - (3) the burden imposed on the party in possession of the information sought, if access is granted; and
  - (4) any previous requests for access to information submitted or resisted by the parties to the same proceeding.
- (e) The member shall be entitled to a reasonable opportunity to question and challenge the impartiality of judicial review committee members and the hearing officer. Challenges to the impartiality of any judicial review committee member or the hearing officer shall be ruled on by the hearing officer.
- (f) It shall be the duty of the member and the MEC or its designee to exercise reasonable diligence in notifying the chair of the judicial review committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

#### 7.4-2 REPRESENTATION

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

The member shall be entitled to representation by legal counsel in any phase of the hearing, if the member so chooses, and shall receive notice of the right to obtain representation by an attorney at law. In the absence of legal counsel, the member

shall be entitled to be accompanied by and represented at the hearing by an individual of the member's choosing who is not also an attorney at law, and the MEC shall appoint a representative who is not an attorney to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions. The MEC shall not be represented by an attorney at law if the member is not so represented.

#### 7.4-3 THE HEARING OFFICER

The MEC shall appoint a hearing officer. The hearing officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the Hospital, the Medical Staff or the involved Medical Staff member or applicant for membership for legal advice regarding their affairs and activities, shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances. If requested by the judicial review committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

#### 7.4-4 RECORD OF THE HEARING

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

#### 7.4-5 RIGHTS OF THE PARTIES

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

#### 7.4-6 MISCELLANEOUS RULES

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be

admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The judicial review committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the judicial review committee may request or permit both sides to file written arguments. The hearing process shall be completed within a reasonable time after the notice of the action is received, unless the hearing officer issues a written decision that the member or the MEC failed to provide information in a reasonable time or consented to the delay.

#### 7.4-7 BURDENS OF PRESENTING EVIDENCE AND PROOF

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

#### 7.4-8 ADJOURNMENT AND CONCLUSION

After consultation with the chair of the judicial review committee, the hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Both the MEC and the member may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

#### 7.4-9 BASIS FOR DECISION

The decision of the judicial review committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the judicial review committee shall be subject to such rights of appeal as described in these Bylaws, but shall otherwise be affirmed by the Board of Trustees as the final action if it is supported by substantial evidence, following a fair procedure.

#### 7.4-10 DECISION OF THE JUDICIAL REVIEW COMMITTEE

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

### 7.5 APPEAL

#### 7.5-1 TIME FOR APPEAL

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

#### 7.5-2 GROUNDS FOR APPEAL

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be: (a) substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice; (b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 7.5-5;

#### 7.5-3 TIME, PLACE, AND NOTICE

If an appellate review is to be conducted, the appeal board shall, within fifteen (15) days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The date of appellate review shall not be less than thirty (30) nor more than sixty (60) days from the date of such notice, provided however, that when a request for appellate review concerns a member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed fifteen (15) days from the date of the notice. The time for appellate review may be extended by the appeal board for good cause.

#### 7.5-4 APPEAL BOARD

The Board of Trustees may sit as the appeal board, or it may appoint an appeal board which shall be composed of not less than three (3) members of the Board of Trustees. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. The appeal board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal. The attorney firm selected by the Board of Trustees shall be neither the attorney firm that represented either party at the hearing before the judicial review committee nor the attorney who assisted the hearing panel or served as hearing officer.

#### 7.5-5 APPEAL PROCEDURE

The proceeding by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the judicial review committee, provided that the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the judicial review committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the judicial review hearing; or the appeal board may remand the matter to the judicial review committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of that party's position on appeal, and to personally appear and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The appeal board shall present to the Board of Trustees its written recommendations as to whether the Board of Trustees should affirm, modify, or reverse the judicial review committee decision consistent with the standard set forth in Section 7.5-6, or remand the matter to the judicial review committee for further review and decision.

#### 7.5-6 DECISION

- (a) Except as provided in Section 7.5-6(b), within thirty (30) days after the conclusion of the appellate review proceedings, the Board of Trustees shall render a final decision and shall affirm the decision of the judicial review committee if the judicial review committee's decision is supported by substantial evidence, following a fair procedure.
- (b) Should the Board of Trustees determine that the judicial review committee decision is not supported by substantial evidence, the board may modify or reverse the decision of the judicial review committee and may instead, or shall, where a fair procedure has not been afforded, remand the matter to the judicial review committee for reconsideration, stating the purpose for the referral. If the matter is remanded to the judicial review committee for further review and recommendation, the committee shall promptly conduct its review and make its recommendations to the Board of Trustees. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the chair of the Board of Trustees and the judicial review committee.

- (c) The decision shall be in writing, shall specify the reasons for the action taken, shall include the text of the report which shall be made to the National Practitioner Data Bank and the Medical Board of California, if any, and shall be forwarded to the Chief of Staff and the MEC the subject of the hearing, and the administrator, at least ten (10) days prior to submission to the Medical Board of California.

#### 7.5-7 RIGHT TO ONE HEARING

Except in circumstances where a new hearing is ordered by the Board of Trustees or a court because of procedural irregularities or otherwise for reasons not the fault of the member, no member shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

#### 7.6 MANDATORY REPORTING

Upon adoption as a final action approved by the Board of Trustees, the authorized hospital representatives shall report an adverse action to the National Practitioner Data Bank, the Medical Board of California, and any other federal or state agency for which reporting is required.



## ARTICLE VIII OFFICERS

### 8.1 OFFICERS OF THE MEDICAL STAFF

#### 8.1.-1 IDENTIFICATION

The officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, Quality Assurance Chair, Secretary-Treasurer and the immediate past Chief of Staff on even years or the past Quality Assurance Chair on odd years, or the immediate past Quality Assurance Chair (depending on the alternate year).

#### 8.1-2 QUALIFICATIONS

Officers must be members of the Active Medical Staff for at least two consecutive years at the time of their nomination and election, and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved. All officers must be licensed as physicians and surgeons, given the nature of their duties in office.

#### 8.1-3 NOMINATIONS:

- (a) A Secretary/Treasurer shall be elected at the December meeting of the Medical Staff. Only members of the Active Medical Staff shall be eligible to vote.
- (b) Nominations may be made from the floor at the time of the annual meeting.
- (c) The other offices will be filled through the progression of officers.

#### 8.1-4 ELECTIONS:

- (a) When there are three (3) or more candidates for the office of Secretary-Treasurer and no candidate receives a majority, there shall be successive balloting, whereby the name of the candidate receiving the fewest votes will be omitted from each successive slate until a majority vote is obtained by one (1) candidate.
- (b) Upon approval of a majority of the Active Medical Staff members present at the meeting:
  - (1) the current Secretary/Treasurer will be advanced to the Vice Chief of Staff position, and
  - (2) the Vice Chief of Staff will be advanced to the position being vacated:
    - i. the Chief of Staff or
    - ii. the Chair of Quality Assurance

#### 8.1-5 TERM OF ELECTED OFFICE

Each elected officer, the Chief of Staff, the Vice Chief of Staff, the Secretary/Treasurer and the Quality Improvement Chair shall serve a 2-year term. Each officer shall serve until the end of his or her term or until a successor is elected, unless he or she shall sooner resign or be removed from office.

#### 8.1-6 RECALL OF OFFICERS

Any Medical Staff officer may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. Except as otherwise provided, removal of a Medical Staff officer may be initiated by the MEC or by a petition signed by at least thirty-three (33) percent of the members of the Medical Staff eligible to vote for officers. Removal shall be considered at a special meeting called for that purpose. Removal shall require a majority vote of the Active Medical Staff members.

#### 8.1-7 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the Medical Staff. Vacancies shall be filled as follows:

- (a) A vacancy in the office of Chief of Staff shall be filled by the Vice Chief of Staff.
- (b) A vacancy in the office of Vice Chief of Staff or Secretary/Treasurer shall be filled by special election held in general accordance with these Bylaws.

### 8.2 DUTIES OF OFFICERS

#### 8.2-1 CHIEF OF STAFF

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

- (a) enforcing the Medical Staff Bylaws and Rules and Regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;
- (b) calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;
- (c) serving as chair of the MEC and calling, presiding at, and being responsible for the agenda of all meetings thereof;
- (d) serving as an ex officio member of all other staff committees without vote, unless Chief of Staff membership in a particular committee is required by these Bylaws;

- (e) interacting with the CEO (or designee) and Board of Trustees in all matters of mutual concern within the Hospital;
- (f) appointing, in consultation with the MEC, committee members for all standing committees other than the MEC and all special Medical Staff, liaison, or multi-disciplinary committees, except where otherwise provided by these Bylaws and, except where otherwise indicated, designating the chairs of these committees;
- (g) representing the views and policies of the Medical Staff to the Board of Trustees and to the CEO (or designee);
- (h) being a spokesperson for the Medical Staff in external professional and public relations;
- (i) performing such other functions as may be assigned to the Chief of Staff by these Bylaws, the Medical Staff, or by the MEC;
- (j) serving on liaison committees with the Board of Trustees and Administration, as well as outside licensing or accreditation agencies.

#### 8.2-2 VICE CHIEF OF STAFF

The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice Chief of Staff shall be a member of the MEC and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws, or by the MEC.

#### 8.2-3 IMMEDIATE PAST CHIEF OF STAFF

The immediate past Chief of Staff shall be a member of the MEC and shall perform such other duties as may be assigned by the Chief of Staff or delegated by these Bylaws, or by the MEC.

#### 8.2-4 SECRETARY-TREASURER

The Secretary-Treasurer shall be a member of the MEC. The responsibilities shall include, but not be limited to:

- (a) maintaining a roster of members;
- (b) keeping accurate and complete minutes of all MEC and general Medical Staff meetings;
- (c) calling meetings on the order of the Chief of Staff or MEC;
- (d) attending to all appropriate correspondence and notices on behalf of the Medical Staff;
- (e) receiving and safeguarding all funds of the Medical Staff;
- (f) excusing absences from meetings on behalf of the MEC; and

- (g) performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or MEC.

#### 8.2-5 QUALITY ASSURANCE CHAIR

The Quality Assurance Chair shall be a member of the MEC and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws and related documents, by the membership, or by the MEC. He or she shall work with the Quality Management Coordinator to see that quality assessment is ongoing in all services of the Hospital and shall report to MEC and Medical Staff quality management activities and findings of importance to these respective bodies.

#### 8.2-6 IMMEDIATE PAST QUALITY ASSURANCE CHAIR

The Immediate Past Director of Quality Management shall be a member of the MEC and perform such other duties assigned by the Chief of Staff or delegated by these Bylaws and related documents, the membership, or the MEC.

## ARTICLE IX CLINICAL DEPARTMENTS

### 9.1 ORGANIZATION OF CLINICAL DEPARTMENTS

The Medical Staff shall be organized into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a chair selected and entrusted with the authority, duties, and responsibilities specified in Section 10.5-5. When appropriate, the MEC may recommend to the Medical Staff the creation, elimination, modification, or combination of departments.

### 9.2 CURRENT DEPARTMENTS

The current departments are:

#### (a) Surgical Department

- (1) Anesthesiology
- (2) Dental
- (3) Gynecology
- (4) Obstetrics
- (5) Orthopedics
- (6) Ophthalmology
- (7) Pathology
- (8) Podiatry
- (9) Radiology
- (10) General Surgery

#### (b) Medical Department

- (1) Emergency
- (2) Family Practice
- (3) Internal Medicine
- (4) Pediatrics

### 9.3 ASSIGNMENT TO DEPARTMENTS

Each member shall be assigned membership in at least one (1) department but may also be granted membership and/or clinical privileges in other department consistent with practice privileges granted.

## 9.4 FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

- (a) Serve as a forum for the exchange of clinical information regarding services provided by department members.
- (b) Develop educational programs to meet the needs of department members.
- (c) Provide information and/or recommendations when requested by the Department chairperson and/or MEC related to:
  - (1) Medical Staff policies and procedures;
  - (2) Issues of standard of practice and/or clinical competence;
  - (3) Criteria for clinical privileges.
- (d) Receive reports related to relevant Medical Staff and/or organizational quality assessment and performance improvement activities.
- (e) Formulating recommendations for department reasonably necessary for the proper discharge of its responsibilities subject to the approval by the MEC and the Medical Staff.
- (f) Evaluate and improve the quality of care provided to patients;
- (g) Conduct patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided by practitioners represented by the department;
- (h) Identify system problems requiring process improvement activity and make such recommendations to the organization;
- (i) Submit written reports to the MEC concerning the department's quality assessment and peer review activities, the actions taken thereon, results of such actions and specific recommendations for maintaining and improving the quality of patient care provided by the department.

## 9.5 DEPARTMENT CHAIRS

### 9.5-1 QUALIFICATIONS

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

## 9.5-2 SELECTION

Department chairs shall be selected every two (2) years by the Chief of Staff and approved by a majority of the voting members of the department and the MEC. Vacancies due to any reason shall be filled by this process.

## 9.5-3 TERM OF OFFICE

Each department chair shall serve a two (2) year term with auto renewal to a second term which coincides with the Medical Staff year or until their successors are chosen, unless they shall sooner resign, be removed from office, or lose their Medical Staff membership or clinical privileges in that department. Department officers shall be eligible to succeed themselves.

## 9.5-4 REMOVAL

After selection, removal of department chairs from office may occur for cause by the MEC or by written request from twenty (20) percent of the members of that department eligible to vote. The removal may be effected by a majority vote of the Active Medical Staff.

## 9.5-5 DUTIES

Each chair shall have the following authority, duties and responsibilities:

- (a) act as presiding officer at department meetings;
- (b) accountable to the MEC and to the Chief of Staff as well as full Medical Staff regarding all professional and administrative activities within the department;
- (c) be responsible for the clinically related activities of the department including the monitoring of the quality of patient care and professional performance rendered by members with clinical privileges in the department through a planned and systematic process; oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the department by the MEC in coordination and integration with organization-wide quality assessment and improvement activities;
- (d) develop and implement department programs for the continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges including retrospective patient care review, ongoing monitoring of practice, credentials review and privilege delineation, medical education, utilization review, and quality assessment and improvement;
- (e) be a member of the MEC, and give guidance on the overall medical policies of the Medical Staff and Hospital and make specific recommendations and suggestions regarding the department;
- (f) transmit to the MEC recommendations concerning practitioner appointment and classification, reappointment, criteria for clinical privileges, proctorship

requirements, monitoring of specified services, and corrective action with respect to persons with clinical privileges in the department;

- (g) endeavor to enforce the Medical Staff Bylaws, Rules and Regulations, and Policies within the department;
- (h) implement within the department appropriate actions taken by the MEC;
- (i) participate in every phase of administration of the department, including cooperation with the nursing service and the Hospital administration in matters such as supplies, special regulations, standing orders and techniques;
- (j) assist in the preparation of such annual reports, including budgetary planning, pertaining to the department up as may be required by the MEC;
- (k) recommend the criteria for and the delineated clinical privileges for each member of the department; and
- (l) perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff or the MEC.
- (m) assess and recommend to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization
- (n) integrate the department into the primary functions of the organization
- (o) coordinate and integrate inter-department and intra-department services
- (p) develop and implement policies and procedures that guide and support the provision of care, treatment, and services
- (q) recommend sufficient number of qualified and competent persons to provide care, treatment, and services
- (r) determine the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services
- (s) continuously assess and improve the quality of care, treatment, and services
- (t) maintain quality control programs, as appropriate
- (u) orient and continuously educate of all persons in the department or service
- (v) recommend space and other resources needed by the department or service.



## ARTICLE X COMMITTEES

### 10.1 DESIGNATION

Medical Staff committees shall include but not be limited to, the Medical Staff meeting as a committee of the whole, meetings of departments, meetings of committees established under this Article, and meetings of special or ad hoc committees created by the MEC (pursuant to this Article). The committees described in this Article shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the MEC to perform specified tasks. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with and approval by the MEC.

Except as otherwise provided in the Bylaws, committees established to perform Medical Staff functions required by these Bylaws may include any category of Medical Staff members; allied health professionals; representatives from Hospital departments such as administration, nursing services, or health information services; and persons with special expertise, depending upon the functions to be discharged. The committee chair, after consulting with the Chief of Staff, may call on outside consultants or special advisors.

Each committee chair shall appoint a replacement fulfill the duties of the chair in his or her absence and to assist as requested by the chair. Each committee chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

Special or ad-hoc committees may be created by the MEC or departments to perform specified tasks. Unless otherwise specified the Chairperson and members of all committees shall be appointed by and removed by the Chief of Staff subject to consultation with and approval of MEC.

The Chief of Staff shall be a ex-officio member on all committees of which he/she is not otherwise assigned. The CEO (or designee), may be a member without vote of all committees of the Medical Staff.

Medical staff committees shall be responsible to the MEC.

The purpose of Medical Staff committees shall be to monitor and improve the quality of patient care services and perform other functions relative to the needs of the facility, the regulations of the state and federal government and the standards of The Joint Commission.

Unless otherwise specified in these Bylaws, all non-Medical Staff members appointed to the Medical Staff committees shall be non-voting. When non-physician members have been granted a vote on a Medical Staff committee, such voting rights shall only be exercised relative to the practitioner's area of clinical expertise and restricted by the practitioner's scope of licensure.

The committees may participate in combined or joint committee meetings with staff members from other Hospitals, healthcare entities, or the County Medical Society; however, precautions shall be taken to assure that confidential Medical Staff

information is not inappropriately disclosed, and to assure that this Medical Staff (through its authorized representative) maintains access to and approval authority of all minutes prepared in conjunction with any such meetings.

## 10.2 GENERAL PROVISIONS

### 10.2-1 TERMS OF COMMITTEE MEMBERS

Unless otherwise specified, committee members shall be appointed for a term of one (1) year, and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee.

### 10.2-2 REMOVAL

If a member of a committee ceases to be a member in good standing of the Medical Staff, or loses employment or a contract relationship with the Hospital, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the MEC. The removal of any committee member who is automatically assigned to a committee because he or she is a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official.

### 10.2-3 VACANCIES

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

### 10.2-4 EXECUTIVE SESSION

The chairperson of any standing, special or ad hoc committee of the Medical Staff, including departments may call an Executive Session meeting. Only members of the Active Medical Staff holding voting privileges on the committee shall attend the Executive Session meeting. The Chairperson, at his or her discretion, may request other individuals to attend the meeting in an informational capacity.

### 10.2-5 ADDITION, DELETION, OR MODIFICATION OF STANDING COMMITTEES OF THE MEDICAL STAFF

The MEC may recommend to the Medical Staff the addition, deletion or modification of any standing committee of the Medical Staff as may be described in these Bylaws, or as has otherwise been appointed. After affirmative vote of the Medical Staff, such change shall be effective upon approval by the Board of Trustees. Any modification of the MEC shall require approval of the Medical Staff pursuant to Bylaws modification requirements of Article XIII.

## 10.3 STANDING MEDICAL STAFF COMMITTEES

The current standing committees of the Medical Staff are:

#### 10.3-1 MEDICAL STAFF ADMINISTRATIVE COMMITTEES

- (a) Medical Executive Committee
- (b) Physician Well-Being Committee
- (c) Interdisciplinary Practice Committee
- (d) Joint Conference Committee

#### 10.3-2 MEDICAL STAFF QUALITY ASSESSMENT AND LEADERSHIP COMMITTEES

- (a) Surgical Services Department
- (b) Medicine Services Department
- (c) Cancer Committee/Institutional Review Board
- (d) Quality Improvement / Pharmacy & Therapeutics / Infection Prevention Committee
- (e) Utilization Review Committee

#### 10.4 MEETING QUORUM/REPORTS

Except as is otherwise provided for a particular committee, three (3) or more voting Medical Staff members of the committee present shall constitute a quorum at any meeting of that committee. The action of the majority of the committee members present and voting at any meeting shall be considered the act of the committee. All committees of the Medical Staff shall report to the MEC and provide regular written reports.

#### 10.5 MEDICAL EXECUTIVE COMMITTEE

##### 10.5-1 COMPOSITION

The MEC shall consist of the following persons: the Medical Staff officers, the Chairpersons or designee of the Medical Department and Surgical Department Groups, the President of the Hospital, who may attend without the right to vote, the Vice President/Chief Operating Officer, who may attend without the right to vote, and other administrative representatives and/or Board of Trustees representatives as approved by the MEC, who may attend without the right to vote. The Chief of Staff shall chair the MEC.

##### 10.5-2 DUTIES

The duties of the MEC shall include, but not be limited to:

- (a) representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;

- (b) coordinating and implementing the professional and organizational activities and policies of the Medical Staff;
- (c) receiving and acting upon reports and recommendations from Medical Staff departments, committees, and assigned activity groups;
- (d) recommending actions to the Board of Trustees on matters of a medical-administrative nature;
- (e) adopting policies regarding the structure of the Medical Staff, the mechanisms to review credentials and delineate individual clinical privileges, the granting of individual staff memberships and privileges, the organization of quality assessment and improvement activities and mechanisms of the Medical Staff, termination of Medical Staff membership and fair hearing procedures, needed changes to Medical Staff Bylaws, and other matters relevant to the operation of an organized Medical Staff;
- (f) evaluating the medical care rendered to patients in the Hospital;
- (g) participating in the development of all Medical Staff and Hospital policy, practice, and planning;
- (h) providing a thorough review of the qualifications, credentials, performance and professional competence, and character of applicants, allied health staff, and staff members, and make recommendations to the Board of Trustees at least quarterly regarding staff appointments and reappointments, assignments to departments, clinical privileges, and corrective action; as the credentials committee recommends expansion or limitation of privileges of staff members and all categories of credentialed staff based on a thorough review of credentials; as the credentials committee receives written applications at least every two (2) years from all providers requiring credentialing, inclusive of Medical Staff members and all other credentialed staff.
- (i) taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in Medical Staff corrective or review measures when warranted;
- (j) taking reasonable steps to develop continuing education activities and programs for the Medical Staff;
- (k) designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the Chief of Staff;
- (l) reporting to the Medical Staff at each regular staff meeting;
- (m) submitting reports to the Board of Trustees pursuant to these Bylaws and related documents information regarding the qualifications of each person applying for membership or privileges, including recommendations for appointment, membership category, privileges, and special conditions;

- (n) developing and maintenance of methods for the protection and care of patients and others in the event of internal or external disaster;
- (o) appointing such special or ad hoc committees as may seem necessary or appropriate to assist the MEC in carrying out its functions and those of the Medical Staff;
- (p) reviewing the quality and appropriateness of services provided by contract physicians;
- (q) reviewing and approving the designation of the Hospital's authorized representative for National Practitioner Data Bank purposes;
- (r) establishing a mechanism for dispute resolution between Medical Staff members (including limited license practitioners) involving the care of a patient;
- (s) assuring that the Medical Staff is informed about the accreditation program and status of the Hospital, and assist in obtaining and maintaining accreditation;
- (t) periodically reviewing and recommending appropriate revisions to these Bylaws and the Medical Staff rules and regulations, and
- (u) Medical Staff oversees library functions and shall assure along with administration that professional staff has access to professional and medical knowledge based resources.
- (v) performing other functions as may be assigned to it by these Bylaws and related documents or the Medical Staff.

#### 10.5-3 MEETINGS

The MEC shall meet at least ten (10) times per year and/or as needed additionally for a cause. The MEC shall maintain a record of its proceedings and actions.

### 10.6 PHYSICIAN WELL-BEING COMMITTEE

#### 10.6-1 COMPOSITION

The Humboldt Del-Norte Medical Society Physician Well-being Committee is the Physician Well-being Committee of Redwood Memorial Hospital. At least one member of the aforementioned Committee will hold Active status on the Redwood Memorial Hospital Medical Staff.

#### 10.6-2 DUTIES

The duties of the committee shall include the:

- (a) education of licensed independent practitioners and other organization staff about illness and impairment recognition issues specific to licensed independent practitioners, including at-risk criteria;

- (b) ability to accommodate self referral by a licensed independent practitioner:
- (c) accommodation of referral by others and maintenance of informant confidentiality
- (d) referral of the licensed independent practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern
- (e) maintenance of confidentiality of the licensed independent practitioner seeking referral or referred for assistance, except as limited by applicable law, ethical obligation, or when the health and safety of a patient is threatened
- (f) evaluation of the credibility of a complaint, allegation, or concern
- (g) monitoring the licensed independent practitioner and the safety of patients until the rehabilitation is complete and periodically thereafter, if required
- (h) reporting to the organized Medical Staff leadership instances in which an licensed independent practitioner is providing unsafe treatment
- (i) initiation of appropriate actions when a licensed independent practitioner fails to complete the required rehabilitation program.

#### 10.6-3 MEETINGS

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

### 10.7 INTERDISCIPLINARY PRACTICE COMMITTEE (IDPC)

#### 10.7-1 COMPOSITION

The IDPC shall consist of at least nine (9) members, including, at a minimum, the Chief Nursing Officer, the Chief Medical Officer of the Hospital or designee, and an equal number of Active Staff members appointed by the CMO and registered nurses appointed by the Chief Nursing Officer. Licensed or certified health professionals other than registered nurses who perform functions requiring standardized procedures shall be included in the committee. The Chair shall be a member of the Active Medical Staff.

#### 10.7-2 DUTIES

- (a) Perform functions consistent with the requirements of law and regulation. These functions shall include but not be limited to: securing recommendations from Medical Staff members in the medical specialty or clinical field of practice under review and from persons in the appropriate non-medical category who practice in the clinical field or specialty under review;

- (b) Be responsible for recommending standardized procedures for the granting of expanded role privileges to registered nurses who provide services in the Hospital to assure compliance with Title 22 and California Business and Professions Code regulations;
- (c) Evaluate and make recommendations regarding the qualifications, credentials, and competencies of Allied Health Practitioners who are eligible to apply for and provide services either utilizing standardized procedures or protocols;
- (d) Assure that each member of the Medical Staff and each practitioner of the Allied Health Professional staff has either a Focused Ongoing Professional Practice Evaluation (FPPE) and/or Ongoing Professional Practice Evaluation (OPPE), as appropriate, at a minimum of every six (6) months. The appraisal shall be performed by the Interdisciplinary Practice Committee of the Medical Staff.

#### 10.7-3 MEETINGS

The IDPC shall meet at a minimum two times a year or at the call of the Chair or when the MEC deems it necessary. The Chair or Chief Medical Officer and two members will constitute a quorum.

### 10.8 JOINT PEER REVIEW COMMITTEE

#### 10.8-1 COMPOSITION

The Joint Peer Review Committee (JPRC) shall be a standing committee of the Medical Staff with members appointed to monitor the quality and appropriateness of clinical care provided by, and the professionalism of those holding clinical privileges. The Chairperson shall be a past Chief of Staff. The membership shall be comprised of the following: Chief of Staff, Vice Chief of Staff, Medicine Department Chair, Surgery Department Chair, Quality Improvement Chair and all past Chiefs of Staff, each with a vote. The Chief Medical Officer will also be a member of this committee, who will vote only to break a tie vote.

#### 10.8-2 DUTIES

- (a) Perform peer review and/or other physician specific intensified assessments when indicated;
- (b) Reviewing and acting upon reported clinical and/or behavioral incidents which involve Medical Staff members.
- (c) Implement intensified FPPE assessment (Focused Professional Practice Evaluation) when warranted
- (d) Taking appropriate actions when opportunities to improve patient care are identified.
- (e) Communicate the significant results of peer review and performance improvement activities to relevant practitioners;

- (f) Assume all duties and responsibilities related to peer review and professionalism
- (g) Maintain confidentiality at all times regarding issues and events discussed

#### 10.8-3 MEETINGS

The Joint Peer Review Committee shall meet quarterly, or as needed.

The Committee shall report to the Medical Executive Committee and submit informational reports to the departments they represent.

### 10.9 JOINT CONFERENCE COMMITTEE

#### 10.9-1 COMPOSITION

The Joint Conference Committee shall be composed of an equal number of members, or designates, of the Board of Trustees and of the MEC. The MEC representatives shall include the Chief of Staff, the Chief of Staff-elect, and the immediate past Chief of Staff or Medical Director for Quality Management. The Administrator or President of the Hospital may serve as a designate of the Board of Trustees. The chairmanship of the Committee shall alternate yearly between a representative of the Board of Trustees and a representative of the Executive Committee.

#### 10.9-2 DUTIES

The Joint Conference Committee shall serve as a forum or vehicle for the discussion of matters of shared concern or interest of the Hospital and Medical Staff, specifically policies, practices, and plans bearing on or affecting patient care activities within the Hospital, and the delivery of healthcare within the Hospital and in the community at present and in the future. The Joint Conference Committee will also serve as a forum for interaction between the Board of Trustees and members of the Medical Staff and administration on such other matters as may be referred by the Executive Committee or the Board of Trustees. The Joint Conference Committee shall exercise any other responsibilities set forth in these Medical Staff Bylaws.

#### 10.9-3 MEETINGS

The Joint Conference Committee shall meet as needed and shall transmit written reports of its activities to the Executive Committee and to the Board of Trustees. Meetings may be called by any member of the Joint Conference Committee.

### 10.10 SURGERY AND MEDICINE SERVICE DEPARTMENTS

#### 10.10-1 COMPOSITION

The Medicine and Surgery Services departments shall consist of at least four (4) Active members of their respective medical or surgical services departments.

#### 10.9-2 DUTIES AND OBLIGATIONS

- (a) evaluate and improve the quality of care provided to patients;



- (b) conduct patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided by practitioners represented by the clinical departments;
- (c) perform peer review and/or other physician specific intensified assessments when indicated;
- (d) identify system problems requiring process improvement activity and make such recommendations to the Quality Assurance Committee;
- (e) submit written reports to the MEC concerning the Service Committee's quality assessment and peer review activities, the actions taken thereon, results of such actions and specific recommendations for maintaining and improving the quality of patient care provided by the department;
- (f) take appropriate actions when important problems in patient care or opportunities to improve patient care are identified;
- (g) recommend to the relevant department chairperson those Medical Staff policies and procedures as may be necessary to conduct patient care and administrative Medical Staff activities;
- (h) communicate the significant results of peer review and performance improvement activities to relevant practitioners;
- (i) implement programs that address the implementation of clinical pathways and assess compliance with practice guidelines and other recognized standards of care;
- (j) assume all duties and responsibilities of the department related to quality assessment, peer review and performance improvement, which have not been otherwise assigned to the department chairperson, and as may be described in the Bylaws and/or Rules and Regulations.
- (k) when requested, make recommendations to the MEC related to specific credentialing issues. The department chairperson, however, shall have the ultimate duty and responsibility to make recommendations regarding credentialing issues to the MEC.

#### 10.9-3 MEETINGS

The Medicine and Surgery department shall meet at least four (4) times per year respectively.

### 10.10 QUALITY IMPROVEMENT/PHARMACY & THERAPEUTICS/INFECTION PREVENTION COMMITTEE

#### 10.11-1 COMPOSITION

The composition of the Quality Improvement/Pharmacy & Therapeutics/Infection Prevention Committee shall include the elected Quality Improvement Chair, who shall serve as chairperson of the committee. The committee shall include:

- (a) two (2) physicians from the medicine department, one of whom must be a pediatrician, and
- (b) two (2) physicians from the surgery department

Voting rights are restricted to physician members.

Additionally, the committee shall incorporate the following reporting bodies into the meeting structure and composition as noted:

- (a) Pharmacy & Therapeutics – at each meeting, as needed;
- (b) Infection Prevention – quarterly

#### 10.11-2 DUTIES

The Quality Improvement/Pharmacy & Therapeutics/Infection Prevention Committee duties shall include overseeing all organizational performance improvement activities, to include, but not be limited to:

- (a) medication therapy and administration, including but not limited to antibiotics and non-antibiotics for all service types of in, out, ambulatory and emergency care patients, and advise professional staff and pharmacist on the choice and use of drugs, evaluate clinical data concerning new drugs requested for use in the Hospital; formulate broad policies on evaluation selection procurement and distribution use of drugs; develop and amend Hospital formulary or list of drugs for use in the Hospital, stocking of same on nursing units.
- (b) blood (including component) product usage review, including for all service types of patients.
- (c) infection control findings including but not limited to community acquired and healthcare acquired infections in patients and health care workers (and shall be reported and discussed on a quarterly basis).
- (d) data management (accuracy, currency, transferability) with emphasis on medical records pertinence and timeliness.
- (e) surgical/invasive and manipulative procedure review, including but not limited to tissue and non tissue producing cases, with and without anesthesia and/or moderate sedation. The Tissue Audit shall evaluate the surgical practice of the institution.;
- (f) complaints regarding Medical Staff related issues;
- (g) discharge planning;
- (h) utilization management;
- (i) restraint/seclusion usage;

- (j) mortality review which shall determine whether all cases had appropriate evaluation and care; evaluate to see if the attending physician was aware of the critical nature of the case as noted in the physician's orders, laboratory procedures ordered, and timelines of consultation orders; review the early recognition of complications, reevaluation based on clinical and laboratory studies, and modification of the therapeutic regime in accordance with the changing condition of the patient to determine if the diagnosis can be supported; report educationally interesting cases to the committee for potential MEC instructional use of the attending and house staffs;
- (k) monitor the outcomes of organizational performance improvement and quality control indicators. Ensures that actions are implemented to effectively respond to improvement opportunities;
- (l) monitor the outcomes of the medical staff performance improvement functions and identify trends in practice patterns. Ensures that actions are implemented to effectively respond to improvement opportunities;
- (m) review the performance improvement annual report, evaluate the effectiveness of the Performance Improvement Program to ensure safe patient care and provide recommendation to the Quality Improvement Committee of the Board regarding accomplishments achieved in support of the strategic goal of perfect Care as well as potential priorities for the forthcoming year;
- (n) develop plans for continuing education of Hospital members and all credentialed staff to assist the organization's staff in assessing and improving processes that are related to patient outcomes. This training should include information related to team dynamics and facilitating process improvement teams;
- (o) serve as a forum for the coordination and communication of performance improvement activities;
- (p) oversee the development of a plan, review of aggregate data, and assessing performance related to the following organizational functions:
  - (1) Leadership
  - (2). Improving Organizational Performance
  - (3). Risk Management;
- (q) provide oversight and review of medication administration patient organizational safety activities;
- (r) ensure medical staff members receive initial and ongoing education regarding performance improvement methodologies, monitoring/reporting tools and analysis of data; and
- (s) . act as a clearinghouse for any organizational concerns related to identified process and system problems.

### 10.11-3 MEETINGS AND REPORTING

The Quality Improvement/Pharmacy & Therapeutics/Infection Prevention Committee shall meet at least ten (10) times per year and report its activities, which will include Pharmacy & Therapeutics, Infection Prevention and Utilization Review, to the MEC and provide a summary report to the Board of Trustees.

## 10.12 UTILIZATION REVIEW COMMITTEE

### 10.12-1 COMPOSITION

The composition of the Utilization Review Committee shall include the Chief of Staff and two members of the Active Medical Staff preferably one from each service – Medicine and Surgery. The Medical Director of the Emergency Department, or its designee, and the Medical Director of New Beginnings, or its designee, shall be on the Committee as voting members. The physician advisor for Care Management and the Chief Medical Officer shall serve as voting members. The Area Director of Care Management shall serve as an ex-officio non-voting member of the Committee, as shall the Director of Nursing representing nursing. The Manager of Quality, the Area Director of Health Information Management, the Area Director for Revenue Cycle, the Manager of the Pharmacy, and the Manager of Diagnostic Imaging shall also attend as advisors.. Other committee members may be appointed and subcommittees formed as needed to carry out the Utilization Review Plan.

### 10.12-2 DUTIES (REFER TO THE UTILIZATION REVIEW PLAN).

### 10.12-3 MEETINGS

The Committee shall meet quarterly, or at a minimum of three times a year. The Committee shall report to the MEC and may provide information and recommendations to the Quality Assurance Committee.

## ARTICLE XI MEETINGS

### 11.1 MEETINGS

#### 11.1-1 GENERAL MEDICAL STAFF

There shall be an annual meeting of the Medical Staff in December of each year. The Chief of Staff, or such other officers, department or division heads, or committee chairs that the Chief of Staff or MEC may designate, shall present reports on actions taken during the preceding year and on other matters of interest and importance to the members. The election of officers shall take place at this meeting. Notice of this meeting shall be given to the members at least thirty (30) days prior to the meeting.

#### 11.1-2 REGULAR MEETINGS

Regular meetings of the Medical Staff shall be held as often as necessary, except that the Annual Medical Staff meeting shall constitute the regular meeting during the quarter in which it occurs. The date, place and time of the regular meetings shall be determined by the MEC, and adequate notice shall be given to the members.

#### 11.1-3 AGENDA

The order of business at a meeting of the Medical Staff shall be determined by the Chief of Staff and MEC. The agenda shall include, insofar as feasible:

- (a) reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;
- (b) administrative reports from the Chief of Staff, departments, and committees, and the administrator;
- (c) election of officers when required by these Bylaws;
- (d) reports by responsible officers, committees and departments on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the staff and on the fulfillment of other required staff functions;
- (e) old business; and
- (f) new business.

#### 11.1-4 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the MEC, or shall be called upon the written request of ten (10) percent of the members of the Active Medical Staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the MEC within thirty (30) days after receipt of such request. No later than ten (10) days prior to the meeting, notice shall be mailed or delivered to the members of the staff which includes the stated purpose of the meeting. No business

shall be transacted at any special meeting except that stated in the notice calling the meeting.

The agenda of special meetings shall be:

- (a) Reading of the notice calling the meeting;
- (b) Transaction of business for which the meeting was called, and;
- (c) Adjournment.

Agenda items for Special Medical Staff meetings may be added by the MEC or a petition presented to the Chief of Staff by thirty three percent (33%) of the Active Staff members not less than twenty (20) days before the scheduled regular meeting.

Only items listed on the agenda may be discussed or subject to action during the meeting.

## 11.2 COMMITTEE AND DEPARTMENT MEETINGS

### 11.2-1 REGULAR MEETINGS

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

### 11.2-2 SPECIAL MEETINGS

A special meeting of any Medical Staff committee or department may be called by the chair thereof, the MEC, or the Chief of Staff, and shall be called or by written request of one-third of the current members, eligible to vote, but not less than three (3) members.

## 11.3 QUORUM

### 11.3-1 GENERAL MEDICAL STAFF MEETINGS

A quorum shall consist of thirty-three (33) percent of the Active Medical Staff in person or through written ballot at any regular or special meeting or through written ballot shall constitute a quorum for the purpose of all business, amending these Bylaws of the Medical Staff, or for the election or removal of Medical Staff officers.

### 11.3-2 DEPARTMENT AND COMMITTEE MEETINGS

A quorum of at least three (3) of the voting members shall be required for Medical Executive and department meetings. For all other committees, a quorum shall consist of no less than three (3) voting members.

## 11.4 VOTING AND MANNER OF ACTION

### 11.4-1 VOTING

Unless otherwise specified in these Bylaws, only members of the Active Medical Staff may vote in Medical Staff department or general Medical Staff elections, and at committee meetings. All duly appointed members of Medical Staff committees are entitled to vote on committee matters, except as may otherwise be specified in these Bylaws.

### 11.4-2 MANNER OF ACTION

- (a) Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these Bylaws. Committee action may be conducted by telephone conference, or other means of secure electronic transmission, which shall be deemed to constitute a meeting for the matters discussed in that telephone conference or secure electronic communication. Valid action may be taken without a meeting by a committee if it is acknowledged by a writing setting forth the action so taken is signed by a quorum and approved by a simple a majority of the members entitled to vote.
- (b) The MEC shall determine if any action to be taken at a regular or special Medical Staff meeting shall be subject to mail-in ballot. Mail-in ballots will always be permitted relevant to the election of officers and amendment of Bylaws of the Medical Staff. If the MEC determines that mail-in ballots are appropriate for other actions to be taken at a Medical Staff meeting, the MEC shall prepare a summary of the issue(s) to be voted upon, and that summary, along with a mail-in ballot, will be sent to each member of the Active Medical Staff at least twenty (20) calendar days before the date of such meeting pursuant to the process described in Section 12.4-2
- (c) Except as otherwise specified, the action of a majority of the members voting in person or by mail-in ballot, at a Medical Staff meeting at which a quorum is present pursuant to Section 11.3-1 shall be the action of the Medical Staff.

## 11.5 MINUTES

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

## 11.6 ATTENDANCE REQUIREMENTS

### 11.6-1 REGULAR ATTENDANCE

Except as stated below, each member of the Active and Provisional Staff shall be required to attend a total of 5 meetings each year over a two-year period based upon assigned Department meetings and General Medical Staff meetings. Meeting attendance will be considered by the MEC at the time of reappointment.

### 11.6-2 MANDATORY ATTENDANCE

At the discretion of the chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular department or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at any meeting to which notice was given, unless excused by the MEC upon a showing of good cause, shall be a basis for administrative suspension of the member's privileges pursuant to Section 6.3-7. This requirement shall not preclude any committee from reviewing the competence or conduct of any practitioner in his/her absence.

## 11.7 CONDUCT OF MEETINGS

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



## ARTICLE XII CONFIDENTIALITY, IMMUNITY AND RELEASES

### 12.1 AUTHORIZATION AND CONDITIONS

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

- (a) authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;
- (b) authorizes persons and organizations to provide information concerning such practitioner to the Medical Staff;
- (c) agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital who would be immune from liability under Section 13.3 of this Article; and
- (d) acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges at this Hospital.

### 12.2 CONFIDENTIALITY OF INFORMATION

#### 12.2-1 GENERAL

Records and proceedings of all Medical Staff committees having the responsibility of evaluation and improvement of quality of care rendered in this Hospital, including, but not limited to, meetings of the Medical Staff meeting as a committee of the whole, meetings of departments and divisions, meetings of committees established under Article X, and meetings of special or ad hoc committees created by the MEC or by departments and including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential.

#### 12.2-2 BREACH OF CONFIDENTIALITY

As effective peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff departments, divisions, or committees, except in conjunction with other Hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff, violates the Medical Staff Bylaws, and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the MEC may undertake such corrective action as it deems appropriate.

#### 12.2-3 PROTECTED HEALTH INFORMATION

At appointment and reappointment to the Medical Staff, practitioners will be required to sign a confidentiality agreement and associated documents regarding medical records confidentiality. This confidentiality agreement includes electronic access to the Hospital's information system and shall affirm the practitioner's commitment to

protection of the confidentiality and security of patient health information in keeping with Federal and State privacy laws.

Access to patient records by Medical Staff shall be limited to use for the provision of patient care, payment, and operation of the Hospital; to include activities such as quality management, peer review, utilization review and other activities.

An alleged breach of confidentiality pursuant to the actions of a Medical Staff member shall be reviewed by the MEC and corrective action taken when appropriate.

## 12.3 IMMUNITY FROM LIABILITY

### 12.3-1 FOR ACTION TAKEN

Each representative of the Medical Staff and Hospital shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or Hospital.

### 12.3-2 FOR PROVIDING INFORMATION

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

## 12.4 ACTIVITIES AND INFORMATION COVERED

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

- (a) application for appointment, reappointment, or clinical privileges as well as periodic reappraisals for reappointment
- (b) corrective action;
- (c) hearings and appellate reviews;
- (d) utilization reviews;
- (e) other department, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and
- (f) queries and reports concerning the National Practitioner Data Bank, peer review organization and other federal or state agency for which reporting is required.

## 12.5 RELEASES

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

## 12.6 INDEMNIFICATION

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

## ARTICLE XIII GENERAL PROVISIONS

### 13.1 ADOPTION AND AMENDMENTS TO THE GENERAL RULES AND REGULATIONS OF THE MEDICAL STAFF.

- (a) The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt and recommend general Medical Staff rules and regulations and their amendments, which shall be effective when approved by the Board of Trustees. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized level of quality, safety, and efficiency, and maintaining a harmony of purpose and effort with the Board of Trustees.

Proposed amendments to the general rules and regulations may be made by one of the following two mechanisms:

- (1) submission of proposed changes to the MEC. Following review and deliberation, the MEC may recommend changes for adoption. The MEC may in turn approve or reject the proposed amendments. The MEC recommendation shall become effective following approval of the Board of Trustees; or
- (2) upon receipt of a petition signed by thirty-three percent (33%) of the Active staff members, the MEC shall distribute the petition's proposed revisions to the Active Medical Staff for a mail-in ballot. If a quorum is represented by the mail-in ballot, and the proposed change receives an affirmative vote of a simple majority of the active staff members, the change shall be considered adopted by the Medical Staff. The changes shall become effective following approval of the Board of Trustees which approval shall not be withheld unreasonably. Neither the Board of Trustees nor the Medical Staff may unilaterally amend the general rules and regulations. If approval by the Board of Trustees is withheld, the reason for doing so shall be specified by the Board of Trustees in writing and shall be forwarded to the Chief of Staff of the Medical Staff and the MEC.

Changes in the Rules and Regulations adopted by either of these mechanisms shall be effective the date of approval by the Board of Trustees.

- (b) The MEC shall adopt Medical Staff policies and procedures as may be necessary for proper conduct of work and shall periodically review and revise such Medical Staff policies and procedures to comply with current Medical Staff practices. Recommended adoptions and/or changes to Medical Staff policies and procedures shall be generated by or submitted to the MEC for review and approval. Such policies and procedures shall become effective following the Board of Trustees approval as described in section 13.1 (a). If there is a conflict between the policies and procedures and the Medical Staff Rules and Regulations or Bylaws, the Rules and Regulations or Bylaws shall prevail.

- (c) Applicants and members of the Medical Staff and others holding clinical privileges or exercising practice prerogatives shall be governed by all applicable Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital administrative policies which have been appropriately approved by the MEC and Board of Trustees.

## 13.2 DUES OR ASSESSMENTS

The MEC shall have the power to recommend the amount of dues or assessments, if any, for each category of Medical Staff membership, subject to the approval of the Medical Staff, and to determine the manner of expenditure of such funds received. Active and Provisional/Active Medical staff members shall be required to pay annual dues at the beginning of the Medical Staff year. At the end of six (6) months, members with unpaid staff dues are reported to the MEC for further action.

## 13.3 AUTHORITY TO ACT

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

## 13.4 DIVISION OF FEES

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

## 13.5 NOTICES

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

Name and proper title of addressee, if known or applicable  
Name of department , division or committee  
[c/o Medical Staff Office, Chief of Staff]  
Redwood Memorial Hospital  
3300 Renner Drive  
Fortuna, CA 95540

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

## 13.6 DISCLOSURE OF INTEREST AND CONFLICT OF INTEREST

### 13.6-1 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff offices, department chairs, or the MEC shall, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the MEC those personal, professional, or financial affiliations or

relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

### 13.6-2 CONFLICT OF INTEREST

- (a) In any instance where a Medical Staff officer or committee chairperson has or reasonably could be perceived to have a conflict of interest or bias in any matter involving another Medical Staff member, or in any instance where any such individual or committee member brought the complaint against that staff member, such individual or member with a conflict shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time. However, that individual or committee member with a conflict may be asked, and may answer, any questions concerning the matter before leaving. As a matter of procedure, the chairperson of that committee designated to make such a review shall inquire, prior to any discussion of the matter, whether any member has any conflict of interest or bias. Any dispute over the existence of bias or a conflict of interest shall be resolved by the chairperson.
- (b) Any committee member with knowledge of the matter may call to the attention of the committee chairperson the existence of a potential or perceived conflict of interest or bias on the part of any committee member.
- (c) A clinical committee chairperson shall have a duty to delegate review of applications for appointment, reappointment or clinical privileges, or questions that may arise to a vice chairperson or other member of the committee, if the chairperson has a conflict of interest with the individual under review, or could be reasonably perceived to be biased.
- (d) If the recusal of an officer or committee member affects the quorum necessary to transact business or applicable functions, the Chief of Staff shall appoint an Active Staff member without a conflict to act on the matter(s) as a temporary replacement for the recused individual.
- (e) A conflict of interest arises when there is a divergence between an individual's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by those interests. A conflict of interest depends on the situation and not on the character of the individual. The fact that an individual practices in the same specialty as a practitioner who is being reviewed does not by itself automatically create a conflict of interest. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No staff member has a right to compel a determination that a conflict exists. The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

### 13.7 NOMINATION OF MEDICAL STAFF REPRESENTATIVES

Candidates for positions as Medical Staff representatives to local, state and national Hospital Medical Staff sections should be filled by such selection process as the Medical Staff may determine.

### 13.8 MEDICAL STAFF CREDENTIALS FILES

#### 13.8-1 INSERTION OF LETTER OF REPRIMAND

The MEC may issue a letter of admonition, censure, reprimand or warning ("Letter of Reprimand") to any member of the Medical or Allied Health Professional Staff. Nothing herein shall be deemed to preclude a departments chairperson, committee chairperson, or the MEC from issuing informal written or oral warning outside of the mechanism for issuance of a Letter of Reprimand as described in these Bylaws. The following provisions apply to issuance of a Letter of Reprimand:

- (a) Only the MEC shall have the authority to issue a Letter of Reprimand and place the Letter of Reprimand into the practitioner's credential file.
- (b) If the MEC authorizes the issuance of a Letter of Reprimand and insertion of a Letter of Reprimand into the practitioner's credential file, the practitioner shall be notified of this action and may respond in accordance with Section 13.8-2.
- (c) Notice to the practitioner shall include a copy of the Letter of Reprimand which will be inserted into the practitioner's credential file

#### 13.8-2 OPPORTUNITY TO REQUEST CORRECTION/DELETION OF INFORMATION CONTAINED IN A LETTER OF REPRIMAND AND/OR MAKE AN ADDITION OF INFORMATION TO THE CREDENTIAL FILE

- (a) When an individual has received notice of insertion of a Letter of Reprimand into his/her credential file, the practitioner may address to the MEC a written request for correction or deletion of information contained in the Letter of Reprimand. Such request shall include a statement of the basis for the action requested.
- (b) The MEC shall review such a request within a reasonable time and determine after such review whether or not to make the correction or deletion requested by the practitioner.
- (c) The member shall be notified in writing of the decision of the MEC in this matter.
- (d) In any case, the practitioner shall have the right to add to his/her own credential file, upon written request to the MEC, a statement responding to the information contained in the Letter of Reprimand.

### 13.8-3 CONFIDENTIALITY

The following applies to records of the Medical Staff and its departments and committees responsible for the evaluation and improvement of patient care:

- (a) The records of the Medical Staff and its departments and committees responsible for the evaluation and improvement of the quality of patient care rendered in the Hospital shall be maintained as confidential.
- (b) Access to such records shall be limited to duly appointed officers and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained. Further release of Medical Staff records will only be as required by law or as authorized by the Chief of Staff and approved by the Medical Staff Executive Committee.
- (c) Information which is disclosed to the Board of Trustees of the Hospital or its appointed representatives—in order that the Board of Trustees may discharge its lawful obligations and responsibilities—shall be maintained by that body as confidential.
- (d) Information contained in the credentials file of any member may be disclosed with the member's consent, or to any Medical Staff or professional licensing board, or as required by law. However, any disclosure outside of the Medical Staff shall require the authorization of the Chief of Staff and the concerned department chair and notice to the member.
- (e) A Medical Staff member shall be granted access to his or her credentials file, subject to the following provisions:
  - (1) timely notice of such shall be made by the member to the Chief of Staff or the Chief of Staff's designee;
  - (2) the member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information—including peer review committee findings, letters of reference, proctoring reports, complaints, etc.—shall be provided to the member, in writing, by the designated officer of the Medical Staff,. Such summary shall disclose the substance, but not the source, of the information summarized;
  - (3) the review by the member shall take place in the Medical Staff office, during normal work hours, with an officer or designee of the Medical Staff present.
- (f) In the event a notice of action or proposed action is filed against a member, access to that member's credentials file shall be governed by Section 7.4-1.



### 13.9 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

The MEC shall review and make recommendations to the Board of Trustees regarding quality of care issues related to exclusive arrangements for physician and/or professional services, prior to any decision being made by the Board of Trustees, in the following situations:

- (a) the decision to execute an exclusive contract in a previously open department or service;
- (b) the decision to renew or modify an exclusive contract in a particular department or service;
- (c) the decision to terminate an exclusive contract in a particular department or service.
- (d) the MEC may post a notice and conduct a meeting as part of its process to assess the quality of care issues related to such arrangements. The results of the meeting of the MEC shall be reported to the CEO (or designee) and the Board of Trustees.
- (e) the Board of Trustees shall give great weight to the recommendations of the MEC related to quality of care issues.
- (f) in the event that any proposed exclusive arrangement will result in termination or limitation of any Medical Staff membership and/or privilege for reasons not related to professional conduct or competence, affected individuals shall not be entitled to procedural rights afforded by Article VII unless the termination or limitation of their membership and/or privileges would have to be reported to the Medical Board of California or National Practitioner Data Bank.

### 13.10 FORMS

Application forms and any other prescribed forms required by these Bylaws for use in connection with Medical Staff appointments, reappointments, delineation of privileges, corrective action, notices, recommendations, reports and other matters shall be approved by the MEC and recommended for approval by the Board of Trustees. They may be amended by approval of the MEC and the Board of Trustees.

## ARTICLE XIV ADOPTION AND AMENDMENT OF BYLAWS

### 14.1 PROCEDURE

The Medical Staff may proposed Bylaws amendments to the MEC for consideration. Upon approval by the MEC, proposed amendments, with or without modification, will be forwarded back to the General Medical Staff for vote. The MEC may conduct a vote in one of two ways:

- (a) At a General Medical Staff meeting, provided the proposed Bylaws amendments have been posted for not less than 20 days prior to the meeting where the vote will be taken; or
- (b) By means of a ballot vote, provided the proposed amendments have been sent out for a period of not less than 20 days, during which time, eligible members of the Medical Staff may review changes and return a signed ballot. (See Section 11.4)

A simple majority vote of at least 33% of the active, eligible voting members of the Medical Staff shall constitute a valid quorum.

The Board of Trustees will review all Bylaws amendments prior to taking effect.

### 14.2 REVIEW

These Bylaws and Rules and Regulations shall be reviewed and updated as necessary to assure congruence with Medical Staff practice and contain a mechanism for review. These Bylaws shall be reviewed periodically no less often than every two (2) years.

#### 14.2-1 ACTION ON BYLAWS CHANGE

If a quorum is present for the purpose of adopting a Bylaw change, the change shall require an affirmative vote of greater than fifty (50) percent of the members voting in person or by written ballot.

### 14.3 APPROVAL

Bylaw changes adopted by the Medical Staff shall become effective following approval by the Board of Trustees which approval shall not be withheld unreasonably, or automatically within sixty (60) days if no action is taken by the Board of Trustees. Medical staff members are provided with copies of the revisions in the Bylaws, Rules and Regulations and Medical Staff policies. If approval is withheld, the reasons for doing so shall be specified by the Board of Trustees in writing, and shall be forwarded to the Chief of Staff and the MEC.

### 14.4 EXCLUSIVITY

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

#### 14.5 AFFILIATIONS

Affiliations between the Hospital and other Hospitals, health care systems or other entities shall not, in and of themselves, affect these Bylaws.

#### 14.6 CONSTRUCTION OF TERMS AND HEADINGS

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

ADOPTED by the Medical Staff on:

July 17, 2019  
(Date)

Validated and Approved by the Medical Executive Committee on:

August 19, 2019  
(Date)

---

By: Peter Goldberg, MD - Chief of Staff

---

By: Dipali Apte, MD, PhD - Secretary-Treasurer

APPROVED by the Board of Trustees on

August 29, 2019  
(Date)

---

By: Its Chair

---

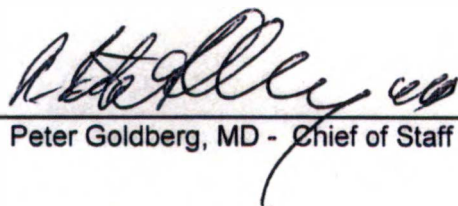
By: Its Secretary

ADOPTED by the Medical Staff on:

July 17, 2019  
(Date)

Validated and Approved by the Medical Executive Committee on:

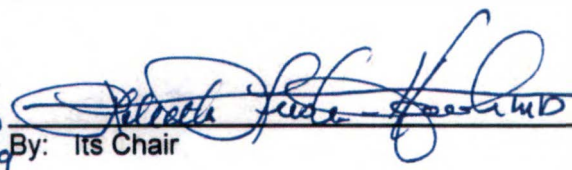
August 19, 2019  
(Date)

  
By: Peter Goldberg, MD - Chief of Staff

  
By: Dipali Apte, MD, PhD - Secretary-Treasurer

APPROVED by the Board of Trustees on

August 29, 2019  
(Date)

  
By: Its Chair

err  
9/10/19

  
By: Its Secretary