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LOMPOC VALLEY MEDICAL CENTER
(LOMPOC HEALTHCARE DISTRICT)

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BYLAWS OF THE MEDICAL STAFF OF LOMPOC VALLEY MEDICAL CENTER
(LOMPOC HEALTHCARE DISTRICT)
March 2023

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 Lompoc Valley Medical Center (Lompoc Healthcare District) and to provide a framework for self-government in order to permit the medical staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. These bylaws provide the professional and legal structure for medical staff operations, organized medical staff relations with the board of directors, and relations with applicants to and members of the medical staff.

1.2 DEFINITION

1.2-1 ADMINISTRATOR, often the Chief Executive Officer, means the person appointed by the board of directors to serve in an administrative capacity.

1.2-2 AUTHORIZED REPRESENTATIVE or HOSPITAL'S AUTHORIZED REPRESENTATIVE means the individual designated by the hospital and approved by the executive committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these bylaws.

1.2-3 BOARD OF DIRECTORS means the board of directors of the hospital.

1.2-4 CHIEF OF SERVICE means the medical staff member duly appointed or elected in accordance with these bylaws to serve as the head of a service.

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 a medical staff member 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 EXECUTIVE COMMITTEE means the executive committee of the medical staff which shall constitute the board of directors of the medical staff as described in these bylaws.

1.2-8 HOSPITAL means Lompoc Valley Medical Center (Lompoc Healthcare District).

1.2-9 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.

1.2-10 INVESTIGATION means a process specifically instigated by the executive committee to determine the validity, if any, to a concern or complaint raised against a member of the medical staff, and does not include activity of the Physician Well-Being Committee.

1.2-11 MEDICAL STAFF OR STAFF means those physicians (M.D. or D.O.), dentists or podiatrists who have been granted recognition as members of the medical staff pursuant to the terms of these bylaws.

1.2-12 MEDICAL STAFF YEAR means the period from July 1 to June 30.

1.2-13 MEMBER means, unless otherwise expressly limited, any physician (M.D. or D.O.) dentist or podiatrist holding a current license to practice within the scope of his or her license who is a member of the medical staff.

1.2-14 PHYSICIAN means an individual with an M.D. or D.O. degree who is currently licensed to practice medicine.

1.2-15 SERVICE means that group of practitioners who have clinical privileges in one of the general areas of emergency medicine, family medicine, internal medicine, obstetrics/gynecology, pediatric medicine, and surgery.

1.2-16 ALLIED HEALTH PROFESSIONALS (AHPs) are not eligible for medical staff membership. They may be granted practice privileges if they hold a license, certificate, or other legal credential in an approved category of AHPs that the board of directors (after securing executive committee/Interdisciplinary Practice Committee recommendations has identified as eligible to apply for practice privileges, and only if the AHPs are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the Lompoc Valley Medical Center (Lompoc Healthcare District) Bylaws.

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 he or she is a member of the medical staff or has been granted temporary privileges in accordance with the procedures set forth in these bylaws. Appointment to the medical staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these bylaws.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2-1 GENERAL QUALIFICATIONS

Only physicians, dentists or podiatrists 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) be willing to participate in and properly discharge those responsibilities determined by the medical staff.

(c) maintain in force professional liability insurance in not less than the minimum amounts, if any, as from time to time may be jointly determined by the board of directors and executive committee. The executive committee, with concurrence of the board of directors, for good cause shown, may waive this requirement with regard to such member as long as such waiver is not granted or withheld on an arbitrary, discriminatory or capricious basis. In determining whether an individual exception is appropriate, the following facts may be considered:
  (1) whether the member has applied for the requisite insurance;
  (2) whether the member has been refused insurance, and if so, the reasons for such refusal; and
  (3) whether insurance is reasonably available to the member, and if not, the reasons for its unavailability.

(d) shall be deemed to possess basic qualifications for membership in the medical staff, except for the honorary and retired staff categories in which case these criteria shall only apply as deemed individually applicable by the medical staff.

2.2-2 PARTICULAR QUALIFICATIONS

(a) Physicians: An applicant for physician membership in the medical staff, except for the honorary staff, must hold a M.D. or D.O. degree, or their

equivalent, issued by a medical or osteopathic school approved at the time of the issuance of such degree by the Medical Board or the Board of Osteopathic Examiners of the State of California and must also hold a valid and unsuspended certificate to practice medicine issued by the Medical Board or the Board of Osteopathic Examiners of the State of California.

(b) Limited License Practitioners:

(1) Dentists: An applicant for dental membership in the medical staff, except for the honorary staff, must hold a D.D.S. or equivalent degree issued by a dental school approved at the time of the issuance of such degree by the Board of Dental Examiners of California and must also hold a certificate to practice dentistry issued by the Board of Dental Examiners of California, which is valid, current and unsuspended.

(2) Podiatrists: An applicant for podiatric membership on the medical staff, except for the honorary staff, must hold a D.P.M. degree conferred by a school approved at the time of issuance of such degree by the Medical Board of the State of California and must hold a valid and unsuspended certificate to practice podiatry issued by the Medical Board of the State of California.

2.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership in the medical staff merely because he or she 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 nonparticipation in a particular medical group, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this hospital.

2.4 NONDISCRIMINATION

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, color, religion, ancestry, national origin, disability, physical or mental impairment, marital status, 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 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, medical staff rules and regulations, and 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 fashion medical records for all the patients to whom the member provides care in the hospital;

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

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

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

(h) making appropriate arrangements for coverage for his or her patients as determined by the medical staff;

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

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

(k) participating in such emergency service coverage or consultation panels as may be determined by the medical staff;

(l) serving as a proctor or other peer review, and otherwise participating in medical staff peer review as reasonably requested;

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

(n) 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; and

(o) performing a medical history and physical examination, as detailed in these bylaws Section 5.6, and the medical staff rules and regulations.

2.6 MEMBERS' CONDUCT REQUIREMENTS

As a condition of membership and privileges, a medical staff member shall continuously meet the requirements for professional conduct established in these bylaws. Non-members with privileges will be held to the same conduct requirements as members. Except as provided in these bylaws, no other codes or policy restricting or defining conduct apply to the medical staff and its members.

2.6-1 ACCEPTABLE CONDUCT

Acceptable medical staff member conduct is not restricted by these bylaws and includes, but is not limited to:

(a) advocacy on medical matters;

(b) making recommendations or criticism intended to improve care;

(c) exercising rights granted under the medical staff bylaws, rules and regulations, and policies;

(d) fulfilling duties of medical staff membership or leadership;

(e) engaging in legitimate business activities that may or may not compete with the hospital.

2.6-2 DISRUPTIVE AND INAPPROPRIATE CONDUCT

Disruptive, unprofessional or inappropriate conduct by a member of the medical staff includes any conduct which may adversely affect the quality of patient care at the hospital, or which interferes with orderly administration of services, or which violates the rights of hospital personnel or others and includes, but is not limited to:

(a) Harassment by a medical staff member against any individual involved with the hospital; (e.g., against another medical staff member, house staff, hospital employee or patient on any basis including race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation.

(b) “Sexual harassment” defined as unwelcome verbal or physical conduct of a sexual or gender-based 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 and/or perpetuates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

(c) Deliberate physical, visual or verbal intimidation or challenge, including disseminating threats or pushing, grabbing or striking another person involved in the hospital.

(d) Illegally carrying a gun or other weapon in the hospital.

(e) Refusal or failure to comply with these member conduct requirements.

2.6-3 MEDICAL STAFF CONDUCT COMPLAINTS

(a) Complaints or reports of inappropriate conduct by medical staff members are subject to review by the executive committee. Complaints or reports must be in writing and will be transmitted to the chief of service and the chief of the medical staff, or to the medical staff officer designated by either the chief of the medical staff or the executive committee.

(b) Complaints are shared with the subject member who will be given the opportunity to respond to the investigating medical staff officer.

(c) The chief of service or assigned medical staff officer in consultation with the chief of the medical staff shall determine if the complaint is obviously specious or of a nature that warrants no further action. Their conclusions will be presented to the next executive committee in an executive session.

(d) If the chief of service or investigating medical staff officer in consultation with the chief of the medical staff determines that the complaint derives from a medical staff member health issue, the matter shall be directly referred to the Medical Staff Physician Well-Being Committee for evaluation and management.

(e) Complaints not dismissed or referred to the Medical Staff Physician Well-Being Committee will be reported to the executive committee in executive session for consideration of further investigation, education or corrective action. Any action taken will be commensurate with the nature and the severity of the conduct in question, and in accordance with these bylaws and the policy and procedure found in the rules and regulations.

2.6-4 HOSPITAL STAFF CONDUCT COMPLAINTS

Medical staff members' reports or complaints about the conduct of any hospital administrators, nurses or other employees, contractors, board members or others affiliated with the hospital must be reduced to writing and submitted to the chief of the medical staff or any medical staff officer. They shall forward the complaint or report to the appropriate hospital authority for action. Reports and complaints regarding hospital staff conduct will be tracked through the executive committee.

2.6-5 ABUSE OF PROCESS

Retaliation or attempted retaliation against complainants or those who are carrying out medical staff duties regarding conduct will be considered inappropriate and disruptive conduct, and could give rise to evaluation and corrective action pursuant to the medical staff bylaws.

ARTICLE III

CATEGORIES OF MEMBERSHIP

3.1 CATEGORIES

The categories of the medical staff shall include the following: active, active office-based, courtesy, consulting, provisional, emergency department, honorary, retired, affiliate, and telemedicine. At 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 and residences which, in the opinion of the executive committee, are located closely enough to the hospital to provide continuity of quality care;

(c) engage in clinical practice activities involving at least twelve (12) inpatients or outpatients in the hospital per calendar year and are regularly involved in medical staff functions, as determined by the medical staff; and

(d) except for good cause shown as determined by the medical staff, 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 committees of which he or she is a member; and

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

3.2-3 TRANSFER OF ACTIVE STAFF MEMBER

After two (2) consecutive years in which a member of the active staff fails to regularly care for patients in this hospital or be regularly involved in medical staff functions as determined by the medical staff, that member shall be automatically transferred to the appropriate category, if any, for which the member is qualified.

3.3 ACTIVE OFFICE-BASED STAFF

3.3-1 QUALIFICATIONS

Active office-based members shall consist of members who:

(a) meet general qualifications for membership set forth in Section 2.2;

(b) have an interest in hospital and medical staff functions, but the nature of their practice is focused in an office-based setting;

(c) demonstrate in the assessment of the executive committee a consistent and sustained record of substantial participation, as set forth in Section 3.3-2 (c), during the prior term of appointment; and

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

3.3-2 PREROGATIVES

Except as otherwise provided, the prerogatives of an active office-based member shall be to:

(a) monitor their patients while they are in the hospital and access the patient's medical records both remotely and at Lompoc Valley Medical Center;

(b) attend and vote on matters presented at general and special meetings of the medical staff and of the committees of which he or she is a member; and

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

3.4 COURTESY MEDICAL STAFF

3.4-1 QUALIFICATIONS

The courtesy medical staff shall consist of members who:

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

(b) do not regularly care for patients (admit or care for less than twelve patients per year) or are not regularly involved in medical staff functions as determined by the medical staff;

(c) are members in good standing of the active or associate medical staff of another California licensed hospital, although exceptions to this requirement may be made by the executive committee for good cause; and

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

3.4-2 PREROGATIVES

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

(a) admit patients to the hospital within the limitations of Section 3.4-1(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, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment. Courtesy staff members shall not be eligible to hold office in the medical staff.

3.4-3 LIMITATION

Courtesy staff members who admit and/or regularly care for more than twelve (12) patients per year shall, upon review of the executive committee, be obligated to seek appointment to the appropriate staff category.

3.5 CONSULTING MEDICAL STAFF

3.5-1 QUALIFICATIONS

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

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

(b) possess adequate clinical and professional expertise;

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

(d) are members of the active or associate medical staff of another hospital licensed by California or another state although exceptions to this requirement may be made by the executive committee for good cause; and

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

3.5-2 PREROGATIVES

The consulting medical staff member shall be entitled to:

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

(b) attend meetings of the medical staff, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment. Consulting staff members shall not be eligible to hold office in the medical staff organization, but may serve upon committees.

3.6 PROVISIONAL STAFF

3.6-1 QUALIFICATIONS

The provisional staff shall consist of members who:

(a) meet the general medical staff membership qualifications set forth in Sections 3.2-1 (a) and (b) or 3.5-1 (a)-(d), and
(b) immediately prior to their application and appointment were not members (or were no longer members in good standing of this medical staff.

3.6-2 PREROGATIVES

The provisional staff member shall be entitled to:

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

(b) attend meetings of the medical staff, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment. Provisional staff members shall not be eligible to hold office in the medical staff organization, but may serve upon committees.

3.6-3 OBSERVATION OF PROVISIONAL STAFF MEMBER

Each provisional staff member shall undergo a period of observation by designated monitors as described in Section 5.3. The observation shall be to evaluate the member's:

(a) proficiency in the exercise of clinical privileges initially granted, and

(b) over-all eligibility for continued staff membership and advancement within staff categories.

Appropriate committees designated by the executive committee shall establish the frequency and format of observation the committee 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 committee chair to the credentials committee.

3.6-4 TERM OF PROVISIONAL STAFF STATUS

A member shall remain in the provisional staff for a period of one year, unless that status is extended by the executive committee for an additional period upon

a determination of good cause, which determination shall not be subject to review pursuant to Articles VI or VII.

3.6-5 ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS

(a) If the provisional staff member has satisfactorily demonstrated his or her ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued medical staff membership, the member shall be eligible for placement in the active, courtesy, or consulting staff status, as appropriate, upon recommendation of the executive committee.

(b) In all other cases, the appropriate service shall advise the credentials/executive committee which, in turn, shall make its recommendation to the board of directors regarding a modification or termination of clinical privileges, or termination of medical staff membership.

3.7 EMERGENCY DEPARTMENT STAFF

3.7-1 QUALIFICATIONS

The emergency department staff shall consist of members who:

(a) meet the general medical staff membership qualifications set forth in Section 2.2;

(b) practice under the immediate jurisdiction of the Emergency Service Director; and

(c) complete a provisional period of observation.

3.7-2 PREROGATIVES

Except as otherwise provided, the prerogatives of an emergency room physician shall be to:

(a) admit and write orders on patients under the direction of an active staff physician;

(b) admit and write orders and provide inpatient care on patients if no active staff physician is immediately available. In this situation, and the preceding, an active staff physician must assume care of the patient by the first 8:00 a.m. after admission;

(c) respond to inpatient emergencies and write orders and provide care until the attending physician assumes care;

(d) serve on committees, if requested; and

(e) become members of the Active Medical Staff if they wish to apply. If appointed they must then pay dues, and will be eligible to vote.

3.8 HONORARY, RETIRED, AND AFFILIATE STAFFS

3.8-1 QUALIFICATIONS

(a) Honorary Staff

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

(b) Retired Staff

The retired staff shall consist of practitioners 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 ten (10) continuous years and who continue to adhere to appropriate professional and ethical standards.

(c) Affiliate Staff

The affiliate staff shall consist of physicians, dentists, and podiatrists who actively practice at a local federal facility.

3.8-2 PREROGATIVES

Honorary, retired, and affiliate 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 without vote at the discretion of the executive committee. They may attend medical staff meetings, including open committee meetings and educational programs.

3.8-3 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these bylaws and by the medical staff rules and regulations.

3.9 TELEMEDICINE STAFF

3.9-1 QUALIFICATIONS

The telemedicine staff shall consist of members who:

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

(b) possess adequate clinical and professional expertise;

(c) provide telemedicine services that have a limited scope of practice under the supervision of a fully credentialed member of the medical staff of Lompoc Valley Medical Center (Lompoc Healthcare District); and

(d) are members of the active or associate medical staff of another hospital licensed by California or another state although exceptions to this requirement may be made by the executive committee for good cause.

3.9-2 CREDENTIALING

With regard to telemedicine services directly contracted with Lompoc Valley Medical Center (Lompoc Healthcare District), The Medical Executive Committee, at its discretion, may rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity when recommending privileges for individual physicians and practitioners providing such services when:

(a) the distant-site hospital is a Medicare-participating hospital;

(b) the individual distant-site physician/practitioner is privileged at the distant-site hospital providing the telemedicine services and a current list of those privileges are provided;

(c) the individual practitioner holds a license issued or recognized by the State in which the hospital whose patients are receiving the telemedicine services is located;

(d) a distant–site telemedicine entity, acting as a contractor of services, furnishes its services in a manner that enables the Lompoc Valley Medical Center to comply with all applicable Medicare Conditions of Participation Standards.

3.9-3 PREROGATIVES

The telemedicine medical staff member shall be entitled to:

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

(b) shall have no right to vote, and are not eligible to hold office in the medical staff organization.

3.10 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership in the medical staff, limited license members:

(a) shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the chairman of the meeting, subject to final decision by the executive committee, 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 CATEGORY

On its own, upon recommendation of the credentials committee, or pursuant to a request by a member under Section 4.6-1(b), or upon direction of the board of directors as set forth in Section 6.1-6, the executive committee may recommend a change in the medical staff category of a member consistent with the requirements of the bylaws.

ARTICLE IV

APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL

Except as otherwise specified herein, no person (including persons engaged by the hospital in administratively responsible positions shall exercise clinical privileges in the hospital unless and until that person applies for and receives appointment to the medical staff or is granted temporary privileges as set forth in these bylaws, or, with respect to allied health practitioners, has been granted a service authorization or privileges under applicable medical staff policies. By applying to the medical staff for initial appointment or reappointment (or, in the case of members of the honorary staff, by accepting an appointment to that category), the applicant acknowledges responsibility to first review these bylaws and medical staff rules, regulations and policies, and agrees that throughout any period of membership that person will comply with the responsibilities of medical staff membership and with the bylaws, rules and regulations and policies of the medical staff as they exist and as they may be modified from time to time. Appointment to the medical staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these bylaws.

4.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. This burden may include submission to a medical or psychological examination, at the applicant's expense. The examining physician may be chosen by the applicant from an outside panel of three physicians selected by the executive committee. The applicant, or executive committee, may withdraw the application from consideration if information is incomplete or inaccurate or required information is not available.

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 one (1) year. Reappointments shall be for a period of up to two (2) years.

4.5 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

4.5-1 APPLICATION FORM

An application form shall be developed by the executive committee. The 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, and continuing medical education information related to the clinical privileges to be exercised by the applicant;

(b) peer references familiar with the applicant's professional competence and ethical character;

(c) requests for membership categories, services, and clinical privileges;

(d) past or pending disciplinary action, including involuntary denial, revocation, suspension, reduction or relinquishment of medical staff

membership or privileges or any licensure or registration, and related matters;

(e) voluntary reduction or relinquishment of medical staff privileges or membership or licensure to avoid disciplinary action;

(f) current physical and mental health status;

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

(h) professional liability coverage; and

(i) proof of a tuberculosis screening test upon initial appointment to the medical staff and subsequent reappointments.

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 executive committee, copies or summaries of any other applicable medical staff policies relating to clinical practice in the hospital.

4.5-2 EFFECT OF APPLICATION

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

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

(b) authorizes consultation with others who have been associated with him or her and who may have information bearing on his or her competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;

(c) consents to inspection of records and documents that may be material to an evaluation of his or her 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 permitted 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 permitted 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 and licensing boards, and to other similar organizations as required by law any information regarding his or her professional or ethical standing that the hospital or medical staff may have, and releases the medical staff and hospital from liability for so doing to the fullest extent permitted by law;

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

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

(i) pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing continuous care of his or her patients, seeking consultation whenever necessary, refraining from failing to disclose to patients when another surgeon or physician will be performing surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners;

(j) pledges to be bound by the medical staff bylaws, rules and regulations, and policies; and

(k) agrees that if membership and privileges are granted, and for the duration of medical staff membership, the member has an ongoing and continuous duty to report to the Medical Staff Office within thirty (30) days any and all information that would otherwise correct, change, modify or add to any information provided in the application or most recent re-application when such corrections, change, modification or addition may reflect adversely on current qualifications or membership or privileges.

4.5-3 VERIFICATION OF INFORMATION

The applicant shall deliver a completely filled-in, signed, and dated application to the appropriate medical staff officer 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 chief of staff. The credentials committee, and the administrator if his or her assistance is requested by the credentials committee, 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 regarding the applicant or member and submit any resulting information to the credentials committee 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 the required information. When collection and verification of information other than the National Practitioner Data Bank is accomplished, the application shall be considered complete, and all such information shall be transmitted to the credentials committee. If after ninety (90) days the required information, other than the National Practitioner Data Bank, has not been transmitted to the credentials committee, the application shall be deemed withdrawn and the withdrawal shall not be subject to appeal. No final action on an application may be taken until receipt of the National Practitioner Data Bank report. When collection and verification is accomplished, all such information shall be transmitted to the credentials committee and other appropriate committees.

4.5-4 EXECUTIVE COMMITTEE ACTION

The executive committee shall review the application, evaluate and verify the supporting documentation and other relevant information. The committee may elect to interview the applicant and seek additional information. The executive committee shall forward to the administrator, for prompt transmittal to the board of directors, a written report and recommendation as to medical staff appointment and, if appointment is recommended, as to membership category, service affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The committee may also defer action on the application. The reasons for each recommendation shall be stated.

4.5-5 EFFECT OF EXECUTIVE COMMITTEE ACTION

(a) Favorable recommendation: When the recommendation of the executive committee is favorable to the applicant, it shall be promptly forwarded, together with supporting documentation, to the board of directors.

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

4.5-6 ACTION ON THE APPLICATION

The board of directors may accept the recommendation of the executive committee or may refer the matter back to the executive committee for further consideration, stating the purpose for such referral. The following procedure shall apply with respect to action on the application:

(a) If the executive committee issues a favorable recommendation and
(1) The board of directors concurs in that recommendation, the decision of the board shall be deemed final action.

(2) The tentative final action of the board of directors 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 the applicant waives his or her procedural rights, the decision of the board of directors shall be deemed final action.

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

(1) If the applicant waives his or her procedural rights, the recommendations of the executive committee shall be forwarded to the board of directors for final action, which shall affirm the recommendation of the executive committee if the executive committee's decision is supported by substantial evidence.

(2) If the applicant requests a hearing following the adverse executive committee recommendation pursuant to section 4.5-6(b) or an adverse board of directors tentative final action pursuant to 4.5-6(a) (2), the board of directors shall take final action only after the applicant has exhausted his or her 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.

4.5-7 NOTICE OF FINAL DECISION

(a) Notice of the final decision shall be given to the chief of staff, the executive committee, 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 clinical privileges granted; and

(3) any special conditions attached to the appointment.

4.5-8 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 one year. 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.

4.5-9 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 time periods provide a guideline for routine processing of applications:

(a) evaluation, review, and verification of application and all supporting documents: sixty (60) days from receipt of all necessary documentation, and

(b) final action one hundred twenty (120) days after receipt of all necessary documentation or conclusion of hearings.

4.6 REAPPOINTMENTS AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

4.6-1 APPLICATION

(a) At least sixty (60) days prior to the expiration date of the current staff appointment (except for temporary appointments, a reapplication form developed by the executive committee shall be mailed or delivered to the member. If an application for reappointment is not received at least forty-five (45) 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 thirty (30) days prior to the expiration date, each medical staff member shall submit to the credentials committee 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 4.5-1, as well as other relevant matters. Upon receipt of the application, the information shall be processed as set forth commencing at Section 4.5-3.

(b) A medical staff member who seeks a change in medical staff status or modification of clinical privileges may submit such a request at any time upon a form developed by the executive committee, except that such application may not be filed within six (6) months 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 4.5-2.

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 Section 4.5-3 through 4.5-9.

4.6-4 FAILURE TO FILE REAPPOINTMENT APPLICATION

If the member in good standing fails to submit a completed application for renewal of membership within 30 days past the date it was due, the member shall be deemed to have resigned membership in the medical staff, unless otherwise extended by the executive committee with the approval of the board of directors so long as processing the member's application is completed prior to the expiration of the privileges. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article VII shall not apply. If the member subsequently submits a new application for medical staff membership within (90) days of resigning membership, the member shall be subject to the procedures set forth in Sections 4.5-3 through 4.5-9, except that the member will not be required to undergo initial proctoring requirements for clinical privileges that were previously granted by the medical staff.

4.7 LEAVE OF ABSENCE

4.7-1 LEAVE STATUS

At the discretion of the executive committee, a medical staff member may obtain a voluntary leave of absence from the staff upon submitting a written request to the executive committee stating the approximate period of leave desired, which may not exceed two years. During the period of the leave, the member shall not exercise clinical privileges at the hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the medical staff.

4.7-2 TERMINATION OF LEAVE

At least 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 executive committee. The staff member shall submit a summary of relevant activities during the leave, if the executive committee so requests. The executive committee shall make a recommendation concerning the reinstatement of the member's privileges and prerogatives, and the procedure provided in Sections 4.1 through 4.5-9 shall be followed.

4.7-3 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall be entitled to the procedural rights provided in Article VII for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, or otherwise. A request for medical staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

4.7-4 MEDICAL LEAVE OF ABSENCE

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

4.7-5 MILITARY LEAVE OF ABSENCE

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

ARTICLE V

CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these bylaws, a member providing clinical services at this hospital shall be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be hospital specific, within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to the medical staff rules and regulations and the authority of the appropriate committee and the medical staff. Medical staff privileges may be granted, continued, modified or terminated by the board of directors 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

(a) Requests for clinical privileges shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance, 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, and

(b) no specific privilege may be granted to a member if the resources necessary to support the requested privilege are not available within the hospital despite the member’s qualifications or ability to perform the requested privilege.

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

Any request for clinical privileges that are either new to the Hospital or that overlap more than one service shall initially be reviewed by the appropriate services, in order to establish the need for, and appropriateness of, the new procedure or services. The executive committee shall facilitate the establishment of hospital-wide credentialing criteria for new or trans-specialty procedures, with the input of all appropriate services, with a mechanism designed to ensure that quality patient care is provided for by all individuals with such clinical privileges. In establishing the criteria for such clinical privileges, the executive committee may establish an ah-hoc committee with representation from all appropriate services.

5.3 PROCTORING

5.3-1 GENERAL PROVISIONS

Except as otherwise determined by the executive committee, all initial appointees to the medical staff who are requesting clinical privileges and all members granted new clinical privileges shall be subject to a period of proctoring. Each appointee requesting clinical privileges or each recipient of new clinical privileges shall be assigned to the appropriate service where performance of an

appropriate number of cases (as established by the executive committee), shall be observed
by the chief of service or the chief's designee, during the period of proctoring specified in the medical staff rules and regulations, to determine suitability to continue to exercise the clinical privileges granted. The exercise of clinical privileges subject to monitoring by another service shall also be subject to direct observation by that chief of service or the chief's designee. The member shall remain subject to such proctoring until the executive committee has been furnished with:

(a) a report signed by the chief of service 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 the hospital, 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 chiefs of the other services 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 services.

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 service, those specific clinical privileges shall be automatically terminated, and the member shall be entitled to a hearing, upon request, pursuant to Article VII.

5.3-3 MEDICAL STAFF ADVANCEMENT

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

5.4 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

5.4-1 ADMISSIONS

When dentists and any oral surgeons or podiatrists who do not hold history and physical privileges who are members of the medical staff admit patients, a physician member of the medical staff with history and physical privileges must

document and conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry, oral surgery 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 and podiatrists shall be under the overall supervision of the chief of the surgery service or the chief's designee.

5.4-3 MEDICAL APPRAISAL

All patients admitted for care in a hospital by a dentist (except a qualified oral surgeon or podiatrist who has been granted such privileges) shall receive the same basic medical appraisal as patients admitted to other services, and a physician member shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate service.

5.5 TEMPORARY CLINICAL PRIVILEGES

Temporary privileges are allowed under two circumstances only: to address a patient care need and to permit patient care to be provided while an application is pending. Temporary privileges for applicants may be granted for no more than one hundred twenty (120) days.

5.5-1 PATIENT CARE NEEDS

(a) Care of Specific Patient

Temporary clinical privileges may be granted, where good cause exists, to allow a physician, dentist or podiatrist to provide care to a specific patient (but not more than two (2) during a calendar year) provided that the procedure described in Section 5.5-4 has been completed.

(b) Locum Tenens

Temporary clinical privileges may be granted to a person serving as a locum tenens for a current member of the medical staff to meet the care needs of that member's patients in that member's absence, provided that the procedure described in Section 5.5-4 has been completed. Such person may attend only patients of the member(s) for whom that person

is providing coverage, for a period not to exceed one hundred twenty (120) days, unless the executive committee recommends a longer period for good cause.

(c) Other Important Patient Care Needs

Temporary clinical privileges may be granted to allow a physician, dentist, or podiatrist to fulfill an important patient care treatment or service need provided that the procedure described in Section 5.5-4 has been completed.

5.5-2 PENDING APPLICATION FOR MEDICAL STAFF MEMBERSHIP

Temporary clinical privileges may be granted while that person's application for medical staff membership and privileges is completed and awaiting review and approval of the executive committee or the board of directors, provided that the procedure described in Section 5.5-4 (a) (2) has been completed, and that the applicant has no current or previously successful challenge to professional licensure or registration, no involuntary termination of medical staff membership at any other organization, and no involuntary limitation, reduction, denial or loss of clinical privileges. Such persons may only attend patients for a period not to exceed one hundred twenty (120) days.

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

Practitioners granted temporary privileges pursuant to Section 5.5 shall not be considered members of the medical staff.

5.5-4 APPLICATION AND REVIEW

(a) Upon receipt of a completed application and supporting documentation from a physician, dentist, or podiatrist authorized to practice in California, the chief executive officer on the recommendation of either the applicable clinical chief of service or 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
  (1) 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
  (2) with respect to a new applicant awaiting review and approval of the medical staff executive committee and the governing body in compliance with the requirements in Section 5.5-2, after the following has been completed:
    (i) the National Practitioner Data Bank report regarding the applicant for temporary privileges has been received and

evaluated and current California licensure has been verified;

(ii) the appropriate chief of service has interviewed the applicant and has contacted at least one person who
  a) has recently worked with the applicant;
  b) has directly observed the applicant's professional performance over a reasonable time; and
  c) provides reliable information regarding the applicant's current professional competence to perform the privileges requested, ethical character, and ability to work well with others so as not to adversely affect patient care, or other criteria required by medical staff bylaws.

(iii) the applicant's file, including the recommendation of the chief of service of the applicable service when available, or the chief of staff in all other case, is forwarded to the executive committee; and

(iv) the executive committee through the chief of staff, after reviewing the applicant's file and attached materials, recommends granting temporary privileges or another designee recommends granting temporary privileges.

(b) If the applicant requests temporary privileges in more than one service, interviews shall be conducted and written concurrence shall first be obtained from the appropriate chief of services and forwarded to the executive committee. In the event of disagreement between the chief executive officer or a designee and the executive committee regarding the granting of temporary clinical privileges, the matter shall be resolved as set forth in Section 4.5-6.

5.5-5 GENERAL CONDITIONS

(a) If granted temporary privileges, the applicant shall act under the supervision of the chief of service to which the applicant has been assigned, and shall ensure that the chief of service, or the chief's designee is kept closely informed as to his or her activities within the hospital.

(b) Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended under Articles VI and/or VII of the bylaws or unless affirmatively renewed following the procedure as set forth in Section 5.5-4. A medical staff applicant's temporary privileges shall automatically terminate if the applicant's initial membership application is withdrawn. As necessary, the appropriate chief of service or, in the chief's absence, the chair of the executive committee, shall assign a member of the medical staff to assume responsibility for the care of such member's patient(s). The wishes of the

patient shall be considered in the choice of a replacement medical staff member.

(c) Requirements for proctoring and monitoring, including but not limited to those in Section 5.3, shall be imposed on such terms as may be appropriate under the circumstances upon any member granted temporary privileges by the chief of staff after consultation with the chief of service or his designee.

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

5.6 HISTORY AND PHYSICAL PRIVILEGES

Histories and physicals can be conducted or updated and documented only pursuant to specific privileges granted upon request to qualified physicians (and other practitioners) who are members of the medical staff or seeking temporary privileges, acting within their scope of practice. Oromaxillofacial surgeons who have successfully completed a postgraduate program in oromaxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Office of Education and have been determined by the medical staff to be competent to do so, may be granted the privileges to perform a history and physical examination related to oromaxillofacial surgery. For patients with existing medical conditions or abnormal findings beyond the surgical indications, a physician member of the medical staff with history and physical privileges must conduct or directly supervise the admitting history and physical examination, except the portion related to oromaxillofacial surgery, and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the oromaxillofacial surgeon's lawful scope of practice. Every patient receives a history and physical within twenty-four (24) hours after admission, unless a previous history and physical was performed within thirty (30) days before admission or registration. In which case that history and physical will be updated within twenty-four (24) hours after admission or prior to a procedure requiring anesthesia services.

5.7 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 service, 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 chief of service 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 chief of service with respect to further care of the patient at the hospital.

(b) In the event of an emergency under subsection (a), 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 services for which they do not hold delineated clinical privileges.

5.8 DISASTER PRIVILEGES

(a) In the case of a disaster in which the disaster plan has been activated and the hospital is unable to handle the immediate patient needs, the chief of staff, or in the absence of the chief of staff, the immediate past chief of staff, may grant disaster privileges. In the absence of the chief of staff and the immediate past chief of staff and chief of services, the administrator or their designee may grant the disaster privileges consistent with this subsection. The granting of privileges under this subsection shall be on a case-by-case basis at the sole discretion of the individual authorized to grant such privileges. An initial granting of disaster privileges is reviewed by a person authorized to grant disaster privileges within 72 hours to determine whether the disaster privileges should be continued.

(b) The verification process of the credentials and privileges of individuals who receive disaster privileges under this subsection shall be developed in advance of a disaster situation. This process shall begin as soon as the immediate disaster situation is under control, and shall meet the following requirements in order to fulfill important patient care needs:
   (1) The medical staff identifies in writing the individual(s) responsible for granting disaster privileges.
   (2) The medical staff describes in writing the responsibilities of the individual(s) responsible for granting disaster privileges.
   (3) The medical staff describes in writing a mechanism to manage the activities of individuals who receive disaster privileges. There is a mechanism to allow staff to readily identify these individuals.
   (4) The medical staff addresses the verification process as a high priority. The medical staff has a mechanism to ensure that the verification process of the credentials and privileges of individuals who receive disaster privileges begins as soon as the immediate situation is under control. This privileging process is identical to the process established under the medical staff bylaws for granting temporary privileges to fulfill an important patient care need.
   (5) Those authorized under subsection (a) may grant disaster privileges upon presentation of a valid government-issued photo identification issued by a state, federal or regulatory agency and at least one of the following:
      (i) A current picture hospital ID card clearly identifying professional designation.

(ii) A current license to practice.
(iii) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organizations or groups.
(iv) Identification indicating that the individual has been granted authority by a federal, state, or municipal entity to render patient care in disaster circumstances.
(v) Identification by current hospital or medical staff member(s) with personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

(c) Current professional licensure of those providing care under disaster privileges is verified from the primary source as soon as the immediate emergency situation is under control or within 72 hours from the time the volunteer licensed independent practitioner presents to the hospital, whichever comes first. If primary source verification cannot be completed within 72 hours of the practitioner's arrived due to extraordinary circumstances, the hospital documents all of the following:
(1) the reason(s) verification could not be performed within 72 hours of the practitioner's arrival;
(2) evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment and services; and
(3) evidence of an attempt to perform primary source verification as soon as possible.

(d) Members of the medical staff shall oversee those granted disaster privileges.

5.9 MODIFICATION OF CLINICAL PRIVILEGES OR SERVICE ASSIGNMENT

On its own, or pursuant to a request under Section 4.6-1(b), the executive committee may recommend a change in the clinical privileges or service of a member. The executive committee 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.

5.10 LAPSE OF APPLICATION

If a medical staff member requesting a modification of clinical privileges or service assignments fails to timely furnish the information reasonably necessary to evaluate the request, the application shall automatically lapse, and the applicant shall not be entitled to a hearing as set forth in Article VII.

ARTICLE VI

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

(a) detrimental to patient safety or to the delivery of quality patient care within the hospital;
(b) unethical;
(c) contrary to the medical staff bylaws and rules or regulations; or
(d) below applicable professional standards, a request for an investigation or action against such member may be initiated by the chief of staff or the executive committee.

6.1-2 INITIATION

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

6.1-3 INVESTIGATION

If the executive committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The executive committee may conduct the investigation itself, or may assign the task to an appropriate medical staff officer or committee other than the executive committee. (The executive committee in its discretion may appoint practitioners who are not members of the medical staff as temporary members of the medical staff for the sole purpose of service on a standing or ad hoc committee, should circumstances warrant.) If the investigation is delegated to an officer or committee other than the executive committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the executive committee as soon as practicable. The report may include recommendations for appropriate corrective action. The member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved. However, such investigation shall not constitute a "hearing" as that term is used in Article VII, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the executive committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

6.1-4 EXECUTIVE COMMITTEE ACTION

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

(a) determining no corrective action be taken and, if the executive committee determines there was no credible evidence for the complaint in the first instance, 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, although nothing herein shall be deemed to preclude the chief of service from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file;

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

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

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

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

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

(i) 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 executive committee, that recommendation shall be transmitted to the board of directors.

(b) Once the executive committee has taken action, it will give the member prompt written notice of its conclusions.

(c) So long as the recommendation is supported by substantial evidence the recommendation of the executive committee shall be adopted by the board as final action unless the member requests a hearing, in which case the final decision shall be determined as set forth in Article VII.

6.1-6 INITIATION BY BOARD OF DIRECTORS

If the executive committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the board of directors may direct the executive committee to initiate investigation or disciplinary action, but only after consultation with the executive committee. The board's request for medical staff action shall be in writing and shall set forth the basis for the request. If the executive committee fails to take action in response to that board of directors' direction, the board of directors may initiate corrective action, but this corrective action must comply with Articles VI and VII of these medical staff bylaws.

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 patients or failure to take that action may result in an imminent danger to the health of any individual, the chief of the medical staff, the immediate past chief of staff in his absence, or the appropriate chief of service (or designee) may summarily restrict or suspend the medical staff membership or clinical privileges of such member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the member, the board of directors, the executive committee and the administrator. 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 appropriate chief of service 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 one working day 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 executive committee 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 EXECUTIVE COMMITTEE ACTION

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

6.2-4 PROCEDURAL RIGHTS

Unless the executive committee promptly terminates the summary restriction or suspension, the member shall be entitled to the procedural right afforded by Article VII. In addition, the affected practitioner shall have the following rights:

(a) Any affected practitioner shall have the right to challenge imposition of the summary suspension, particularly on the issue of whether or not the facts stated in the notice present a reasonable possibility of "imminent danger" to an individual. Initially, the practitioner may present this challenge to the executive committee at the meeting held within one week of imposition of the suspension. If the executive committee's decision is to continue the summary suspension, then any practitioner who has properly requested a hearing under the medical staff bylaws may request that the hearing be bifurcated, with the first part of the hearing being devoted exclusively to procedural matters, including the propriety of summary suspension. Along with any other appropriate requests for rulings, the affected practitioner may request that the hearing officer [or hearing panel] stay the summary suspension, pending the final outcome of the hearing and any appeal.

(b) At the conclusion of the procedural portion of the hearing, the hearing officer [or hearing panel] shall issue a written opinion on the issues raised, including whether or not the facts stated in the written notice to the affected practitioner adequately support a determination that failure to summarily restrict or suspend could reasonably result in "imminent danger" to an individual. Such written opinion shall be transmitted to both the affected practitioner and the executive committee within one week of the date of the procedural hearing.

(c) If the hearing officer's [or hearing panel's] determination is that the facts stated in the notice required by Section 6.2-2 do not support a reasonable determination that failure to summarily restrict or suspend the practitioner's privileges could result in imminent danger, the summary

suspension shall be immediately stayed pending the outcome of the hearing and any appeal.

(d) If the hearing officer [or hearing panel] determines that the facts stated in the notice required by Section 6.2-2 support a reasonable determination that summary suspension was necessary to avoid imminent danger to an individual, the summary suspension shall remain in effect pending conclusion of the hearing and any appellate review.

6.2-5 INITIATION BY BOARD OF DIRECTORS

If the chief of staff, immediate past chief of staff and the chief of service (or designee) in which the member holds privileges are not available to summarily restrict or suspend the member's membership or clinical privileges, the board of directors (or designee) may immediately suspend a member's privileges if a failure to suspend those privileges is likely to result in an imminent danger to the health of any patient, prospective patient, or other person, provided that the board of directors (or designee) made reasonable attempts to contact the chief of staff, the immediate past chief of staff and the chief of service (or designee) before the suspension. Such a suspension is subject to ratification by the executive committee. If the executive committee does not ratify such a summary suspension within two working days, excluding weekends and holidays, the summary suspension shall terminate automatically. If the executive committee 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 executive committee for purposes of compliance with notice and hearing requirements.

6.3 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the member's privileges or membership may be suspended or limited as described, and a hearing, if requested, shall be limited to the question of whether the grounds for automatic suspension as set forth below have occurred.

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 are restricted in a similar manner, as of the date such action becomes effective and throughout its term.

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

6.3-2 CONTROLLED SUBSTANCES

(a) Whenever a member's 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 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

A member who fails without good cause to appear and satisfy the requirements of Section 11.1-4 and 12.8 shall automatically be suspended from exercising all or such portion of clinical privileges as may be specified in accordance with the provisions of that section. The automatic suspension shall remain in effect until the practitioner has provided requested information and/or satisfied the special attendance requirement which has been made by the medical staff committee.

6.3-4 MEDICAL RECORDS

Members of the medical staff are required to complete medical records within such reasonable time as may be prescribed by the executive committee. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, shall be imposed by the chief of staff, or his or her designee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this Section, "related privileges" means 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 executive committee. 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 designee.

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 90 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 HOSPITAL CONTRACT PRACTITIONER

Physicians who are contracted with, or employed by, an organization that has an exclusive contract with the hospital for professional services shall be members of the medical staff with privileges. Their exclusive privileges, but not their medical staff membership and other privileges, will be governed by the terms of the individual contracts with the hospital.

6.3-7 EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable after action is taken or warranted as described in Sections 6.3-1 (b) or (c), Sections 6.3-2, 6.3-3, the executive committee shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth commencing at Section 6.1-3.

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.

7.1-3 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 directors.

7.2 GROUNDS FOR HEARING

Except as otherwise specified in these bylaws, any one or more of the following actions or recommended actions shall be deemed actual or potential adverse action and constitute grounds for a hearing:

(a) denial of medical staff membership;

(b) denial of requested advancement in staff membership status, or category;

(c) denial of medical staff reappointment;

(d) demotion to lower medical staff category or membership status;

(e) suspension of staff membership;

(f) revocation of medical staff membership;

(g) denial of requested clinical privileges (excluding temporary privileges denied for other than medical disciplinary reasons.

(h) involuntary reduction of current clinical privileges (excluding temporary privileges reduced for other than medical disciplinary reasons;

(i) suspension of clinical privileges (excluding temporary privileges suspended for other than medical disciplinary reasons;

(j) termination of all clinical privileges (excluding temporary clinical privileges terminated for other than medical disciplinary reasons;

(k) involuntary imposition of significant consultation or monitoring requirements (excluding monitoring incidental to provisional status and Section 5.3); or

(l) any other disciplinary action or recommendation that must be reported to the Medical Board of California.

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 executive committee, shall give the member prompt written notice of: (1) the recommendation or final proposed action, and that such action, if adopted, shall

be taken and reported to the Medical Board of California and/or 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. If the recommendation or final proposed action is reportable to the medical Board of California and/or to the National Practitioner Data Bank, the written notice shall state the text of the proposed reports.

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 executive committee with a copy to the board of directors. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

7.3-3 TIME AND PLACE FOR HEARING

Upon receipt of a request for hearing, the executive committee shall schedule a hearing and, within fifteen (15) days (but in no event less than ten (10) days prior to the hearing 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 fifteen (15) days, nor more than sixty (60) days from the date of receipt of the request by the executive committee for a hearing; provided, however, that when the request is received from a member who is under summary suspension the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed forty-five (45) days from the date of receipt of the request.

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 executive committee 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 executive committee. 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 executive committee shall recommend a judicial review committee to the board of directors for appointment. The board of

directors shall be deemed to approve the selection unless it provides written notice to the executive committee stating the reasons for its objections within five (5) days. 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 executive committee 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 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 M.D. or D.O. 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 EXTENSION

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these bylaws may be permitted by the judicial review committee, or its chairman acting upon its behalf, within the discretion of the committee or its chairman on a showing of good cause, or upon agreement of the parties.

7.4 HEARING PROCEDURE

7.4-1 PREHEARING 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 executive committee in determining whether to proceed with the adverse action, any exculpatory evidence in the possession of the hospital or medical staff. The member and the executive committee 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 executive committee 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 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 executive committee or its designee to exercise reasonable diligence in notifying the chair of the judicial review committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the

hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

7.4-2 REPRESENTATION

The hearings provided for in these bylaws are for the purpose of intraprofessional 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 members choosing who is not also an attorney at law, and the executive committee shall appoint a representative who is not an attorney at law to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions. The executive committee shall not be represented by an attorney at law if the member is not so represented.

7.4-3 THE HEARING OFFICER

The executive committee shall appoint a hearing officer to preside at the hearing. The hearing officer may be an attorney at law qualified to preside over a quasi-judicial hearing, but an attorney regularly utilized by the hospital for legal advice regarding its 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 prehearing 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 executive committee and examined as if under cross-examination.

7.4-6 MISCELLANEOUS RULES

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

7.4-7 BURDENS OF PRESENTING EVIDENCE AND PROOF

(a) At the hearing the executive committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The member shall be obligated to present evidence in response.

(b) An applicant shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, of his/her qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning his/her 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 executive committee shall bear the burden of persuading the judicial

review committee, by a preponderance of the evidence, that its action or recommendation was 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 executive committee and the member may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

7.4-9 BASIS FOR DECISION

The decision of the judicial review committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the judicial review committee shall be subject to such rights of appeal as described in these bylaws, but shall otherwise be affirmed by the board of directors 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 executive committee. If the member is currently under suspension, however, the time for the decision and report shall be fifteen (15) days. A copy of said decision shall also be forwarded to the administrator, the board of directors, and to the member. The report shall contain a concise statement of the reasons in support of the decision, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. If the final proposed action adversely affects the clinical privileges of a physician or dentist for a period longer than 30 days and is based on competence or professional conduct, the decision shall state that the action if adopted will be reported to the National Practitioner Data Bank, and shall state the text of the report as agreed on by the committee. The decision shall also state whether the action if adopted will be reported to the Medical Board of California [and shall state the text of the report as agreed by the committee]. Both the member and the executive committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the judicial review committee shall be, subject to such rights of appeal or review as described in these bylaws, but shall otherwise be affirmed by the board of directors 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 executive committee 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 made within such period, that action or recommendation shall be affirmed by the board of directors 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;

(c) the text of the reports to be filed with the Medical Board of California and/or the National Practitioner Data Bank is not accurate.

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 directors may sit as the appeal board, or it may appoint an appeal board which shall be composed of not less than three (3) members of the board of directors. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not

take part in a prior hearing on the same matter. The appeal board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal. The attorney firm selected by the board of directors shall be neither the attorney firm that represented either party at the hearing before the judicial review committee nor the attorney who assisted the hearing panel or served as hearing officer.

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 other representation in connection with the appeal, to present a written statement in support of their 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 directors its written recommendations as to whether the board of directors should affirm, modify, or reverse the judicial review committee decision, or remand the matter to the judicial review committee for further review and decision.

7.5-6 DECISION

(a) Except as provided in Section 7.5-6(b), within thirty (30) days after the conclusion of the appellate review proceedings, the board of directors shall render a final decision 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 directors 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 a 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 recommendation to the board of directors. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may

otherwise agree or for good cause as jointly determined by the chair of the board of directors and the judicial review committee.

(c) The decision shall be in writing, shall specify the reasons for the action taken, 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, the executive committee, and credential committees, 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

No member shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

7.6 EXCEPTIONS TO HEARING RIGHTS

7.6-1 APPROPRIATENESS OF EXCLUSIVE CONTRACTS

Privileges can be reduced or terminated as a result of a decision to close or continue closure of a service pursuant to an exclusive contract, or to transfer an existing exclusive contract, only following review by the medical staff of the related quality of care issues pursuant to Section 12.9 and a determination of appropriateness of the closure, continued closure or transfer as set forth below. The board of directors' decision shall uphold the medical staff's determination unless the board of directors makes specific written findings that the medical staff's determination is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.

(a) The medical staff shall determine the need to close or continue closure of a service pursuant to an exclusive contract to be appropriate where:
  (1) a failure to provide full coverage of a needed service cannot be remedied by less extreme measures, such as mandated call schedules; or
  (2) irreconcilable differences within an existing service adversely affecting quality of care have not been resolved by less extreme measures; or
  (3) demonstrable efficiencies would result, producing significant improvement in the ability of the medical staff to dispense quality care, which have not been accomplished through less extreme measures.

A determination to close a service pursuant to an exclusive contract must be based upon the preponderance of the evidence, viewing the record as a whole, presented by any and all interested parties, following notice and opportunity for comment.

A determination to continue closure of a service pursuant to an exclusive contract must be based upon the preponderance of the evidence presented by members of the medical staff, following notice and opportunity for comment.

(b) The medical staff shall determine the transfer of an existing exclusive contract to be appropriate only when
  (1) continued closure of the service pursuant to an existing contract is found appropriate pursuant to (a) above, and
  (2) quality of care is maintained or improved by the transfer.

(c) The medical staff members whose privileges may be adversely affected by the medical staff's determination of appropriateness of the closure or continued closure of a service pursuant to an exclusive contract, or transfer of an exclusive contract, may request a hearing before the judicial review committee. Such a hearing will be governed by the provisions of Article VII, except that
  (1) the hearing shall be limited to the following issues:
    (i) whether the medical staff's determination of appropriateness is supported by a preponderance of the evidence;
    (ii) whether the medical staff followed its requirement for notice and comment on the issue of appropriateness;
    (iii) in cases of transfer, whether the medical staff's determination of effect on quality of care was appropriate.
  (2) All requests for such a hearing will be consolidated. Should an affected medical staff member request a hearing under this subsection, the medical staff's recommendation regarding the exclusive contract will be deferred, pending the outcome of the judicial review committee hearing.

(d) A medical staff member providing professional services under a contract with the hospital shall not have medical staff privileges terminated for reasons pertaining to the quality of care provided by the medical staff member without the same rights of hearing and appeal as are available to all members of the medical staff.

(e) Except as specified in this Section, the termination of privileges following the decision determined to be appropriate by the medical staff to close a service pursuant to an exclusive contract or to transfer an exclusive contract shall not be subject to the procedural rights set forth in Article VII.

(f) Except in cases of contemporaneous transfer of an existing exclusive contract determined to be appropriate by the medical staff, a decision to terminate an exclusive contract shall not affect the privileges of medical staff members who were performing services pursuant to that contract, except that their privileges shall no longer be exclusive.

(g) Terms of this Section 7.6-1 will take precedence over any inconsistent terms in a contract between a member of the medical staff and the hospital, including, but not necessarily limited to, any contractual provisions purporting to waive all rights of hearing and appeal provided in these bylaws.

7.6-2 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

No hearing is required when a member's license or legal credential to practice has been revoked or suspended as set forth in Section 6.3-1(a). In other cases described in Section 6.3-1 and 6.3-2, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority of the DEA was unwarranted, but only whether the member may continue practice in the hospital with those limitations imposed.

7.6-3 SERVICE FORMATION OR ELIMINATION

A medical staff service can be formed or eliminated only following a determination by the medical staff of appropriateness of service elimination or formation. The board of directors' decision shall uphold the medical staff's determination unless the board of directors makes specific written findings that the medical staff's determination is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.

(a) The medical staff shall determine the formation or elimination of service to be appropriate based upon consideration of its effects on quality of care in the facility and/or community. A determination of the appropriateness of formation or elimination of a service must be based upon the preponderance of the evidence, viewing the record as a whole, presented by any and all interested parties, following notice and opportunity for comment.

(b) The medical staff members whose privileges may be adversely affected by a medical staff's determination of appropriateness of service formation or elimination may request a hearing before the judicial review committee. Such a hearing will be governed by the provisions of Article VII, except that
   (1) the hearing shall be limited to the following issues:
      (i) whether the medical staff's determination of appropriateness is supported by the preponderance of the evidence;
      (ii) whether the medical staff followed its requirements for notice and comment on the issue of appropriateness.
   (2) all requests for such a hearing will be consolidated.

Should an affected medical staff member request a hearing under this subsection, the medical staff's recommendation regarding the service elimination or formation will be deferred, pending the outcome of the judicial review committee hearing.

(c) Except as specified in this Section, the termination of privileges pursuant to formation or elimination of a service determined to be appropriate by the medical staff shall not be subject to the procedural rights otherwise set forth in Article VII.

7.7 EXPUNCTION OF DISCIPLINARY ACTION

Upon petition, the executive committee, in its sole discretion, may expunge previous disciplinary action upon a showing of good cause or rehabilitation.

7.8 NATIONAL PRACTITIONER DATA BANK REPORTING

The authorized representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as final action and only using the description set forth in the final action as adopted by the board of directors. The authorized representative shall report any and all revisions of an adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

7.9 DISPUTING REPORT LANGUAGE

If no hearing was requested, a member who is the subject of a proposed adverse action report to the Medical Board of California or the National Practitioner Data Bank may request an informal meeting to dispute the text of the report filed. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report filed is consistent with the final action issued. The meeting shall be attended by the subject of the report, the chief of staff, the chair of the subject's service, and the hospital's authorized representative, or their respective designees. If a hearing was held, the dispute process shall be deemed to have been completed.

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, immediate past chief of staff, and secretary-treasurer.

8.1-2 QUALIFICATIONS

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

8.1-3 NOMINATIONS

(a) The medical staff election shall be annually at the May staff meeting. A nominating committee shall be appointed by the chief of staff at the April meeting. The nominating committee shall nominate one or more candidates for each office. The nominations shall be reported to the voting members of the staff at least seven (7) days prior to the election.
(b) Further nominations may be made from the floor during the May meeting.

8.1-4 ELECTIONS

The election shall be held at the regular May meeting of the medical staff. Only members of the active medical staff shall be eligible to vote. A nominee shall be elected by receiving a majority of the valid votes cast.

8.1-5 TERMS OF ELECTED OFFICE

Each officer shall serve a one (1) year term, commencing on the first day of the medical staff year following his or her election. Each officer shall serve in each office until the end of his or her term, or until a successor is elected, unless he shall sooner resign or be removed from office. At the end of his or her term, the chief of staff shall automatically assume the office of immediate past chief of staff.

8.1-6 RECALL OF OFFICERS

Any medical staff officer may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. Recall of a medical staff officer may be initiated by the executive committee or shall be initiated by a petition signed by at least one-third of the members of the medical staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require two-thirds vote of the medical staff members eligible to vote for medical staff officers who actually cast votes at the special meeting in person or by mail ballot.

8.1-7 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the medical staff. Vacancies, other than that of chief of staff, shall be filled by appointment by the executive committee until the next regular election. If there is a vacancy in the office of

chief of staff, the then immediate past chief of staff shall serve out that remaining term.

8.2 DUTIES OF OFFICERS

8.2-1 CHIEF OF STAFF

The chief of staff shall serve as the chief officer of the medical staff. The duties of the chief of staff shall include, but not be limited to:

(a) enforcing the medical staff bylaws and rules and regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;

(b) calling, presiding at, and being responsible for the agenda of all meetings of the medical staff;

(c) serving as chair of the executive committee;

(d) serving as an ex-officio member of all other staff committees without vote, unless his or her membership in a particular committee is required by these bylaws;

(e) interacting with the administrator and board of directors in all matters of mutual concern within the hospital;

(f) appointing, in consultation with the executive committee, committee members for all standing and special medical staff, liaison, or multi-disciplinary committees, except where otherwise provided by these bylaws and, except where otherwise indicated, designating the chairman of these committees;

(g) representing the views and policies of the medical staff to the board of directors and to the administrator;

(h) being a spokesperson for the medical staff in external professional and public relations;

(i) performing such other functions as may be assigned to him or her by these bylaws, the medical staff, or by the executive committee;

(j) serving on liaison committees with the board of directors and administration, as well as outside licensing or accreditation agencies.

8.2-2 IMMEDIATE PAST CHIEF OF STAFF

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

8.2-3 SECRETARY-TREASURER

The secretary-treasurer shall be a member of the executive committee. The duties shall include, but not be limited to:

(a) maintaining a roster of members;

(b) keeping accurate and complete minutes of all executive committee and medical staff meetings;

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

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

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

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

(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 executive committee.

8.3 CHIEFS OF SERVICES

8.3-1 QUALIFICATIONS AND APPOINTMENTS

Each major service shall have a chief of service appointed by the chief of staff with the concurrence of the executive committee. The chief of service shall be a member of the active medical staff and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the service. Chiefs of services must be certified by an appropriate specialty board or must demonstrate comparable competence. Each chief of service shall serve a year term or until his or her successor is chosen, unless he or she shall sooner resign or be removed from office or lose medical staff membership or clinical privileges in that service. A chief of service may be removed by the executive committee, and vacancies due to any reason shall be filled for the unexpired term by the executive committee.

8.3-2 DUTIES

(a) be a member of the executive committee, giving guidance on the overall medical policies of the hospital and making specific recommendations and suggestions regarding his own service in order to assure quality patient care;

(b) serve on the quality of care committee. One purpose of such committee is to conduct the initial phase of patient care evaluation;

(c) be responsible for enforcement of the hospital bylaws and of the medical staff bylaws, rules and regulations within his service;

(d) be responsible for implementation within his service of actions taken by the executive committee of the medical staff;

(e) be responsible for the proctoring of provisional staff members as well as other staff members requesting new privileges in his service;

(f) transmit to the executive committee his service's recommendations concerning the staff classification, the reappointment, and the delineation of clinical privileges for all practitioners in his service;

(g) participate in every phase of administration of his service through cooperation with the nursing service and the hospital's administration in matters affecting patient care, including personnel, supplies, specific regulations, standing orders and techniques.

ARTICLE IX

SERVICES

9.1 ORGANIZATION OF SERVICES

There shall be services of emergency medicine, family medicine, internal medicine, obstetrics/gynecology, pediatric medicine, and surgery. Each service shall be headed by a chief of service and shall function under the executive committee.

9.2 ASSIGNMENT TO SERVICE

The executive committee shall, after consideration of the recommendations of the clinical services, recommend initial service assignments for all medical staff members and for all other approved practitioners with clinical privileges.

ARTICLE X

COMMITTEES

10.1 DESIGNATION

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 executive committee to perform specified tasks. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the chief of staff, subject to consultation with and approval by the executive committee. Medical staff committees shall be responsible to the executive committee.

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 executive committee.

10.2-3 VACANCIES

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

10.3 EXECUTIVE COMMITTEE

10.3-1 COMPOSITION

The executive committee shall consist of the following persons:

(a) the officers of the medical staff; and

(b) the chiefs of services.

10.3-2 DUTIES

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

(a) seeking out views of the medical staff on all appropriate issues;

(b) conveying accurately to the board of directors the views of the medical staff on all issues, including those relating to safety and quality;

(c) 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;

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

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

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

(g) establishing the structure of the medical staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of quality assurance activities and mechanisms of the medical staff, termination of medical staff membership and fair hearing procedures, as well as other matters relevant to the operation of an organized medical staff;

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

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

(j) reviewing the qualifications, credentials, performance and professional competence and character of applicants and staff members and making recommendations to the board of directors regarding staff appointments and reappointments, clinical privileges, and corrective action;

(k) 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;

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

(m) 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;

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

(o) assisting in the obtaining and maintaining of accreditation;

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

(q) appointing such special or ad hoc committees as may seem necessary or appropriate to assist the executive committee in carrying out its functions and those of the medical staff;

(r) reviewing the quality and appropriateness of services provided by contract physicians;

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

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

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

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

(w) affirmatively implementing, enforcing and safeguarding the self-governance rights of the medical staff to the fullest extent permitted by law.

10.3-3 MEETINGS

The executive committee shall meet monthly, shall maintain permanent record of its findings, proceedings and actions and shall make a monthly report to the medical staff.

10.4 JOINT CONFERENCE COMMITTEE

10.4-1 COMPOSITION

The Joint Conference Committee shall be composed of an equal number of members of the board of directors and of the executive committee, but the medical staff members shall at least include the chief of staff, and the immediate past chief of staff. The administrator shall be a non-voting ex-officio member. The chair of the committee shall alternate yearly between the board of directors and the medical staff.

10.4-2 DUTIES

The Joint Conference Committee shall constitute a forum for the discussion of matters of hospital and medical staff policy, practice, and planning, and a forum for interaction between the board of directors and the medical staff on such matters as may be referred by the executive committee or the board of directors. The Joint Conference Committee shall exercise other responsibilities set forth in these bylaws.

(a) Accreditation: It shall be responsible for the acquisition and maintenance of the Centers for Medicare and Medicaid Services (CMS) Accreditation for which purpose it shall form a subcommittee that includes key hospital personnel who are important in implementing the accreditation program. From time to time, it shall require that accrediting organization survey forms be used as a review method to estimate the accreditation status of the hospital and it should supervise a trial survey during the interim between regular CMS accreditation surveys for purposes of constructive self-criticism. It shall identify areas of suspected non-compliance with CMS standards and shall make recommendations to the executive committees of the board of directors and of the medical staff for appropriate action.

(b) Disaster Planning: It shall be responsible for the development and maintenance of methods for the protection and care of hospital patients and others at the time of internal and external disaster. Specifically, it shall form subcommittees to:

(1) Adopt and periodically review a written plan to safeguard patients at the time of an internal disaster, particularly fire, and shall assure that all key personnel rehearse fire drills at least four (4) times a year.

(2) Adopt and periodically review a written plan for the care, reception and evacuation of mass casualties, and shall assure that such plan is coordinated with the inpatient and outpatient services of the hospital; that it adequately reflects developments in the hospital community and the anticipated role of the hospital in the event of disasters in nearby communities; and that the plan is rehearsed by key personnel at least twice yearly.

10.4-3 MEETINGS

The Joint Conference Committee shall meet quarterly and shall transmit written reports of its activities to the executive committee and to the board of directors.

10.5 QUALITY OF CARE COMMITTEE

10.5-1 COMPOSITION

The Quality of Care Committee shall consist of at least six (6) representatives from the medical staff including chiefs of service and pathologist. The chairman of the committee may appoint representatives from any of the hospital services he deems necessary to his committee, such as Medical Records representative, Nursing Service representative, Pharmacist, Utilization Review Coordinator, Infection Control Nurse, Nurse Epidemiologist. The chair may appoint any ad-hoc committee he or she feels necessary to include members of the medical staff and representatives from any of the hospital services.

The chair may also appoint subcommittees representing medicine, surgery, pediatrics, obstetrics and gynecology, emergency services, critical care, pharmacy and therapeutics, infection control and other clinical areas to assist the committee in performing its functions. Subcommittees will meet as necessary and report in writing to the Quality of Care Committee.

10.5-2 FUNCTIONS

It shall be responsible for staff functions relating to medical records, patient care evaluation, utilization review, pharmacy and therapeutics, infection control, transfusion review, tissue review, antibiotic review, intensive-coronary care, emergency services and other such functions as the executive committee shall from time to time assign to it.

(a) Medical Records/Patient Care Evaluation: The committee shall be responsible for assuring that all medical records meet the highest standards of patient care usefulness and of historic validity. The medical staff representatives shall be specifically responsible for assuring that the medical records reflect realistic documentation of medical events. The committee shall conduct a monthly review of currently maintained medical records to assure that they properly describe the condition and progress of the patient, the therapy provided, the results thereof, and the identification of responsibility for all actions taken, and that they are sufficiently complete at all times so as to allow good continuity of care in the event of transfer of physician responsibility of patient care. It shall also conduct a review of records of discharged patients to determine the promptness, pertinence, adequacy and completeness thereof. In addition, criteria for patient care evaluation studies shall be drawn up. The results of the audits shall be analyzed and recommendations for corrective action made. There shall be a review of all death cases.

(b) Utilization Review: The committee shall conduct utilization review studies designed to evaluate the appropriateness of admissions to the hospital, length of stay, discharge practices, use of medical and hospital services and all related factors which may contribute to the effective utilization of hospital and physician services. Specifically, it shall analyze how under-utilization and over-utilization of each of the hospital's services effects the quality of patient care provided at the hospital, shall study patterns of care and obtain criteria relating to average or normal (usual) lengths of stay by specific disease categories, and shall evaluate systems of utilization review employing such criteria. It shall also work toward the assurance of proper continuity of care upon discharge through, among other things, the accumulation of appropriate data on the availability of other suitable health care facilities and services outside the hospital. The committee shall communicate the results of its studies and other pertinent data to the entire medical staff and shall make recommendations for the optimum utilization of hospital resources and facilities commensurate with quality of patient care and safety. It shall also formulate a written utilization review plan for the hospital. Such a plan must be approved by the medical staff and board of directors.

(c) Pharmacy and Therapeutics: The committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the hospital in order to assure optimum clinical results and a minimum potential for hazard. The committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the hospital. It shall also perform the following specific functions:

(1) Serve as advisory group to the hospital medical staff and the Pharmacist on matters pertaining to the choice of available drugs.
(2) Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.
(3) Develop and review periodically, a formulary or drug list for use in the hospital.
(4) Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients.
(5) Evaluate clinical data concerning new drugs or preparations requested for use in the hospital.
(6) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

(d) Infection Control: The committee shall be responsible for the surveillance of inadvertent hospital infection potentials, the review and analysis of actual infections, the promotion of a preventive and corrective program

designed to minimize infection hazards, and the supervision of infection control in all phases of the hospital's activities including the following:

(1) operating rooms, delivery rooms, recovery rooms, special care units;
(2) sterilization procedures by heat, chemicals or otherwise;
(3) isolation procedures;
(4) prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment;
(5) testing of hospital personnel for carrier status;
(6) disposal of infectious material;
(7) other situations as requested by the executive committee.

(e) Tissue and Transfusion Review: The committee shall review surgical procedures to determine whether surgery was justified. Cases shall be reviewed where the preoperative and pathological diagnoses do not agree. This review shall include those procedures where no tissue was removed. The committee shall educate the staff in blood transfusion therapy; shall monitor laboratory procedures; shall investigate transfusion reactions and review records for proper usage of blood and blood derivatives.

(f) Intensive-Coronary Care: The committee shall educate the personnel assigned to the unit and monitor the use of the unit.

(g) Emergency Department Review: The committee shall monitor ER activities to assure high standards of patient care. There shall be a regular review of ER records and deaths occurring in the ER.

10.5-3 MEETINGS

The Quality of Care Committee shall meet monthly, shall maintain a permanent record of its findings, proceedings and actions and shall make a monthly report to the executive committee.

10.6 MEDICAL EDUCATION

10.6-1 COMPOSITION

The medical education committee shall consist of those members of the medical staff appointed by the chief of staff, and representatives from the hospital services as necessary.

10.6-2 DUTIES

(a) The committee shall be responsible for an analysis of the changing needs of the hospital's library service. These activities shall include elimination of outmoded material as well as the acquisition of new material.

(b) Presentation of an educational program at the medical staff meetings.

(c) Supervision of other medical education programs sponsored by the medical staff. This will include keeping records or subjects discussed and attendance.

10.6-3 MEETINGS

The medical education committee shall meet quarterly and provide written reports of its activities to the executive committee.

10.7 MEDICAL STAFF PHYSICIANS WELL-BEING COMMITTEE

10.7-1 COMPOSITION

The Medical Staff Physicians Well-Being Committee shall consist of no less than three medical staff members appointed by the chief of staff. Insofar as possible, members should not be active participants on other peer review or quality assurance committees.

10.7-2 DUTIES

(a) The committee may receive reports related to the health, well-being, or impairment of medical staff members and, as it deems appropriate, may investigate such reports. For matters involving individual medical staff members, the committee may provide such advice, counseling, or referrals as may seem appropriate. These activities shall be confidential; however, if information received by the committee clearly demonstrates that the health or known impairment of a medical staff member poses an unreasonable risk of harm to hospitalized patients, that information may be referred for corrective action.

(b) The committee may provide suggestions and advice to other appropriate committees or officers regarding reasonable safeguards concerning a physician's continued practice in the Hospital while undergoing treatment.

(c) The committee shall also consider general matters related to the health and well-being of the medical staff, including educational programs or related activities in coordination with other appropriate committees.

10.7-3 MEETINGS

The committee shall meet as often as necessary, but at least quarterly. It shall maintain such records of its proceedings, as it deems advisable, but shall report on its activities on a routine basis to the executive committee. Any records

regarding individual physicians shall be kept strictly confidential and maintained independently from the general records of the committee.

10.8 QUALITY OF CARE COMMITTEE – COMPREHENSIVE CARE CENTER (CCC)

10.8-1 COMPOSITION

The Quality of Care Committee-CCC shall consist of at least four (4) representatives from the medical staff including the Medical Director of the CCC, the Hospital Administrator, the Director of Patient Services, the Utilization Review Coordinator, the Infection Control Nurse, the CCC Pharmacist, the Dietary Supervisor, the Medical Records Supervisor, the Maintenance Supervisor, the Housekeeping Supervisor, and the Social Service Worker. The chair of the committee may appoint representatives from any of the hospital services he deems necessary to the committee. The Chairman may appoint any ad-hoc committee he feels necessary to include members of the medical staff and representatives from any of the hospital services.

10.8-2 FUNCTIONS

It shall be responsible for staff functions relating to medical records, patient care evaluation, utilization, pharmacy and therapeutics, infection control and other such functions as the executive committee shall from time to time assign to it.

(a) Medical Records/Patient Care Evaluation: The committee shall be responsible for assuring that all medical records meet the highest standards of patient care usefulness and of historic validity. The medical staff representatives shall be specifically responsible for assuring that the medical records reflect realistic documentation of medical events. The committee shall conduct periodic review of currently maintained medical records to assure that they properly describe the condition and progress of the patient, therapy provided, the results thereof, and the identification of responsibility for all actions taken, and that they are sufficiently complete at all times so as to allow good continuity of care in the event of transfer of physician responsibility of patient care. It shall also conduct a review of records of discharged patients to determine the promptness, pertinence, adequacy and completeness thereof. In addition, criteria for patient care evaluation studies shall be drawn up. The results of the audit shall be analyzed and recommendations for corrective action made. There shall be a review of all death cases.

(b) Utilization Review: The committee shall conduct utilization review studies designed to evaluate the appropriateness of admissions to the CCC, length of stay, discharge practices, use of medical and hospital services and all related factors which may contribute to the effective utilization of CCC and physician services. Specifically, it shall analyze how under-utilization and over-utilization of each of the CCC's services affects the quality of patient care provided at the CCC. It shall also work toward the

assurance of proper continuity of care upon discharge through, among other things, the accumulation of appropriate data on the availability of other suitable health care facilities and services outside the CCC. The committee shall communicate the results of its findings and other pertinent data to the entire medical staff and shall make recommendations for the optimum utilization of CCC resources and facilities commensurate with quality of patient care and safety. It shall also formulate a written utilization review plan for the CCC. Such a plan must be approved by the medical staff and board of directors.

(c) Pharmacy and Therapeutics: The committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the CCC in order to assure optimum clinical results and a minimum potential for hazard. The committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the CCC. It shall also perform the following specific functions:

(1) Serve as advisory group to the hospital medical staff and the pharmacist on matters pertaining to the choice of available drugs.
(2) Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.
(3) Evaluate clinical data concerning new drugs or preparations requested for use in the CCC.

(d) Infection Control: The committee shall be responsible for the surveillance of inadvertent CCC infection potentials, the review and analysis of actual infections, the promotion of a preventive and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the CCC activities including the following:

(1) Sterilization procedures by heat, chemicals or otherwise.
(2) Isolation procedures.
(3) Prevention of cross-infection by anesthesia apparatus or respiratory therapy equipment.
(4) Testing of CCC personnel for carrier status.
(5) Disposal of infectious material.
(6) Other situations as requested by the executive committee.

10.8-3 MEETINGS

The Quality of Care Committee shall meet monthly, shall maintain a permanent record of its findings, proceedings and actions and shall make a monthly report to the executive committee.

10.9 MEDICAL ETHICS COMMITTEE

10.9-1 COMPOSITION

The Medical Ethics Committee shall consist of physicians and such other staff members as the executive committee may deem appropriate. It may include nurses, lay representatives, social workers, clergy, ethicists, attorneys, administrators and representatives from the board of directors, although a majority shall be physician members of the medical staff.

10.9-2 DUTIES

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

10.9-3 MEETINGS

The committee shall meet as often as necessary at the call of its chair. It shall maintain a record of its activities and report to the executive committee.

ARTICLE XI

MEDICAL STAFF MEETINGS

11.1 MEETINGS

11.1-1 REGULAR MEETINGS

The executive committee shall, by standing resolution, designate the time and place for all regular staff meetings. Notice of the original resolution and any changes thereto shall be given to each member of the staff in the same manner as provided in Section 11.1-2 of this Article XI for notice of a special meeting. Staff meetings shall be held at least monthly to review and evaluate the medical performance of the staff, including the medical, surgical and obstetrical audit activities of the respective services and to consider and act upon committee reports.

11.1-2 SPECIAL MEETINGS

Special meetings of the medical staff may be called at any time by the chief of staff or the executive committee, or shall be called upon the written request of ten percent (10%) 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 executive committee within ten (10) days after receipt of such request. No later than seven (7) days prior to the meeting, notice shall be mailed or delivered to the members of the staff which includes the

stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

11.1-3 QUORUM

The presence of two-thirds of the total members of the active medical staff at any regular or special meeting in person or through written ballot shall constitute a quorum for the purpose of amending these bylaws or the rules and regulations of the medical staff or for the election or removal of medical staff officers. The presence of fifty percent (50%) of such members shall constitute a quorum for all other actions.

11.1-4 ATTENDANCE REQUIREMENTS

(a) Active staff and active office-based staff: In each year, each member of the active medical staff and active office-based staff shall be required to attend at least seventy-five percent (75%) of the regular staff meetings or to have attendances and excused absences totaling seventy-five percent (75%) of the regular staff meetings. A member who is compelled to be absent from any of the regular staff meetings shall promptly submit to the chief of staff, in writing, his reasons for this absence. Unless excused for cause by the executive committee, the failure to meet the foregoing annual attendance requirements shall be grounds for corrective action. The member will be required to donate $100.00 to the Medical Staff Library Fund for each subsequent unexcused absence. Failure to donate within two weeks after each absence will result in the loss of privileges for thirty (30) days.

(b) Other Categories: Members of other categories of the medical staff may attend, but not participate in the business meetings, and it is expected that they will attend and participate in the medical portion of the meetings, unless excused by the chief of staff.

(c) Special Attendance: A practitioner whose patient's clinical course is scheduled for discussion at a regular staff meeting shall be so notified and shall be expected to attend such meeting. If such practitioner is not otherwise required to attend the regular monthly staff meeting, the chief of staff shall so inform the administrator who shall give the practitioner advance written notice of the time and place of the meeting at which his attendance is expected. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the practitioner shall so state, shall be given by certified mail, return receipt requested, and shall include a statement that his attendance at the meeting at which the alleged deviation is to be discussed is mandatory. Failure by the practitioner to attend any meeting with respect to which he was given notice that attendance was mandatory, unless excused by the executive committee upon showing good cause, shall result in an automatic

suspension of all or such portion of the practitioner's clinical privileges as the executive committee may direct, and such suspension shall remain in effect until the matter is resolved through any mechanism that may be appropriate, including corrective action, if necessary. In all other cases, if the practitioner shall make a timely request for postponement supported by an adequate showing that his absence shall be unavoidable, such presentation may be postponed by the chief of staff, or the executive committee if the chief of staff is the practitioner involved, until not later than the next regular staff meeting; otherwise the pertinent clinical information shall be presented and discussed as scheduled.

11.1-5 AGENDA

(a) Call to order
(b) Program
(c) Minutes of the Previous Staff Meeting
(d) Committee Reports
(e) Unfinished Business
(f) New Business
(g) Administrative Report
(h) Communications
(i) Adjournment

ARTICLE XII

COMMITTEE AND SERVICE MEETINGS

12.1 REGULAR MEETINGS

Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

12.2 SPECIAL MEETINGS

A special meeting of any committee or service may be called by or at the request of the chair or chief thereof, by the chief of the medical staff, or by one-third of the group's then members, but not less than two.

12.3 NOTICE OF MEETINGS

Written or oral notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the committee or service not less than two (2) days before the time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his address as it appears on the records of the hospital with postage thereon prepaid.

The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

12.4 QUORUM

Fifty percent (50%), but not less than two (2), of the active medical staff members of a committee or service shall constitute a quorum at any meeting.

12.5 MANNER OF ACTION

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee or service. Action may be taken without a meeting by unanimous consent in writing signed by each member entitled to vote thereat.

12.6 MINUTES

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

12.7 ATTENDANCE REQUIREMENTS

Except as stated below, each member of the active and provisional staff, and all members of the temporary staff during the term of appointment who are entitled to attend meetings under Article III shall be required to attend at least seventy-five percent (75%) of all meetings of each service, division, and committee of which he or she is a member or to have attendances and excused absences totaling seventy-five percent (75%) of all meetings. A member who is compelled to be absent from any of the regular committee meetings shall promptly submit to the chief of staff, in writing, his reasons for this absence. Unless excused for cause by the executive committee, the failure to meet the foregoing annual attendance requirements shall be grounds for corrective action. He will be required to donate $100.00 to the Medical Staff Library Fund for each subsequent unexcused absence. Failure to donate within two weeks after each absence will result in the loss of privileges for thirty (30) days. Each member of the consulting or courtesy staff and members of the provisional staff who qualify under criteria applicable to courtesy or consulting members shall be required to attend such other meetings as may be determined by the executive committee.

12.8 SPECIAL ATTENDANCE

At the discretion of the chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular 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 with respect to which he was given such notice, unless excused by the executive committee upon a showing of good cause, shall be a basis for corrective action.

12.9 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.

12.10 EXECUTIVE SESSION

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

ARTICLE XIII

CONFIDENTIALITY, IMMUNITY AND RELEASES

13.1 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 acts in accordance with the provisions of this Article; and

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

13.2 CONFIDENTIALITY OF INFORMATION

13.2-1 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 committees established under Article X, and meetings of special or ad hoc committees created by the executive committee and including information regarding any member or applicant to this medical staff shall, to the fullest extent permitted by law, be confidential.

13.2-2 BREACH OF CONFIDENTIALITY

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

13.3 IMMUNITY FROM LIABILITY

13.3-1 FOR ACTION TAKEN

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

13.3-2 FOR PROVIDING INFORMATION

Each representative of the medical staff and hospital and all third parties shall be exempt, to the fullest extent permitted by law, from liability to 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.

13.4 ACTIVITIES AND INFORMATION COVERED

13.4-1 ACTIVITIES

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

(a) applications for appointment, reappointment, or clinical privileges;

(b) corrective action;

(c) hearings and appellate reviews;

(d) utilization reviews;

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

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

13.5 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.

13.6 INDEMNIFICATION

The hospital shall indemnify, defend and hold harmless the medical staff and its individual members from and against losses and expenses (including attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to negligent acts, errors, omissions 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 service, committee or hearing panel, (2) as a member of or witness for the hospital board or any hospital task force, group, or committee, or hearing panel, 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. Notwithstanding the foregoing, the hospital shall have no obligation to indemnify the medical staff or any medical member if the activities of the medical staff or member complained of occurred outside the formal peer review process. In addition, the hospital shall have no obligation to indemnify the medical staff or its individual members if the activities of the medical staff or member were not in good faith and were not without malice and were not in the best interests of the medical staff and hospital. The hospital shall have no obligation to reimburse a member or the medical staff for attorneys' fees or costs for legal counsel retained independently of counsel provided by the hospital or its insurance carrier. 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 (Lompoc Valley Medical Center's (Lompoc Healthcare District) liability carrier will act as the primary carrier) 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 XIV

GENERAL PROVISIONS

14.1 RULES AND REGULATIONS

Upon the request of (1) the executive committee, or the chief of staff after approval by the executive committee, or (2) upon timely written petition signed by at least 10% of the members of the medical staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of the Medical Staff rules, and regulations and p**o**licies. Such rules and regulations shall be limited to procedural details and processes implementing these bylaws and shall not affect the organizational structure of the medical staff to be self-governing. Such action shall be taken at a regular or special meeting of the medical staff, provided (1) written notice of the proposed change was sent to all members on or before the last regular or special meeting of the medical staff, and such changes were offered at such prior meeting and (2) notice of the next regular or special meeting at which action is to be taken included notice that a rules or regulations change would be considered. Both notices shall include the exact wording of the existing language of the rule(s) or regulation(s), if any, and the proposed change(s) and that there be a 30-day period for responding to submission of petitions.

Following adoption such rules, and regulations and policies shall become effective upon approval of the board of directors, which approval shall not be withheld unreasonably, or automatically after [60] days if no action is taken by the board of directors. In the latter event, the board of directors shall be deemed to have approved the rule(s), and regulation(s) and policy(s) adopted by the medical staff. Rules and regulations and policies shall be reviewed (and may be revised if necessary) every [2] years. Applicants and members of the medical staff shall be governed by such rules and regulations and policies as are properly initiated and adopted. If there is a conflict between the bylaws and the rules and regulations and policies, the bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the medical staff rules and regulations and policies.

14.2 DUES AND ASSESSMENTS

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

14.3 CONSTRUCTION OF TERMS AND HEADINGS

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

14.4 AUTHORITY TO ACT

Any member or members who act in the name of this medical staff without proper authority shall be subject to such disciplinary action as the executive committee may deem appropriate.

14.5 MEDICAL STAFF CREDENTIALS FILES

14.5-1 INSERTION OF ADVERSE INFORMATION

The following applies to actions relating to requests for insertion of adverse information into the medical staff member's credentials file:

(a) As stated previously, in Section 6.1-1, any person may provide information to the medical staff about the conduct, performance or competence of its members.

(b) When a request is made for insertion of adverse information into the medical staff member's credentials file, the respective chief of service and chief of staff shall review such a request.

(c) After such review a decision will be made by the respective chief of service and chief of staff to:
  (1) not insert the information;
  (2) notify the member of the adverse information by a written summary and offer him/her the opportunity to rebut this assertion before it is entered into his/her file; or
  (3) insert the information along with a notation that a request has been made to the executive committee for an investigation as outlined in Sections 6.1-2 of these bylaws.

(d) This decision shall be reported to the executive committee. The executive committee when so informed, may either ratify or initiate contrary actions to this decision by a majority vote, and provide notice to the member.

14.5-2 REVIEW OF ADVERSE INFORMATION AT THE TIME OF REAPPRAISAL AND REAPPOINTMENT

The following applies to the review of adverse information in the medical staff member's credentials file at the time of reappraisal and reappointment.

(a) Prior to recommendation on reappointment, the executive committee, as part of its reappraisal function, shall review any adverse information in the credentials file pertaining to a member.

(b) Following this review, the executive committee shall determine whether documentation in the file warrants further action.

(c) No later than sixty (60) days following final action on reappointment, the executive committee shall, except as provided in (e):
(1) initiate a request for corrective action, based on such adverse information or
(2) cause the substance of such adverse information to be summarized and disclosed to the member.

(d) The member shall have the right to respond thereto in writing, and the executive committee may elect to remove such adverse information on the basis of such response.

(e) In the event that adverse information is not utilized as the basis for a request for corrective action, or disclosed to the member as provided herein, it shall be removed from the file and discarded, unless the executive committee, by a majority vote, determines that such information is required for continuing evaluation of the member's:
(1) character;
(2) competence; or
(3) professional performance.

14.5-3 CONFIDENTIALITY

The following applies to records of the medical staff and its committees responsible for the evaluation and improvement of patient care:

(a) The records of the medical staff and its 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.

(c) Information which is disclosed to the board of directors of the hospital or its appointed representatives—-in order that the board of directors 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 chief of service.

(e) A medical staff member shall be granted access to his/her own credentials file, subject to the following provisions:
(1) timely notice of such shall be made by the member to the chief of staff or his/her 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, within a reasonable period of time, as determined by 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.

14.5-4 MEMBER'S OPPORTUNITY TO REQUEST CORRECTION/DELETION OF AND TO MAKE ADDITION TO INFORMATION IN FILE

(a) When a member has reviewed his/her file as provided under Section 14.5-3(e) he/she may address to the chief of staff a written request for correction or deletion of information in his/her credentials file. Such request shall include a statement of the basis for the action requested.

(b) The chief of staff shall review such a request within a reasonable time and shall recommend to the executive committee, after such review, whether or not to make the correction or deletion requested. The executive committee, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote.

(c) The member shall be notified promptly, in writing, of the decision of the executive committee.

(d) In any case, a member shall have the right to add to his/her own credentials file, upon written request to the executive committee, a statement responding to any information contained in the file.

14.6 RETALIATION PROHIBITED

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

(b) The medical staff recognizes and embraces that it is the public policy of the State of California that a physician and surgeon be encouraged to advocate for medically appropriate health care for their patients. To advocate for medically appropriate health care includes, but is not limited to, the ability of a physician to protest a decision, policy, or practice that the physician, consistent with that degree of learning and skill ordinarily possessed by reputable physicians practicing according to the applicable legal standard of care, reasonably believes impairs the physician's ability to provide medically appropriate health care to their patients. No person, including but not limited to the medical staff, the hospital, its employees, agents, directors or owners, shall retaliate against or penalize any member for such advocacy or prohibit, restrict or in any way discourage such advocacy, nor shall any person prohibit, restrict, or in any way discourage a member from communicating to a patient information in furtherance of medically appropriate health care.

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

14.7 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

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

(a) the decision to execute an exclusive contract in a previously open 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 service.

ARTICLE XV

ADOPTION AND AMENDMENT OF THE BYLAWS

15.1 PROCEDURE

Upon the request of the chief of staff, the executive committee, the ad hoc bylaws committee, or upon timely written petition signed by at least 10% of the members of the medical staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these bylaws.

Such action shall be taken at a regular or special meeting provided (1) written notice of the proposed change was sent to all members on or before the last regular or special meeting of the medical staff, and such changes were offered at such prior meeting, and (2) notice of the next regular or special meeting at which action is to be taken included notice that a bylaw change would be considered. Both notices shall include the exact wording of the existing bylaw language, if any, and the proposed changes.

15.2 ACTION ON BYLAW CHANGE

If a quorum is present for the purpose of enacting a bylaw change, the change shall require an affirmative vote of two-thirds of the members voting in person or by written ballot.

15.3 APPROVAL

Bylaw changes adopted by the medical staff shall become effective following the approval by the board of directors, which approval shall not be withheld unreasonably, or automatically within sixty (60) days of receipt by the board if no action is taken by the board of directors.

15.4 EXCLUSIVITY

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the medical staff bylaws.

15.5 REVIEW OF BYLAWS

The medical staff shall biennially review these bylaws.

15.6 SUCCESSOR IN INTEREST/AFFILIATIONS

15.6-1 SUCCESSOR IN INTEREST

These bylaws, and privileges of individual members of the medical staff accorded under these bylaws, will be binding upon the medical staff, and the board of directors of any successor in interest in this hospital, except where hospital medical staffs are being combined. In the event that the staffs are being combined, the medical staffs shall work together to develop new bylaws, which will govern the combined medical staffs, subject to the approval of the hospital's

board of directors or its successor in interest. Until such time as the new bylaws are approved, the existing bylaws of each institution will remain in effect.

15.6-2 AFFILIATIONS

Affiliations between the hospital and other hospitals, health care systems or other entities shall not, in and of themselves, affect these bylaws.

ARTICLE XVI

MEDICAL EXECUTIVE COMMITTEE – MEDICAL STAFF CONFLICT MANAGEMENT

16.1 CONFLICT MANAGEMENT PROCESS

Upon the receipt of a written petition signed by at least 10% of the members of the medical staff in good standing who are entitled to vote, specifying issues in which there is disagreement between the petitioners and the medical staff leadership, the executive committee shall provide written notice of the petition to all members within ten (10) days. The notice shall include the exact wording of the petition.

16.1-1 CONFLICT MANAGEMENT COMMITTEE

A conflict management committee shall be formed within fifteen (15) days of written notification of the petition to all medical staff members. The committee shall be composed of at least six (6) people, comprised of equal numbers of members of the executive committee and petitioners. A quorum shall consist of at least 50% of the committee members from each side. The chair of the committee shall alternate every other meeting between the executive committee and the petitioners.

16.1-2 DUTIES

The conflict management committee shall discuss and resolve conflicts between the medical staff and the executive committee related to medical staff policy, practice, and planning. The committee shall gather information concerning the dispute and shall meet and confer in good faith, as early as possible, to resolve such disputes. The committee will implement a process for dispute resolution as follows:

(a) Identify the conflict.

(b) Identify the stakeholders.

(c) Receive statements, ask questions and gather information to better understand the conflict facts from the perspective of all stakeholders.

(d) Prioritize issues.

(e) Produce a written summary of what was accomplished during the conflict management session. The summary could include facts, definition or clarification of issues, agreement on options for resolution, agreement to meet again, and delineation of the barriers to reaching resolution. The summary shall be made available to all stakeholders, and stakeholders shall have reasonable opportunity to respond to the summary in a timely fashion.

(f) File a report of the outcome with the medical staff office for review by members of the medical staff. The report will document:
(1) the use of the conflict management process, and
(2) the recommendation of the committee as to how the conflict should be managed.

(g) Any decision by the conflict management committee requires approval by 50% or more of both the petitioners on the conflict management committee and the representatives of the executive committee on the conflict management committee.

(h) The conflict management committee shall submit recommendations to the executive committee for ratification, which shall not be unreasonably withheld.

16.1-3 MEDICAL STAFF MEETING

If the committee is not able to resolve the conflict within forty-five (45) days of written notice to members of the medical staff or if the executive committee does not approve the recommendations from the conflict management committee, action as defined below shall be taken at a regular or special meeting of the medical staff. Medical staff members shall receive:

(a) a written summary of what was accomplished during the conflict management session; and

(b) notice of the next regular or special meeting at which the issue is to be discussed and action is to be taken. The purpose of the meeting shall be to either override the executive committee's rejection or to formulate and approve an alternative proposal. The change shall require an affirmative vote of greater than 50% of the members voting.