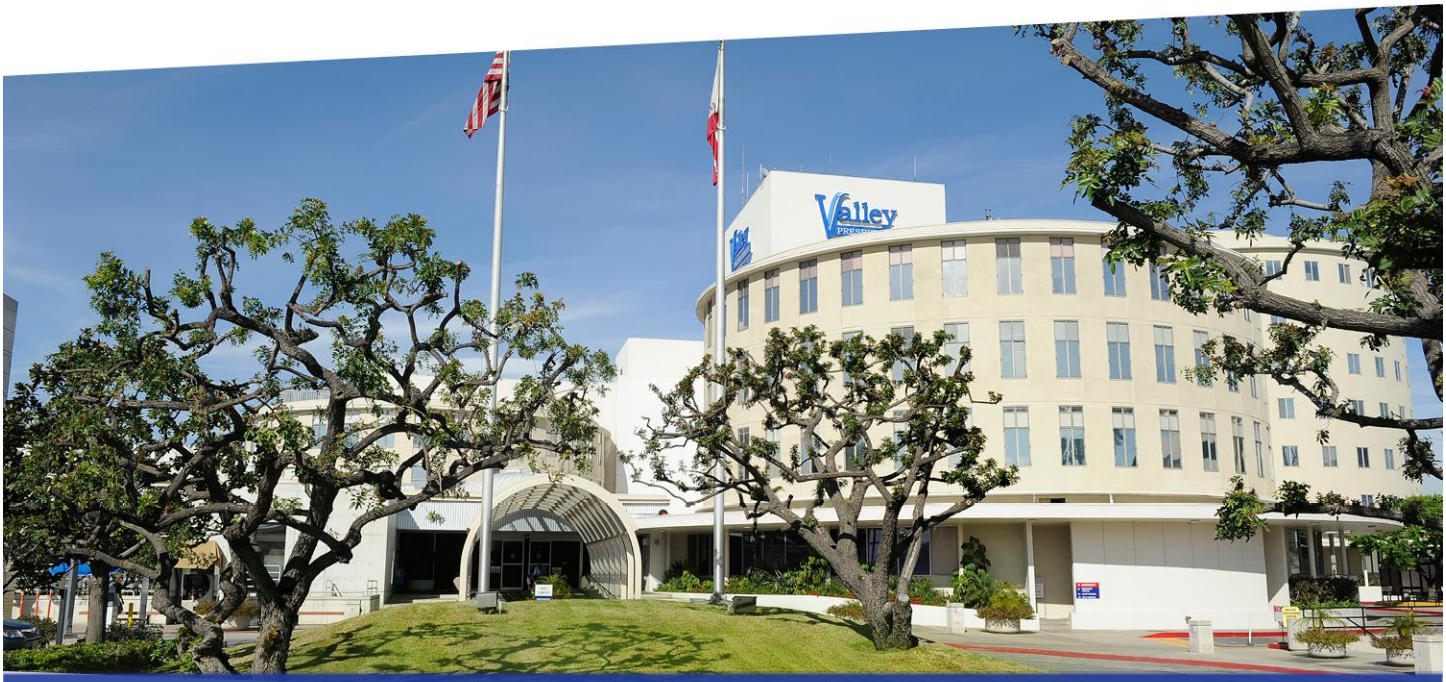
VALLEY PRESBYTERIAN HOSPITAL



Medical Staff **Bylaws** 2022

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Preamble

These Bylaws are adopted in recognition of the mutual accountability, interdependence and responsibility of the Valley Presbyterian Hospital Medical Staff and the Hospital's Board of Directors protecting the quality of medical care provided in the Hospital and overseeing the competency of Medical Staff members. These Bylaws provide a framework for self-governance to assure an organization of that Medical Staff which permits it to discharge its responsibilities in matters involving the quality of medical care; to govern the orderly resolution of Medical Staff related issues and the conduct of Medical Staff functions supportive of those purposes; and, to account to the Board of Directors for an effective performance of such responsibilities.

Accordingly, these Bylaws address the Medical Staff's responsibility to establish criteria and standards for Medical Staff membership and clinical privileges, and to enforce such criteria and standards. Further, these Bylaws establish clinical criteria and standards to oversee and manage quality improvement, utilization review and other Medical Staff activities, including, but not limited to periodic meetings of the Medical Staff, Medical Staff committees and clinical departments and divisions and the review and analysis of patient medical records. These Bylaws describe the standards and procedures for selecting and removing Medical Staff Officers, and these Bylaws address the respective rights and responsibilities of the Medical Staff itself and the Board of Directors.

Finally, notwithstanding the provisions of these Bylaws, the Medical Staff acknowledges that the Board of Directors must act to protect the quality of medical care provided in the Hospital and the clinical competency of the Medical Staff providing such care; and, to oversee the responsible governance of the Medical Staff. In adopting these Bylaws, the Medical Staff commits to exercising its responsibilities with diligence and in good faith. By its approval of these Bylaws, the Board of Directors commits to allowing the Medical Staff reasonable independence in conducting the affairs of the Medical Staff. Accordingly, the Board of Directors will not assume a duty or responsibility of the Medical Staff precipitously, unreasonably or in bad faith, and will do so only in the reasonable and good faith belief that the Medical Staff has failed to fulfill a substantive duty or responsibility in matters pertaining to the quality of patient care.

Definitions

1. "**Administrator**" or "**President**" or "**Chief Executive Officer**" or "**Administration**" means the person appointed by the Board of Directors to serve in an administrative capacity for the Hospital, or his or her designee. He or she will act on behalf of the Board of Directors in the overall management of the Hospital.

2. "**Advanced Practice Professional**" or "**APP**" means a health care professional other than a physician, dentist, or podiatrist, whose license or other legal credential permits the professional to provide health care services at a medical level of care, whether independently or under the supervision or order of a physician, podiatrist, or dentist. APPs are ineligible for Medical Staff membership but are eligible for privileges established through practice prerogatives or as otherwise established in these Bylaws.

3. "**Advanced Practice Professional Staff**" or "**APP Staff**" means the organization of those Advanced Practice practitioners.

4. "**Authorized Representative**" or "**Hospital's Authorized Representative**" means the individual designated by the Hospital and approved by the Medical Executive Committee to provide information to and request information from the National Practitioner Data Bank according to terms of these Bylaws.

5. "**Board of Directors**" means the governing body of the Hospital.

6. "**Chief Medical Officer**" or "**CMO**" means an MD or DO who is part of the VPH Administrative Executive Team designated to serve as a liaison between the Medical Staff and Administration.

7. "**Chief of Staff**" means the chief Officer of the Medical Staff elected by members of the Medical Staff.

8. "**Clinical Privileges**" or "**Privileges**" means the permission granted by the Valley Presbyterian Hospital Board of Directors to practitioners to independently provide patient care services. All privileges are limited as appropriate by licensure and legal restrictions on the practitioner's scope of practice.

9. "**Conflict of Interest**" means a person or financial interest or conflicting fiduciary obligation on the part of the individual or immediate family member of that individual; (including a spouse, domestic partner, child, or parent) that may negatively impact, as a practical matter, the individual's ability to act in a fiduciary role, without regard to the individual's private or personal interest, or creates the impression of such conflict.

10. "**Dependent Practitioner**" means an appropriately licensed or certified health care practitioner whose licensure or certification does not permit, and/or the Hospital does not authorize, the independent exercise of practice privileges. Dependent Practitioners may only provide patient care services pursuant to approved practice prerogatives or as otherwise established in these Bylaws. Dependent Practitioners may be eligible to become members of the Advanced Practice Professional Staff at the Hospital.

11. "**Federal Health Care Program**" means any plan or program that provides health benefits whether directly, through insurance or otherwise, which is funded directly or in part by the United States government or a state health program (with the exception of the Federal Employees Health Benefits program). Federal health care programs include but are not limited to Medicare, Medicaid, Blue Cross Federal Employees Program (FEP) / Tricare / CHAMPUS, and the veterans' programs.

12. "**Hospital**" means Valley Presbyterian Hospital (VPH).

13. "**Ineligible Person**" means any person who is currently excluded, suspended, debarred, or ineligible to participate in any federal health care program, or is currently charged with or has been convicted of a criminal offense related to the provision of health care items or services, or has not been reinstated in a federal health care program after a period of exclusion, suspension, debarment, or ineligibility.

14. "**Investigation**" means the formal process initiated by the Medical Executive Committee or Board of Directors, as set forth in Article VII of these Bylaws. To constitute an investigation, this process generally must be the precursor to a decision regarding whether or not to take corrective action, and is ongoing until either formal action is taken, or the investigation is closed. Except as otherwise provided in these Bylaws, only the Medical Executive Committee or Board of Directors may take or recommend corrective action as the result of an investigation.

15. "**Licensed Independent Practitioner**" means any individual permitted by law and by the Medical Staff and Board of Directors to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

16. "**Limited Licensed Practitioner**" means dentists and podiatrists eligible for Medical Staff membership, whose licensure or certification permits, and the Hospital authorizes, the independent provision of patient care services without direction or supervision and within the scope of individual delineated clinical privileges.

17. "**Medical Executive Committee**" or **"MEC"** means the committee of the Medical Staff that shall constitute the governing body of the Medical Staff as described in these Bylaws.

18. "**Medical Staff**" means the organization of those allopathic physicians, osteopathic physicians, dentists, and podiatrists who have been granted recognition as members of the Medical Staff pursuant to the terms of these Bylaws.

19. "**Medical Staff Year**" means the period from January 1 through December 31 of a calendar year.

20. "**Member**" unless otherwise expressly limited, means any physician, dentist, or podiatrist holding a current license to practice within the scope of his or her licensure who is a member of the Medical Staff.

21. "**Notice**" means a written communication (1) sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the Medical Staff or the Hospital, (2) sent by an electronic means approved by the Medical Executive Committee as an appropriate means of communication, including email, or (3) by any manner identified in the Special Notice definition.

22. "**Organized Medical Staff**" means the governance structure of the Medical Staff, including these Medical Staff Bylaws, Rules and Regulations, and policy and procedure to which the Medical Staff is subject. This structure is approved by the Board of Directors.

23. "**Patient Care Activity**" means any provision of medical care by a practitioner to a patient at the Hospital, including but not limited to, admission, consultation, surgical or other procedure, and care management, performed in any facility included on the Hospital's license or provided through a Telemedicine link. The provision of medical care to a patient during a discrete admission at the Hospital is one patient care activity, regardless of the extent of medical care provided during that admission.

24. "**Performance Improvement**" means the continuous study and adaption of the Hospital and Medical Staff functions and processes to increase the probability of achieving desired outcomes.

25. "**Physician**" means an individual with an MD or DO degree or the equivalent degree (i.e., foreign) as recognized by the Medical Board of California (MBC) or the California Board of Osteopathic Examiners (BOE) who is licensed by either the MBC or BOE.

26 "**Policies and Procedures**" means those documents approved as Medical Staff policies in accordance with these Bylaws.

27. "**Practice Prerogatives**" means the patient care activities that a Dependent Practitioner has been authorized to perform.

28. "**Practitioner**" unless otherwise qualified, means both Licensed Independent Practitioners and Dependent Practitioners.

29. "**Rules and Regulations**" or "**Rules**" means the Medical Staff Rules and Regulations adopted in accordance with these Bylaws unless otherwise specified.

30. "**Special Notice**" means a notice sent by (1) certified or registered mail, return receipt requested, (2) via a courier delivery service that documents delivery (such as, but not limited to, FedEx or UPS), or (3) hand-delivery, with a signed receipt (or, if there is a refusal to sign, documentation that it was delivered).

31. "**Telehealth**" is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.

32. "**Telemedicine**" means that subset of Telehealth services delivered to Hospital patients by Practitioners.

33. "**Telemedicine Provider**" means a Practitioner who has been granted privileges by this Hospital to provide services only via Telehealth modalities.

Article I Name and Function

1.1 The name of the organization shall be the Medical Staff of Valley Presbyterian Hospital.

1.2 The Medical Staff is responsible for the establishment and maintenance of patient care standards, including participation in the development of hospital-wide policy involving the oversight of care, treatment, and services provided by members and others in the hospital. The Medical Staff also bears responsibility for oversight regarding the treatment and services delivered by practitioners credentialed and privileged through the mechanisms described in these Bylaws and the functions of credentialing and peer review. These Bylaws are not intended to, and do not, create any professional legal duties between, on the one hand, the Medical Staff (including, without limitation, its departments, divisions, committees, and the individual Medical Staff members) and, on the other hand, patients being treated at the hospital, on the sole basis of any Medical Staff functions reviewing the quality of care at the hospital. These Bylaws also are not intended to affect the physician-patient relationships at the hospital under existing applicable laws.

1.3 The Medical Staff is determined to exercise its rights and responsibilities in a manner that does not jeopardize the Hospital's license, Medicare and Medi-Cal status, accreditation, or tax-exempt status.

Article II Membership

2.1 Nature of Membership

A. No physician, dentist, or podiatrist, including those in a medical administrative position by virtue of a contract with the Hospital, shall admit or provide medical or health-related services to patients in the Hospital unless the physician is a member of the Medical Staff or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws. Medical Staff membership shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws. These Bylaws establish the exclusive means for the granting, revoking, restricting, or modifying of Medical Staff membership and privileges at the Hospital. A Medical Staff member is neither an employee nor an independent contractor of the Hospital, unless such a relationship is separately established between the Hospital and such Medical Staff member.

B. Clinical Privileges

1. Clinical privileges, described in Article V, shall be granted, revoked or otherwise restricted or modified as designated by the Board of Directors based on professional training, experience and current competence criteria as set forth in these Bylaws.

2.2 Qualifications for Membership

A. Membership, like clinical privileges, shall be granted, revoked, or otherwise restricted or modified as designated by the Board of Directors based on professional training, experience and current competence criteria as set forth in these Bylaws.

B. General Qualifications

1. Only those physicians and Limited Licensed Practitioners shall be deemed to possess basic qualifications for membership in the Medical Staff, except for the Honorary Staff category in which case these criteria shall only apply as deemed individually applicable by the Medical Staff, who:

a. Document their current licensure, adequate experience, education and training, current professional competence in the exercise of the privileges which they seek, demonstrate good judgment and current adequate physical and mental health status related to the privileges requested, and pass a background check, so as to demonstrate to the satisfaction of the Medical Staff and Board of Directors that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;

b. Except for the Honorary, Administrative and Community Affiliate Staff categories, meet the criteria for membership in at least one department and hold clinical privileges in at least one department of the Medical Staff;

c. Are determined:

    1. To adhere to the ethics of their profession;

    2. To work cooperatively with others so as not to adversely affect patient care;

    3. To keep as confidential, as required by law, all information or records received through the physician-patient relationship;

    4. To be willing to participate in and properly discharge responsibilities as determined by the Medical Staff;

    5. To be willing to keep confidential and discuss only within established Medical Staff clinical department, division and/or committee proceedings all Medical Staff activities related to quality improvement and peer review activities;

    6. To meet all other qualifications and requirements for Medical Staff membership and clinical privileges;

    7. To not have been convicted of or be currently charged with a felony or misdemeanor involving (a) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (b) controlled substances; (c) homicide or felony assault; (d) sexual assault, battery, or rape; (e) child pornography; (f) moral turpitude; or (g) child, dependent adult, or elder abuse. Exceptions to this rule may be considered by the Medical Executive Committee on a case-by-case basis with regard to currently charged felonies and misdemeanors with approval from the Board of Directors, but not convictions. Any such exceptions made under this clause may be subject to a monitoring or performance agreement which will be signed by the individual.

d. Maintain in force individual professional liability insurance covering the exercise of all requested clinical privileges, in not less than the amounts specified in the Rules and Regulations or Policies and Procedures. Limits of coverage may not be shared between individuals. Professional liability insurance must be held with an insurance carrier approved by the California State Insurance Commissioner to conduct business in the State of California, or the practitioner may demonstrate membership in a physician’s cooperative as defined in Section 1280.7 of the California Insurance Code.

    1. The Medical Executive Committee may waive the above requirements for members who qualify for coverage under the Federal Tort Claims Act by virtue of employment or contract with a Federally Qualified Health Center (FQHC) or

other entity able to present a Notice of Deeming Action from the Health Resources and Services Administration. In order to qualify for such a waiver, the member or applicant thereto must utilize the Hospital only for the care of patients within the scope of such employment or contract.

2. Each member of the Medical Staff or applicant thereto shall certify in writing at the time of application, and provide ongoing documentation as required by the Medical Executive Committee, that he or she possesses professional liability insurance in the amount and type designated in this Section, that the policy contains an agreement by which the policy or coverage shall not be cancelled, reduced or modified without at least 15 days' advance written notice to the Hospital, which agreement shall also cover any cancellation for nonpayment of insurance premium; and that such professional liability insurance includes either prior acts (nose coverage) or an extended reporting enhancement (tail coverage) if the insurance carrier has changed during their prior appointment period. Such certification shall include the name of the carrier, the period of coverage, assurance that the coverage can be reduced or canceled only after notification to the Hospital and, if requested by the Medical Executive Committee, a certified or photocopy of the face sheet of his or her policy evidencing such coverage or the entire policy if requested. The applicant shall execute the appropriate releases with the insurer to transmit such information to the Hospital;

e. Except for the Honorary or Community Affiliate Staff categories, are eligible to participate in federal health care programs. The practitioner may not currently be an Ineligible Person and shall not become an Ineligible Person during any term of membership.

f. Except for Pathologists, Telemedicine Providers in the Division of Radiology, Radiologists applying for privileges for diagnostic testing only, and applicants to the Community Affiliate and Honorary Staff, hold current DEA registration which includes Schedules 2, 2N, 3, 3N, 4, and 5.

2. Practitioners who meet the above-noted criteria shall be deemed to possess basic qualifications for membership on the Medical Staff. If it is determined during the processing that a practitioner does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic qualifications is not entitled to any Hearing and appeal rights under these Bylaws. Insofar as is consistent with applicable laws, the Board of Directors has the discretion to deem a practitioner to have satisfied a qualification, after consulting with the Medical Executive Committee, if it determines that the practitioner has demonstrated substantially comparable qualifications and that the waiver is necessary to serve the best interests of the patients and of the Hospital. However, there is no obligation to grant any such waiver, and practitioners have no right to have a waiver considered and/or granted. A practitioner who is denied a waiver or consideration of a waiver shall not be entitled to any Hearing and appeal rights under these Bylaws.

C. Specific Qualifications

1. Physicians

a. An applicant for physician membership on the Medical Staff, except for the Honorary Staff, must hold an MD or DO degree or their equivalent and a valid and unsuspended certificate to practice medicine issued by the Medical Board of California or the California Board of Osteopathic Examiners. For the purpose of this

Section “their equivalent” shall mean any degree (i.e., foreign) recognized by the Medical Board of California or the California Board of Osteopathic Examiners.

2. Limited License Practitioners

a. Dentists

1. An applicant for dental membership on the Medical Staff, except for the Honorary Staff, must hold a DDS equivalent degree and a valid and unsuspended certificate to practice dentistry issued by the California Board of Dental Examiners.

b. Podiatrists

1. An applicant for podiatric membership on the Medical Staff, except for the Honorary Staff, must hold a DPM degree and a valid and unsuspended certificate to practice podiatry issued by the Medical Board of California.

2.3 Effect of Other Affiliations

A. No person shall be entitled to membership on the VPH Medical Staff; to assignment to a particular Medical Staff category, or to exercise any clinical privileges merely because that person:

1. Holds a certain degree;

2. Is licensed to practice medicine in California or any other state, or;

3. Is a member of any particular professional organization, or;

4. Is certified by any particular medical specialty board, or;

5. Had, or presently has, medical staff membership or clinical privileges at any healthcare facility, or;

6. Requires a hospital affiliation in order to participate on healthcare plan provider panels, to obtain malpractice insurance coverage, or to pursue other professional or personal business interests unrelated to the treatment of patients at Valley Presbyterian Hospital.

2.4 Non-Discrimination

A. Medical Staff membership and/or clinical privileges shall not be denied on the basis of sex, gender identity, gender expression, age, religion, race, creed, color, national origin, sexual orientation, genetic information, military or veteran status, political affiliations or activities, marital status, or any other legally-protected status. Medical Staff membership and/or clinical privileges shall not be denied on the basis of any physical or mental condition or disability if the applicant meets the standards set forth in these Bylaws with or without reasonable accommodation.

2.5 Contractors / Subcontractors with Clinical Privileges

A. A practitioner with whom the Hospital contracts to provide services which involve clinical duties or privileges must be a member of the Medical Staff, achieving his or her status by the procedures described in these Bylaws. If a written contract is in place with the Hospital, unless otherwise required by law, those privileges made exclusive pursuant to a closed-staff agreement will automatically terminate, without the right of access to the review, Hearing, and Appeal

procedures of the Bylaws in Article VIII, upon termination of such practitioner's contract or agreement with the Hospital, or the provider's termination of employment or contract with the group contracted with the Hospital. The rights of individual physicians whose privileges are so affected are further detailed in Section 13.11.

2.6 General Responsibilities of Medical Staff Membership

A. Medical Staff members will act in a manner that supports the responsibilities of the Medical Staff, and will cooperate with the Organized Medical Staff leadership in performing its necessary functions. Medical Staff members will refrain from acting in a manner that jeopardizes the Hospital's license, Medicare and Medi-Cal status, accreditation, or tax-exempt status.

B. Except for the Honorary Staff, each member of the Medical Staff shall:

1. Provide patients with care meeting the professional standards of the Medical Staff of this Hospital;

2. Abide by the Medical Staff Bylaws, Rules and Regulations, Policies and Procedures, and Hospital administrative policies;

3. Discharge in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments;

4. Prepare and complete in a timely fashion medical and other required documentation for all the patients to whom the member provides care in the Hospital as provided for in the Medical Staff Bylaws and Rules;

5. Abide by the lawful, ethical principles of the member's profession as well as federal and state regulations and requirements and the applicable standards of Det Norske Veritas;

6. Actively participate in and regularly cooperate with the Medical Staff in assisting the Hospital to fulfill its obligations related to patient care, including, but not limited to, continuous organization-wide quality measurement, assessment and improvement, utilization management, quality evaluation, peer review, ongoing and focused professional practice evaluations (OPPE / FPPE), and related monitoring activities required of the Medical Staff;

7. Refrain from any unlawful harassment or discrimination against any person (including any patient, Hospital employee, Hospital independent contractor, Medical Staff member, volunteer, or visitor) based upon the person's age, sex, religion, race, creed, color, gender identity, sexual orientation, ancestry, national origin, disability, medical condition, genetic information, marital status, citizenship, immigration status, primary language, ability to pay, or source of payment;

8. Except for the Community Affiliate and Administrative Staff, provide continuous care of his or her patients, make appropriate arrangements for coverage when not available, and refrain from delegating responsibility for the diagnosis or care of Hospital patients to any practitioner who lacks the qualifications or privileges to undertake such responsibility. This includes coverage for the member's patients who may come to the Hospital for emergency services. Initial applicants shall provide the name(s) of appropriate back-up physician(s) on the application form and agree to alert applicable patient floors and departments and the Medical Staff Services Department if coverage changes.

9. Abide by all applicable requirements for appropriately informing patients and obtaining consent as further described in the Hospital's Informed Consent policy;

10. Refrain from unlawful fee-splitting or in improper inducements for patient referral;

11. Complete continuing medical education that meets all licensing requirements, the Medical Staff Bylaws and Rules and Regulations, and is appropriate to the practitioner's specialty;

12. Fulfill the responsibilities and assignments applicable for emergency service coverage and consultation obligations as may be required by the Medical Executive Committee;

13. Communicate with the appropriate clinical department chairperson and/or the Chief of Staff when the Medical Staff member obtains credible information indicating that a fellow Medical Staff member may have engaged in unprofessional or unethical conduct or may have a heath condition which poses a significant risk to the well-being or care of patients and then cooperate as reasonably necessary toward the appropriate resolution of any such matter.

14. Discharge such other staff obligations as may be lawfully established from time to time by the Medical Staff and/or Medical Executive Committee;

15. Provide information to and/or testify on behalf of the Medical Staff or an accused practitioner regarding any matter under an investigation pursuant to Article VII or which is the subject of a Hearing pursuant to Article VII;

16. Execute such releases and authorizations as necessary to acknowledge and give effect to provisions of these Medical Staff Bylaws, including those relating to release and immunity from civil liability;

17. Serve as a proctor or other peer reviewer, and otherwise participate in Medical Staff peer review as reasonably requested;

18. Work cooperatively with Medical Staff members, nurses, Hospital administration, and others so as not to adversely affect patient care;

19. Adhere to the Medical Staff Standards of Conduct as described in these Bylaws so as not to adversely affect patient care or Hospital operations;

20. Cooperate with the Medical Staff in assisting the Hospital to meet its uncompensated or partially compensated patient care obligations;

21. Comply with any rules relating to any training program for health care practitioners and professionals that the Hospital may sponsor or participate in, including Residency programs;

22. Respond within 14 business days to all notices or requests made by a peer review body of the Medical Staff in adherence to such provisions of the Rules governing such matters and abide by the consequences of failing to do so. Such requests may include requests for information, clarification of information or a request for personal appearance by the practitioner at a specific peer review meeting;

23. Comply with the policies and rules of the Hospital and the Rules and Regulations of the Medical Staff regarding the confidentiality of medical records and other patient health information;

24. Within five calendar days of such notification or action as described below will notify the Medical Staff Services Department Director in writing of:

    a. The initiation of formal proceedings by a medical licensing authority or the DEA to suspend, revoke, restrict or place on probation a license or DEA certificate;

    b. An action by the medical executive committee or the governing body of another hospital or health care entity to suspend, revoke, restrict, or deny clinical privileges for reasons related to professional competence or conduct;

    c. Development of any mental or physical condition or other such personal health situation that may significantly compromise the Medical Staff member's ability to perform the functions associated with his or her clinical privileges in a safe and effective manner.

    d. Member's non-voluntary exclusion from participation in Medicare, Medi-Cal, or any federal health care program;

    e. Any formal allegations of fraud or abuse or illegal activity relating to a member's professional practice or conduct made by any state or federal government agency;

    f. Any felony or misdemeanor charges from a law enforcement agency;

    g. Any report filed with any state licensing board or the National Practitioner Data Bank;

    h. Notice of any adverse action taken or pending by any state licensing board;

    i. Any actual or proposed reductions, restrictions, cancellation, or termination of the required professional liability coverage, or change in insurance carrier;

    j. Any other action that could affect the member's Medical Staff standing and/or clinical privileges at the Hospital.

25. Continuously meet the qualifications for membership as set forth in these Bylaws. A member may be required to demonstrate continuing satisfaction of any of the requirements of these Bylaws upon the reasonable request of the Medical Executive Committee or a clinical department or Medical Staff committee, which may include submission to a medical or mental health examination;

26. Provide the Medical Staff Services Department with a complete and current mailing address, cell phone number, and email address, keep each of these items current and updated with changes as they occur; and accept certified mail from the Medical Staff. Members are responsible for accepting communications by these methods and for ensuring that the information sent by such means is personally receivable, and;

27. All newly appointed physicians must be oriented by their Department Chairperson, or designee, per Policies and Procedures, Rules and Regulations and these Bylaws. All newly appointed physicians who have not completed such an orientation within the required timeframe will have clinical privileges automatically suspended until such time as orientation has been completed.

C. Failure of a member to demonstrate behavior as described above in this Section may result in corrective action by the Medical Staff, which may include, but is not limited to, disciplinary action described in Article VII.

2.7 Members' Conduct Requirements

A. 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, the Rules and Regulations and those Policies and Procedures that directly address the conduct of Medical staff Members, no other codes or policy restricting or defining conduct apply to the Medical Staff and its members. Acceptable and unacceptable (unprofessional and/or inappropriate) conduct is further explained in those documents. Any form of disruptive behavior that harms or intimidates others to the extent that quality of care or patient safety could be compromised, or any other form of unprofessional conduct reasonably deemed to be disruptive or negatively impactful to patient care and Hospital operations is considered unacceptable conduct. Examples of unacceptable conduct include but are not limited to:

1. Harassment by a Medical Staff member against any individual involved with the Hospital on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, or sexual orientation;

2. Sexual Harassment

3. Deliberate physical, visual, or verbal intimidation or challenge

4. Carrying a gun or other weapon in the Hospital;

5. Refusal or failure to comply with these member conduct requirements.

B. Medical Staff Conduct Complaints

1. Complaints regarding the conduct of Medical Staff members will be handled as described in the Rules and Regulations or in Policies and Procedures. Reports and complaints of this type will be tracked through the Medical Staff Services Department and reported to the Medical Executive Committee when required, which shall include reporting of any unacceptable conduct. Any action taken as a result of Medical staff conduct complaints shall be commensurate with the nature and severity of the conduct in question, at the discretion of the Medical Executive Committee.

C. Hospital Staff Conduct Complaints

1. 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 in writing and submitted to the Chief of Staff or any Medical Staff Officer. The Chief of Staff and/or Medical Staff Officer will collaborate with the appropriate Hospital authority to help resolve this issue. If needed, a report will be made to the Medical Executive Committee.

2. Complaints involving patient safety must be reported in writing via the Hospital's event reporting system.

D. Abuse of Process

1. Retaliation or attempted retaliation against complainants or those who are carrying out Medical Staff duties regarding conduct will be considered unacceptable conduct, and could give rise to evaluation and corrective action pursuant to the Medical Staff Bylaws.

Article III Categories of the Medical Staff

3.1 Categories of Medical Staff Membership

A. Each Medical Staff member shall be assigned to a Medical Staff category based on his or her qualifications. The member shall have the prerogatives and responsibilities detailed for the membership category in these Bylaws.

B. The approved categories of Medical Staff membership are: Active, Courtesy, Provisional, Community Affiliate, Administrative, and Honorary. At the time of initial appointment to the Medical Staff and each subsequent reappointment, the member's staff category shall be determined. Specific exceptions to the membership category requirements in this Article may be made by the Medical Executive Committee, to be considered on a case-by-case basis.

3.2 Active Staff

A. Qualifications

1. The Active Staff shall consist of members who:

a. Meet the general qualifications for membership set forth in Article II;

b. Have been involved in at least 20 patient care activities during the past two consecutive calendar years, although exceptions to this requirement may be recommended by the Medical Executive Committee for good cause ;

c. Meet the Medical Staff meeting attendance requirements for Active Staff outlined in the Rules and Regulations;

d. Have satisfactorily completed their designed term on the Provisional Staff category as set forth in these Bylaws.

B. Prerogatives

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

a. Apply for admitting and attending privileges and exercise those clinical privileges which are granted to the member pursuant to Article V;

b. Admit, consult, and refer patients (inpatient and outpatient) as appropriate to the member's specialty and privileges, as determined by the Medical Executive Committee;

c. Attend and vote on matters within the scope of the member's licensure and clinical privileges that are presented at general and/or specialty meetings of the Medical Staff at large, or any meeting of any clinical department or division or committee of which he or she is a member;

d. If not a Telemedicine Provider, hold any Medical Staff or clinical department office for which the member is qualified so long as the activity required by the position falls within the member's scope of practice as authorized by law; and

e. Serve as a voting member on any Medical Staff committee to which he or she is duly appointed or elected.

C. Relinquishment of Active Staff Category

1. Failure of an Active Staff member to meet the requirements Section 3.2, Subsection A shall be deemed an automatic relinquishment of assignment to the Active Staff category of Medical Staff membership and the member shall automatically be transferred to the appropriate Medical Staff category, if any, for which the member is eligible. In the event the member is not eligible for any other category, he or she shall be deemed to have automatically resigned their Medical Staff membership and relinquished the clinical privileges they have been granted. In the event a practitioner disagrees with a decision related to such automatic transfer or automatic resignation, the practitioner may request that the Medical Executive Committee review the validity of fact related to compliance with the requirements in Section 3.2, Subsection A, however, no such transfer or automatic resignation shall be subject to the provisions of Article VIII.

3.3 Courtesy Staff

A. Qualifications

1. The Courtesy Staff shall consist of members who:

a. Meet the general qualifications for membership set forth in Article II;

b. Have been involved in at least one patient care activity at the Hospital during the past two consecutive calendar years, although exceptions to this may be recommended by the Medical Executive Committee for good cause.

c. Have been involved in at least 20 patient care activities during the immediate past 24 months at a hospital that is accredited by CMS or has Medicare deemed status, although exceptions to this requirement may be recommended by the Medical Executive Committee for good cause, and;

d. Have satisfactorily completed their designated term in the Provisional Staff status as set forth in these Bylaws.

B. Prerogatives

1. Courtesy Staff members shall not be eligible to hold any Medical Staff or department office.

2. Except as otherwise provided, a Courtesy Staff member shall be entitled to:

a. Apply for admitting and attending privileges and exercise those clinical privileges which are granted pursuant to Article V;

b. Admit, consult, and refer patients (inpatient and outpatient) as appropriate to the member’s specialty and privileges, as determined by the Medical Executive Committee;

c. Attend in a nonvoting capacity, general and special meetings of the Medical Staff and open committee meetings and educational programs of any department of which he or she is a member. Courtesy Staff members may attend closed meetings of the Medical Staff only by invitation of the Chief of Staff or by the chairperson of the committee or department holding such meeting, but shall have no right to vote at such meetings, and;

C. Relinquishment of Courtesy Staff Category

1. The failure of a Courtesy Staff member to meet the requirements of Section 3.3, Subsection A, shall be deemed an automatic relinquishment of assignment as a member of the Courtesy Staff status and the member shall be automatically transferred to the appropriate staff category, if any, for which the member is eligible. In the event the member is not eligible for any other category, he or she shall be deemed to have automatically resigned from the Medical Staff. In the event a practitioner disagrees with a decision related to such automatic transfer of Medical Staff category or resignation, the practitioner may request that the Medical Executive Committee review compliance with the requirements of Section 3.3, Subsection A. However, no such transfer or termination shall entitle the member to a formal hearing under the provisions of Article VIII.

3.4 Provisional Staff

A. Qualifications

1. All new members of the Medical Staff requesting clinical privileges, except those requesting temporary privileges, will initially be appointed to the Provisional Staff status. The Provisional Staff shall consist of members who:

a. Meet the general Medical Staff membership qualifications set forth in Article II.

B. Prerogatives

1. Provisional Staff members shall not be eligible to hold any Medical Staff or department office unless they are a member of a department or division that is considered closed per an exclusive contract and meet the requirements in Section 10.6.

2. The Provisional Staff member shall be entitled to:

a. Apply for admitting and attending privileges and exercise those clinical privileges which are granted pursuant to Article V;

b. Admit, consult, and refer patients (inpatient and outpatient) as appropriate to the member’s specialty and privileges, as determined by the Medical Executive Committee;

c. Attend general and special meetings of the Medical Staff, committee meetings and educational programs of any department of which he or she is a member. Provisional Staff members may attend closed meetings of the Medical Staff only by invitation of the Chief of Staff or by the chairperson of the committee or department holding such meeting. If the Provisional member belongs to a department or division considered to be closed by virtue of an exclusive contract and the chairperson is also currently a member of the Provisional staff under the exception granted in Section 10.6, such a Provisional member may vote only in meetings of his or her own department or division. Otherwise, a Provisional staff member has no right to vote at Medical Staff meetings.

C. Observation of Provisional Staff Member

1. Each Provisional Staff member shall undergo an initial focused professional practice evaluation (FPPE), a period of observation, evaluation, and proctoring by designated monitors as may be established by the Medical Executive Committee and as described in Section 5.3. The observation shall be to evaluate the member’s (1) proficiency in the

exercise of clinical privileges initially granted, and; (2) overall eligibility for continued staff membership and advancement within staff categories. Observation, evaluation and proctoring of Provisional Staff members shall follow a format as may be established by the Medical Executive Committee. Such observation should include concurrent observation and proctoring; however, retrospective chart review may also be utilized. Appropriate observation and proctoring records shall be maintained, and results of the observation and proctoring shall be communicated by the department chairperson to the Medical Executive Committee.

D. Conclusion of Provisional Staff Category Status

1. All new members of the Medical Staff requesting clinical privileges will initially be appointed to the Provisional Staff and must remain in the Provisional Staff status for a period of at least six months but no longer than 24 months. Advancement from the Provisional Staff status requires substantial completion of initial proctoring requirements. Recommendations for advancement from Provisional Staff status shall be made by the department chairperson to the Medical Executive Committee. Proctoring requirements may be removed by action of the Medical Executive Committee.

E. Action at Conclusion of Provisional Staff Category

1. If the Provisional staff member has substantially completed proctoring requirements and has satisfactorily demonstrated his or her ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued Medical Staff membership, and upon recommendation of the Medical Executive Committee, the member shall be placed as appropriate in the Active Staff category if requirements have been met per Section 3.2, or otherwise in the Courtesy staff.

2. At the discretion of the Medical Executive Committee, failure to complete one or more procedure-specific proctoring requirements shall not of itself preclude advancement to another staff category provided that all basic proctoring requirements have been successfully completed pursuant to any applicable Rules and Regulations.

3. Unless terminated sooner by other provisions of these Bylaws, membership and privileges of practitioners who do not qualify for advancement to another staff category within the prescribed 24-month provisional period following their initial appointment shall be terminated at the end of his/her Provisional term. Such individuals shall only be entitled to the procedural rights set forth in Article VIII of these Bylaws if their failure to advance is based on a medical disciplinary cause or reason and such failure is required to be reported to the Medical Board of California and the National Practitioner Data Bank. Failure to satisfactorily conclude Provisional Staff status because of a failure to complete proctoring requirements shall be governed by the provisions of Section 5.

3.5 Community Affiliate Staff

A. The Community Affiliate Staff consists of members of the Medical Staff who desire to be associated with the Hospital, but do not intend to engage in patient care activities at the Hospital.

B. Qualifications

1. Community Affiliate staff members must meet each of the minimum qualifications for Medical Staff membership detailed in Article II, except they do not need to:

a. Hold a DEA number.

b. Be eligible to received Medicare or Medi-Cal payments, or qualify as an ordering, referring, and prescribing provider for Medicare or Medi-Cal.

C. Prerogatives

1. Community Affiliate Staff members may:

a. Refer patients to the Hospital for admission and care, but may not admit or provide clinical services at the Hospital.

b. Refer patients to the Hospital's diagnostic facilities and order diagnostic tests.

c. Communicate with the clinical staff about the care of patients who they refer; visit those patients; and review the medical records and test results for those patients, but may not admit or attend to patients, write orders for inpatients, input information into the medical record, perform consultations, assist in surgery or otherwise participate in the management of clinical care to patients at the Hospital.

d. Attend general and special Medical Staff meetings and open committee meetings in a nonvoting capacity.

e. Attend educational programs.

2. Community Affiliate Staff members may change categories of membership only through the application and credentialing process as established in these Bylaws.

3.6 Honorary Staff

A. Qualifications

1. Honorary Medical Staff Membership

a. The Honorary Staff shall consist of physicians, dentists, and podiatrists who do not actively practice at the Hospital but are deemed deserving of honorary membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the Hospital, including members who have retired from active practice and, at the time of their retirement, were members in good standing of the Active Medical Staff for a period of at least five continuous years, and who continue to exemplify high standards of professional and ethical conduct.

B. Prerogatives

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

3.7 Administrative Staff

A. The Administrative Staff consists of Medical Staff members under contract with the Hospital or Medical Staff to serve in administrative capacities subject to review by and input from the Medical Executive Committee.

B. Qualifications

1. Administrative Staff category membership shall be held by any physician retained by the Hospital or Medical Staff, either individually or by virtue of a contracted service, solely to perform ongoing medical administrative activities, and does not have clinical privileges.

2. The Administrative Staff shall consist of members who:

a. Document their (1) current licensure, (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and (5) current physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent to exercise their duties.

b. Are determined to (1) adhere to the ethics of their respective professions and any applicable conflicts of interest policies, (2) be able to work cooperatively with others so as not to adversely affect their judgment in carrying out the quality assessment and improvement functions, and (3) be willing to participate in and properly discharge those responsibilities determined by the Medical Staff.

C. Prerogatives

1. All Administrative Staff shall be entitled to attend open meetings of the Medical Staff and various departments and educational programs without vote.

2. Administrative Staff members shall not be eligible to hold office in the Medical Staff organization or to chair Medical Staff committees.

D. Change in Membership Category

1. Administrative Staff members may change categories of membership only through the application and credentialing process as established in these Bylaws.

3.8 Limitation of Membership Category Prerogatives

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

3.9 General Exceptions to Prerogatives

A. Regardless of the category of Medical Staff membership, members shall only exercise those privileges, and shall only have the right to vote on those matters within the scope of their licensure.

3.10 Modification of a Medical Staff Member’s Staff Category

A. A member may be assigned to a different membership category by the Medical Executive Committee either during appointment or at reappointment if a change in qualifications occurs. A change in Medical Staff category is not in and of itself grounds for a Hearing under these Bylaws.

Article IV Appointment and Reappointment

4.1 General Provisions and Application of Article

A. No person shall exercise clinical privileges in the Hospital unless and until that person applies for and receives appointment to the Medical Staff or is otherwise granted privileges as set forth in these Bylaws. By applying to the Medical Staff for appointment or reappointment, the applicant acknowledges responsibility to review the Medical Staff Bylaws, Rules and Regulations, and Policies and Procedures, and agrees that, regardless of whether he or she is appointed or granted the requested privileges, he or she will comply with the Medical Staff Bylaws, Rules and Regulations, and Polices and Procedures as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the member only such clinical privileges as have been granted in accordance with these Bylaws.

B. 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 Executive Committee and final action by the Board of Directors, or as set forth in this Section.

4.2 Burden of Producing Information

A. In connection with all applications for appointment, reappointment, new clinical privileges, advancement or transfer, the applicant shall have the burden of producing sufficient information of clinical and professional performance to permit an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, to resolve any reasonable doubts about these matters, and to satisfy any request for such information.

1. The applicant's failure to produce any required information, including items listed in Section 4.3, shall render the application incomplete and it shall not be acted upon. Should the applicant thus fail to make the application complete after being given a reasonable opportunity to do so, the credentialing process may be terminated at the discretion of the Medical Executive Committee. If the application is for reappointment, Medical Staff membership will automatically expire. Termination of the credentialing process as described herein this provision shall not entitle the applicant to any Hearing or appeal.

2. This same burden of producing clinical, medical, and psychological information rests with any practitioner required to produce information as part of an authorized Medical Staff peer review activity. Failure to a practitioner to produce required information related to authorized Medical Staff peer review, quality assessment, performance improvement, or credentialing activities in a timely manner shall result in automatic suspension of all clinical privileges until such time as the required information has been provided.

B. A revocation, suspension, restriction, or other disciplinary or corrective action by any state licensing authority, professional organization, certification board or health care facility regarding a practitioner's license, certificate, membership or clinical privileges, whether constituted or voluntarily accepted, shall constitute grounds for an unfavorable credentialing or peer review action by this Medical Staff. The Medical Staff shall consider the nature and gravity of the charges or allegations and the resulting disciplinary or corrective action, but shall not be obligated to conduct evidentiary proceedings regarding events that occurred elsewhere.

C. Misstatements or Omissions

1. An applicant may be given an opportunity to render an incomplete application complete as described below. However, it is the applicant's responsibility to review the application carefully and verify that the information provided in it, or as part of it, is accurate and complete before it is submitted. Any substantial misrepresentation or misstatement in or

omission from the application shall, itself alone, be grounds for the Medical Staff to discontinue processing and dismiss the application, or if such misrepresentations, misstatements, or omissions are discovered after the application has been granted, for summary dismissal and/or immediate revocation of Medical Staff membership and/or all clinical privileges. This provision may be invoked by the Medical Executive Committee, at its discretion, after giving the applicant an opportunity to address the issues in writing or at a meeting. Termination of the credentialing process as described herein this provision shall not entitle the applicant to any Hearing or appeal.

D. Current Competency

1. Applicants for clinical privileges who cannot demonstrate current competency are ineligible to request clinical privileges and such clinical privilege requests will not be processed.

E. Changes in Information

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

4.3 Complete Application

A. The Medical Staff will not take action on an application that is not complete.

B. An application for appointment, reappointment, or new clinical privileges shall be deemed incomplete until:

1. The applicant submits an electronic application, using the prescribed form, in which all of the requisite information is provided. All entries and attachments must be legible, understandable and substantively responsive on every point of inquiry;

2. The applicant responds to all further requests from the Medical Staff, through its authorized representatives, for clarifying information or the submission of supplementary materials. This may include, but is not necessarily limited to, a complete history and physical examination, which may include blood or other chemical analysis, and/or a psychiatric or psychological evaluation to resolve questions about the applicant's fitness to perform the physical and/or mental functions associated with requested clinical privileges or to determine reasonable accommodations. Any such examinations shall be at the applicant's expense and shall be performed by a practitioner approved by the Medical Executive Committee. If the requested items or information or materials, such as reports or memoranda, are in the exclusive possession of another person or entity, the applicant shall take such measures as are necessary to obtain them or to arrange for them to be submitted to the Medical staff directly by the source; and

3. The applicant has assisted as necessary in the solicitation of written evaluations from those listed by the applicant as references and from other potential sources of relevant information. Such assistance may include the signing of a special release or similar document, as requested.

C. Once further information is requested, the applicant will have 30 days to provide the information to the Medical Staff Services Department, unless an exception is made by the Credentials Committee chairperson or Chief of Staff. Failure to provide all requested information will cause processing to cease and the file will be retired by the provisions of Section 4.2.

4.4 Duration of Appointments and Reappointments

A. Except as otherwise provided for in these Bylaws, initial appointments and subsequent reappointments to the Medical Staff and/or renewal of clinical privileges shall be for a period of not more than 24 months.

4.5 Requests for Application for Initial Medical Staff Appointment and Subsequent Reappointments

A. Those individuals who are willing to incur the obligations of Medical Staff membership and clinical privileges and are prepared to demonstrate that they meet the threshold criteria for consideration for appointment to the Medical Staff and clinical privileges shall receive an application to the Medical Staff.

B. The application process for initial appointment and reappointment to the VPH Medical Staff is electronic. For initial application online access, an applicant shall contact the Medical Staff Services Department at the Hospital during normal business hours. Applicants demonstrating that they meet threshold criteria for initial appointment shall be given appropriate and necessary information to allow them to access an online application for membership and an associated request for clinical privileges. All supporting information and assistance shall be made available to potential members at the onset and during the initial application process.

4.6 Applications for Initial Appointment and Reappointment to the Medical Staff

A. Verification of Information

1. The applicant shall deliver a completely filled-in, signed, and dated application and supporting documents to the Medical Staff Services Department with an advance payment of Medical Staff application fees paid to the Medical Staff, as required. The Medical Staff Services Department shall expeditiously seek to conduct primary source verification of licensure, current DEA (if required), education, specific training, experience, and current competence, collection and review of peer recommendations, involvement in any professional liability, and receipt of data base profiles (e.g., AMA, AOA, OIG, Medicare / Medicaid Exclusions) 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 any reasonably requested information, including signing any supplemental release that may be required. 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 and the appropriate department. No final action on an application may be taken until receipt of the National Practitioner Data Bank report.

B. Effect of Application

1. In addition to the matters set forth above, by applying for appointment to the Medical Staff each applicant:

a. Agrees to appear for interviews and provide additional information as requested by the Chief of Staff, Chief Medical Officer, Clinical Department chairperson, the Credentials Committee, the Medical Executive Committee or the Board of Directors in regard to the application;

b. Authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;

c. Consents to inspection of records and documents that, in the judgment of the Chief of Staff, Clinical Department chairperson, the Credentials Committee, the Medical Executive Committee, or the Board of Directors, may be material to an evaluation of the applicant's qualifications and ability to carry out the clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

d. Releases from any liability, to the fullest extent provided by law, all persons for their acts performed in connection with investigating and evaluating the applicant;

e. Releases from any liability, to the fullest extent provided by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;

f. Consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations, any information regarding the applicant's professional or ethical standing that the Hospital or Medical Staff may have, and releases the Medical Staff and Hospital from liability for so doing to the fullest extent permitted by law;

g. If a requirement then exists for Medical Staff dues or other fees, acknowledges responsibility for timely payment;

h. Pledges to provide for continuous quality care for patients, unless applying to the Community Affiliate or Administrative Staff;

i. Pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, seeking consultation with the bioethics committee to resolve bioethical dilemmas, abiding by bioethics policies and standards of care, refraining from providing ghost 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, Policies and Procedures and applicable Hospital policies;

k. Acknowledges that any misrepresentations or misstatement in, or omission from, the application, whether intentional or not, may result in termination of the credentialing process, and that if appointment or reappointment has been granted prior to discovery of such misrepresentation, misstatement or omission, such discovery may result in nullification of an approval if granted, or for summary dismissal and/or immediate revocation of Medical Staff membership and/or all clinical privileges.

l. Acknowledges that the Hearing and Appeal procedures set forth in this policy shall be the sole and exclusive remedy with respect to any professional review action taken by the Medical Staff at this Hospital;

m. Certifies that he or she will report any changes in the information submitted on the application form, which may subsequently occur, to the Medical Executive Committee;

n. Consents to any requested medical or psychological examination by a practitioner acceptable to the Medical Executive Committee, at the applicant's expense, if deemed necessary by the Medical Executive Committee, and inspection of the records of such examination, and;

o. Consents to the review and inspection of records and documents related to the individual's clinical and/or technical skill and the review of documents related to the results of quality assessment and improvement activities.

C. Credentials Committee and Clinical Department Action

1. After the receipt of the completed Medical Staff electronic application and following review and verification of the application and all supporting documentation by the Medical Staff Services Department, the completed / verified application shall be reviewed by the chairperson of the clinical department to which the applicant seeks assignment. The clinical department chairperson shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges requested, the individual's clinical or technical skills, as indicated by the results of quality improvement and peer review activities and shall then present his or her recommendation to the Credentials Committee at its next scheduled meeting. The Credentials Committee shall, subsequently, review the application, evaluate the supporting documentation and other relevant information. The Credentials Committee and/or its chairperson shall interview the applicant, if they so choose, and seek additional information as appropriate and necessary. As soon as practical, the Credentials Committee shall transmit to the Medical Executive Committee a written recommendation as to appointment and if appointment is recommended as to membership category, department and division affiliation, clinical privileges to be granted and any special conditions to be attached to the appointment.

D. Medical Executive Committee Action

1. At its next regular meeting following recommendation by the department chairperson and the Credentials Committee, the Medical Executive Committee shall consider the recommendations of the Credentials Committee and clinical department chairperson and any other relevant information. The Medical Executive Committee may defer action on the application, request additional information, return the matter to the Credentials Committee or clinical department chairperson for further consideration and/or collection of information, elect to interview the applicant, or make its recommendation regarding the appointment. The Medical Executive Committee shall forward to the Board of Directors a recommendation as to Medical Staff appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, any conditions to be attached to the appointment, including but not limited to consultation, monitoring and/or proctoring requirements, and any other information pertinent to its recommendation. The committee may also defer action on the application for good cause (not to exceed 90 days) which shall be recorded in the minutes.

E. Effect of Medical Executive Committee Action

1. When the Medical Executive Committee recommends appointment and the granting of all requested privileges, the recommendation shall be promptly forwarded, together with any necessary supporting documentation, to the Board of Directors.

2. When a final recommendation of the Medical Executive Committee is adverse to the applicant, the Board of Directors, President / Chief Executive Officer, and the applicant shall be promptly informed by written notice. The applicant shall then be entitled to procedural rights as provided in Article VIII.

F. Action on the Application

1. In all instances, the Board of Directors shall give great weight to the recommendation of the Medical Executive Committee and in no event shall the Board of Directors act arbitrarily or capriciously. The following procedures shall apply with respect to action on the application:

   a. If the Medical Executive Committee recommends appointment and the granting of all requested privileges, and:

      1. The Board of Directors concurs in that recommendation, the decision of the Board of Directors shall be deemed final action.

      2. If the Board of Directors requires further consideration or collection of additional information regarding any aspect of the application that is unclear or of concern, the application will be returned to the Medical Executive Committee (or the Credentials Committee or clinical department chairperson) for clarification.

      3. The tentative final action of the Board of Directors is unfavorable, based upon the professional competence or conduct of the applicant, the President / Chief Executive Officer, acting on behalf of the Board of Directors, 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 VIII, although the Hearing may be modified as appropriate to the nature of the matter as a Board proceeding rather than as a Medical Staff proceeding. If the applicant waives his or her procedural rights, the decision of the Board of Directors shall be deemed a final action.

   b. If the Medical Executive Committee recommends denial of appointment or denial of any requested privilege and the applicant waives his or her procedural rights, the recommendations of the Medical Executive Committee shall be forwarded to the Board of Directors for final action.

   c. If the applicant requests a Hearing following an adverse Medical Executive Committee recommendation or an adverse Board of Directors tentative final action, the Board of Directors shall take final action only after the applicant has exhausted or waived his or her procedural rights as established by Article VIII.

   d. In instances in which the Medical Executive Committee and Board are unable to reach agreement, the issue shall be referred to the Joint Conference Committee for resolution.

G. Notice of Final Decision

1. Notice of the final decision shall be given to the President / Chief Executive Officer, the Chief of Staff, the Medical Executive Committee, and the chairperson of the applicable clinical department. The applicant shall be notified by certified mail.

2. 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 department to which he or she

is assigned, (3) the clinical privileges granted, and (4) any conditions attached to the appointment.

3. In the case of an adverse decision, the applicant shall be informed of the reason for denial in writing via certified mail.

H. Reapplication After an Adverse Recommendation, Action, Decision, or Withdrawal of Application

1. An applicant who has received a final adverse decision regarding appointment based on professional competence or conduct, or a practitioner whose membership and/or privileges have been terminated or application has been denied following hearing, or whose membership and/or privileges have been recommended for revocation or denial and the practitioner resigned without exhausting hearing rights, shall not be eligible to reapply to the Medical Staff for a period of 60 months from the date of the decision. Any such reapplicant shall be processed as an initial application, and the applicant shall have the burden to submit information as set forth in Sections 4.2 and 4.3, including such information as may be required to demonstrate that the basis for the earlier adverse action no longer exists. Materials submitted in the prior application will be part of the reapplication.

2. If an application for appointment or reappointment to the Medical Staff was not acted upon because the credentialing process was terminated as a result of the applicant's failure to render the application complete after being given a reasonable opportunity to do so, the practitioner shall not be eligible to reapply to the Medical Staff for a period of 12 months. Any such reapplicant shall be processed as an initial application. Should an applicant fail a second time to submit a complete application, the practitioner shall not be eligible to reapply to the Medical Staff without express permission from the Medical Executive Committee, subject to such terms and conditions as the Medical Executive Committee may impose. No right of Hearing or appeal shall be available in connection with a decision not to entertain another application from such a practitioner.

3. If an application for appointment or reappointment to the Medical Staff was dismissed and not acted upon or Medical Staff membership and/or clinical privileges were revoked based on misrepresentation, misstatement or omission in the application, the practitioner shall not be eligible to reapply to the Medical Staff for a period of 12 months, and then only with express permission from the Medical Executive Committee, subject to such terms and conditions as the Medical Executive Committee may impose. Any such reapplication shall be processed as an initial application. No right of Hearing or appeal shall be available in connection with a decision not to entertain another application from such a practitioner.

I. Timely Processing of Applications

1. All individuals and groups shall act on applications in good faith and in a timely manner. Incomplete applications, as defined in Section 4.3, will not be processed and will be returned to the applicant for completion. Except when additional information must be secured, or for other good cause, the following time period provide a guideline for routine processing of applications.

a. Evaluation, review, and verification of a complete application and all supporting documents by Medical Staff Services Department: 30 days from receipt of all necessary documentation;

b. Review and recommendation by department and/or department chairperson: 30 days after receipt of all necessary documentation from the Medical Staff Services Department;

c. Review and recommendation by Credentials Committee 30 days after receipt of all necessary documentation from department and/or department chairperson;

d. Review and recommendation by the Medical Executive Committee 30 days after receipt of all necessary documentation from the Credentials Committee;

e. Final action by the Board of Directors: 180 days after receipt of all necessary documentation from Medical Executive Committee, or 14 days after conclusion of Hearings.

2. These time periods are guidelines and are not directives which create any rights for an applicant or reapplicant to have an application processed within these precise periods.

4.7 Reappointments and Requests for Modification of Staff Status or Clinical Privileges

A. Application

1. At least 120 calendar days prior to the expiration of a Medical Staff member's current appointment and/or granted associated clinical privileges, a member shall be informed via email of the impending expiration of his or her current Medical Staff appointment and the need to electronically apply for reappointment. The reappointment application must be submitted within 30 calendar days of receipt of the electronic notification. Reminders shall be sent to the Medical Staff member 15 calendar days of said deadline. Notwithstanding this provision, it is the obligation and responsibility of the practitioner to maintain current appointment, including submitting applications for reappointment in a timely manner. Failure, without good cause, to return the form to the Medical Staff Services Department 45 calendar days prior to the expiration of the member's current appointment shall result in a determination that the application for reappointment is incomplete.

a. A Medical Staff member who seeks a change in Medical Staff status or modification of clinical privileges may submit such a request at any time, except that such application may not be filed within one year of the time a similar request has been denied, absent a showing of good cause.

B. Processing of Reappointments and Requests for Modification of Status and/or Clinical Privileges

1. The processing of an application for reappointment or modification of staff status or privileges is the same as that set forth in Section 4.6 with the exception of:

a. The application for reappointment and requests for modification of Staff Status or privileges need not contain requests for information which, in the opinion of the Medical Executive Committee, is not subject to change between the initial appointment and subsequent reappointments.

C. Standards and Procedure for Review

1. When a Medical 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 4.6. In each such instance, the member's eligibility for Medical Staff membership as set forth in Article II and the member's eligibility for assignment to a category of the Medical Staff as set forth in Article III, shall be re-determined. Any member who has failed to engage in at least one patient care activity at the Hospital for the preceding two years shall be ineligible to apply for renewal of clinical privileges unless the applicant is applying for reappointment to a staff category that does

not require clinical activity. The Medical Executive Committee for good cause may make exceptions to this activity requirement. The procedures set forth in Article VIII shall not apply.

2. At reappointment, the Credentials Committee and clinical department shall review individual performance data for variation from benchmark. Any variations shall go to peer review for determination of validity, written explanation of findings and, if appropriate, an action plan to include improvement strategies.

4.8 Leave of Absence

A. Request for Leave of Absence and Its Duration

1. Members may request a leave of absence which, except for a military leave of absence as described herein, requires approval by the Medical Executive Committee. During the period of the leave, the member shall not exercise privileges at the Hospital and membership rights and responsibilities shall be inactive. No refunds of Medical Staff dues or assessments shall be provided.

2. At the discretion of the Medical Executive Committee and Board, a Medical Staff member may obtain a voluntary leave of absence from the staff upon submitting a written request to the Medical Executive Committee stating the approximate period of leave desired, which may not exceed two consecutive calendar years or the term of the current appointment, whichever is less. A leave of absence from the Medical Staff is effective only upon acceptance by the Medical Executive Committee. The member is responsible for fulfilling all the responsibilities of Medical Staff membership under Section 2.6 until notified in writing that the Medical Executive Committee has granted the leave of absence.

B. Obligations to be Met Prior to and During Leave of Absence

1. Before any voluntary leave of absence may begin, all medical records must be completed and dues and/or assessments must be paid.

2. Reappointments to the Medical Staff are required every two years through the normal procedure, regardless of leave.

C. Termination of Leave of Absence

1. At least 30 days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff member may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee. The staff member shall submit a summary of relevant activities during the leave.

2. All members are subject to a routine focused review upon their return from leave. If so requested, the member may be required to present relevant information regarding his or her fitness to return to practice, including when the Medical Executive Committee deems necessary, obtaining clearance from the member’s treating physician or submit to an evaluation or consultation with the Well-Being Committee. The Medical Executive Committee shall make a recommendation to the Board of Directors concerning the reinstatement and any change of privileges following the member's return from leave of absence. The reappointment procedure provided in Article IV must be followed prior to reinstatement.

3. Periods of leave shall not be considered in calculating a member’s satisfaction of requirements relating to patient care and Medical Staff activities.

4. If a leave takes place while a restriction is in place or pending, that restriction shall be put into place upon the practitioner's return to practice.

D. Failure to Request Reinstatement

1. Failure to request reinstatement in a timely manner shall be deemed a resignation from the Medical Staff and shall result in automatic expiration of membership and privileges. 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.

E. Military Leave of Absence

1. Requests for leaves of absence to fulfill military service obligations shall be granted upon written notice to the Medical Executive Committee.

2. Reactivation of membership and clinical privileges previously held shall be granted upon request, except that the following may apply:

a. If the leave of absence has been for more than two years, the member shall be required to submit a reappointment application;

b. If the request for reactivation occurs in less than two years but after the expiration of the members' current appointment term, the member may be required to update information in his or her credential file, which may be done by submitting a reappointment application.

3. In cases where reactivation from a military leave of absence is requested after the expiration of the member's current appointment term, the member shall be treated as if he or she had been continuously appointed to the Medical Staff for purposes of determining Medical Staff category status and eligibility for Officer or other positions.

4. Notwithstanding the above, the Medical Staff may take appropriate measures to ensure the current clinical competence of any member requesting a reinstatement from a military leave of absence.

4.9 Providing Notifications and Updates to the Medical Staff

A. Each applicant or member agrees to notify the Medical Staff promptly and within five calendar days of the occurrence of any event representing a change or modification of information required as a condition of appointment and/or reappointment. Such information includes but is not limited to:

1. Receipt of written notice of any adverse action taken or pending by any state licensing board, including the Medical Board of California, Osteopathic Medical Board of California, Podiatric Medical Board of California, Dental Board of California, or California Board of Registered Nursing, including but not limited to an accusation filed, temporary restraining order, or imposition of any interim suspension, probation, or limitations affecting the practitioner's license to practice medicine or the practitioner's designated profession.

2. Any action taken by any health care organization which has resulted in the filing of a Section 805 report with the Medical Board of California or a report with the National Practitioner Data Bank.

3. The denial, revocation, suspension, reduction, limitation, probation or relinquishment by resignation of Medical Staff membership or clinical privileges at any health care organization.

4. Any material reduction in professional liability coverage, including changes in the scope of coverage.

5. Conviction of any crime excluding minor traffic violations.

6. Receipt of any proposed or actual exclusion or adverse action under Medicare or Medicaid programs or any other federally funded or state health care programs including but not limited to fraud and abuse proceedings or convictions.

7. Any arrest.

8. Any misdemeanor or felony charges levied by a law enforcement agency.

9. Any expiration, revocation, limitation, or suspension of a DEA certificate.

4.10 Resignation of Medical Staff Membership and Surrender of Clinical Privileges

A. A Medical Staff member may resign his or her Medical Staff membership and relinquish associated clinical privileges upon submitting a written notification to the Medical Executive Committee. If a date is not specified in the written document, then the resignation will be considered effective upon receipt. A resignation will not be acknowledged unless all medical records are completed and dues are current. Medical Staff members who resign and do not meet such expectations shall be deemed to have resigned under “unfavorable conditions” with details of such conditions provided in response to affiliation queries.

B. Reapplication fees will be waived for physicians who resigned or were terminated from staff for non-disciplinary reasons and under favorable conditions within the past six calendar months, including those terminated for non-completion of proctoring as stated in Section 5.4. Those reapplying beyond a timeframe of six months shall pay the customary application fee set by the Medical Executive Committee. If a member who previously completed proctoring resigns for non-disciplinary reasons, and then chooses to reapply for privileges within a 23-month time period, the requirement to undergo initial proctoring for those clinical privileges that were previously granted by the Medical Staff may be waived at the discretion of the department chairperson.

Article V Clinical Privileges

5.1 Exercise of Privileges

A. A practitioner shall be entitled to exercise only those clinical privileges or practice prerogatives specifically granted. Said privileges or practice prerogatives must be Hospital specific and within the scope of the person’s license, certificate, or other legal credential authorizing practice in this State and consistent with any restrictions thereon, and shall be subject to the Bylaws, Rules and Regulations, and Policies and Procedures, and the authority of the department chairperson and the Medical Executive Committee. 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 the reasons directly related to patient care and other provisions of the Medical Staff Bylaws, and only following the procedures outlined in these Bylaws.

5.2 Delineation of Clinical Privileges in General

A. Requests

1. 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.

B. Basis for Clinical Privileging Determinations

1. Requests for privileges shall be granted only where the Hospital has the need and ability to support the requested privileges, despite the member's qualifications or ability to perform the requested privilege. Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or for a new technique to perform an existing procedure ("new procedure") will not be processed until a determination has been made that the new procedure will be offered by the Hospital and criteria for the clinical privileges have been adopted. The Hospital may develop a process to determine whether sufficient space, equipment, staffing and financial resources are in place or available within a specific time frame to support each requested new procedure. Once the Hospital has determined that a new procedure will be performed at the Hospital, the Medical Staff may, subject to the Board of Director's approval, develop privileging criteria for new procedures.

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

3. The burden of providing sufficient information to evaluate a request for privileges rests with the applicant. If the applicant is unable to provide sufficient documentation to evaluate the requested privilege the following options are available:

a. Proctoring of the first two cases;

b. Submission of documentation of additional education;

c. Submission of peer letters attesting to specific privilege competence;

d. Submission of operative reports or lists;

e. Withdrawal of privilege request.

5.3 Performance Monitoring

A. The Medical Staff is responsible to the Board of Directors for the adequacy and quality of patient care services provided at the Hospital, and the Board of Directors has ultimate responsibility for those services. To fulfill its responsibility, the Medical Staff will develop processes, subject to the Board of Directors' approval, for the evaluation of care provided by Medical Staff members and others with privileges. Those processes will be consistent with state and federal legal and accreditation requirements. Decisions regarding the granting, renewing, and termination of membership or privileges shall be, among other things, detailed, current, accurate, objective, and evidence-based. Ongoing performance evaluation and monitoring will be designed to assure timely identification of matters that may require correction. Performance monitoring in its various forms is not a disciplinary measure, but rather is an information-gathering activity. Performance monitoring in itself does not give rise to the procedural rights described in these Bylaws, Article

VIII, Hearings and Appellate Reviews. Concerns regarding professional performance or conduct will be addressed pursuant to Articles VII and VII of these Bylaws.

B. Ongoing Peer Review

1. Peer review, fairly conducted, is essential to preserving the highest standards of medical practice. All individuals holding Hospital privileges are subject to evaluation based on Medical Staff peer review criteria, adopted in concert with these Bylaws. Evaluation results are used in privileging, system improvement, and when warranted, corrective action.

2. Peer Review Criteria

a. Departments shall develop and routinely update peer review criteria based on current practices and standards of care, which shall be the sole criteria used in evaluating those applying for membership and privileges and the performance of members and privilege holders. Departments should, where relevant, collect and evaluate department members' data which may include at least:

1. Operative and other clinical procedure(s) performed and their outcomes.

2. Patterns of blood and pharmaceutical usage.

3. Requests for tests or procedures.

4. Patterns of length of stay.

5. Use of consultants.

6. Morbidity and mortality.

7. Items listed by Det Norske Veritas-NAIHO as "Performance Data"

b. In addition, each department shall review and update department-specific criteria and other relevant data to be collected at least every two years for ongoing peer review of department members.

c. Department criteria are subject to approval of the Medical Executive Committee. Approved criteria as updated are made known and accessible to all members.

C. Ongoing Professional Performance Evaluation (OPPE)

1. The Medical Staff shall recommend, for Medical Executive Committee and Board of Directors approval, the criteria to be used in the conduct of Ongoing Professional Performance Evaluations (OPPE) for its practitioners.

2. Methods that may be used to gather information for OPPE purposes include but are not limited to:

a. Periodic chart review.

b. Direct observation.

c. Monitoring of diagnostic and treatment techniques.

d. Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing and administrative personnel.

e. Compilation of peer review information.

f. Collection of data pertaining to the utilization of resources.

g. Collection of data pertaining to outcomes including but not limited to morbidity, mortality, surgical complications, and readmissions.

3. Ongoing performance reviews shall be factored into the decision to maintain, revise, or revoke the existing privileges of every person holding Hospital privileges.

D. Focused Professional Practice Evaluation (FPPE)

1. Responsibility for FPPE

a. The Medical Staff is responsible for developing a focused professional evaluation process that will be used in predetermined situations to evaluate, for a time-limited period, a practitioner's competency in performing specific privilege(s). The Medical Staff may supplement these Bylaws with policies, for approval by the Medical Executive Committee and the Board of Directors, that will clearly define the circumstances when a focused evaluation will occur, what criteria and methods should be used for conducting the focused evaluation, the duration of the evaluation period, requirements for extending the evaluation period, and how the information gathered during the evaluation process will be analyzed and communicated.

2. FPPE Data Sources

a. Information for a focused evaluation process may be gathered through a variety of measures in addition to those used for OPPE including, but not limited to:

1. Retrospective or concurrent chart review.

2. Monitoring clinical practice patterns.

3. Simulation.

4. External peer review.

5. Discussion with other individuals involved in the care of each patient.

6. Proctoring, as more fully described in Section 5.4 below.

3. Initial FPPE

a. All new members to the Medical Staff and all members granted new privileges shall be subject to a period of initial focused professional practice evaluation in accordance with these Bylaws and the Rules pertaining to the department in which the applicant or member will be exercising those privileges. Such focused evaluation will generally include a period of proctoring in accordance with this Section. The Medical Executive Committee may, however, impose additional consultation, other monitoring, or enhanced proctoring requirements as a condition of granting a privilege.

4. FPPE for Renewal of Privileges

a. A focused professional practice evaluation may be imposed as a condition of renewal of privileges if there is insufficient information to make a recommendation to approve the renewal of that privilege (for example, when a member requests renewal of a privilege that has been performed so infrequently that it is difficult to assess the member's current competency in that area). Such evaluation will generally consist of proctoring in accordance with this Section, unless additional circumstances appear to warrant other enhanced monitoring.

5. FPPE for Cause

a. When information raises concern regarding a practitioner's competency in performing specific privilege(s) at the Hospital, a focused professional practice evaluation for cause may be imposed.

1. The decision to assign a period of enhanced performance monitoring, FPPE for cause, is based on the evaluation of the practitioner's current clinical competence practice behavior, and ability to perform the privilege(s) in question.

2. An FPPE for cause process is not intended to be an investigation. Notwithstanding the above, for the purposes of complying with applicable reporting requirements under Business and Professions Code Sections 805 and 805.01, or the National Practitioner Data Bank (collectively, "the Reporting Requirements"), the Medical Executive Committee will, as needed and on a case-by-case basis, evaluate whether a focused professional practice evaluation for cause falls within the definition or description of "investigation" under the statues, regulations or guidance that govern the Reporting Requirements.

3. At the outset of a new FPPE for cause, the Medical Staff will establish a monitoring plan specific to the practitioner and the privilege(s) in question to include the type of enhanced monitoring to be conducted, the sources of data to be used, and the duration of the FPPE.

4. The FPPE for cause process may result in the following:

a. A determination that the FPPE should be concluded without further action;

b. A determination that the practitioner should be subject to a plan that specifies non-restrictive measures designed to improve performance (see "Progressive Measures" below); or

c. A referral to the Medical Executive Committee for investigation or corrective action.

E. Fitness for Practice Evaluations

1. At any time, the Medical Executive Committee may require a practitioner to submit to a medical or psychological examination, including blood, urine or other biological or physiological testing, and to allow the Medical Executive Committee (and/or the Physician Well-Being Committee, if the Medical Executive Committee chooses) to inspect the records of the examination. The Medical Executive Committee shall provide in writing to the practitioner a brief description of the reasons for the requirement and identify a deadline for compliance.

F. Informal Remediation

1. At any time when warranted, the Medical Staff may employ informal remediation to address matters related to a practitioner's clinical or professional performance. The Medical Staff Officers, departments and committees may counsel, educate, or issue letters of warning or censure without initiating formal corrective action. Such comments, suggestions, and warnings may be issued orally or in writing. The practitioner shall be given an opportunity to respond in writing and may be given an opportunity to meet with the Officer, department or committee. Any informal actions, monitoring, or counseling shall be documented in the practitioner's file. The activities shall be reported to the Medical Executive Committee, but Medical Executive Committee approval is not required. These activities are not a restriction of privileges or grounds for the Hearing or Appeal rights under these Bylaws. Notwithstanding the availability of informal remediation, the Medical Staff may initiate investigations and/or take corrective action against a practitioner without first initiating informal remediation.

G. Progressive Measures

1. The Medical Staff may develop progressive measures to address matters related to a Medical Staff or APP Staff member's clinical or professional performance. "Progressive Measures" means formal interventions that do not constitute investigations or corrective actions. Examples of Progress Measures include, but are not limited to, referrals to anger management courses, medical record keeping courses, and continuing education courses on clinical matters. Such interventions, if used, shall be documented in the practitioner's file. The Progressive Measures shall be reported to the Medical Executive Committee, but Medical Executive Committee approval is not required for such Measures. Progressive Measures are not a restriction of privileges or grounds for the Hearing and Appeal rights under these Bylaws. Notwithstanding the availability of Progressive Measures, the Medical Staff may initiate investigations and/or take corrective action against a practitioner without first initiating Progressive Measures.

5.4 Proctoring

A. General Provisions

1. A member of the Medical Staff in good standing who has completed his or her proctoring requirements may act as a proctor at the request of the department chairperson or division chief.

2. All initial appointees to the Medical Staff granted clinical privileges shall be assigned to the appropriate department / division where performance of an appropriate number of cases shall be observed during a period of initial FPPE as specified by the Medical Executive Committee.

3. Reapplication fees will not be charged to a physician who reapplies within 90 days after automatic termination for failure to complete proctoring.

4. Department chairperson / division chiefs or the Chief of Staff, at their discretion, may accept the full required number of proctored case reports from reciprocal facilities if the proctor is a member in good standing of the reciprocal hospital's medical staff who has completed his or her proctoring requirements.

5. Members of the Advanced Practice Practitioner Staff shall be proctored as determined by the Medical Executive Committee.

6. Proctoring may be imposed for practitioners granted temporary privileges pursuant to these Bylaws.

7. New clinical privileges granted to an existing Medical Staff member shall be proctored as determined by the Medical Executive Committee.

8. The Medical Executive Committee may utilize retrospective chart reviews in proctoring; however, significant concurrent review of a member should be a part of all proctoring.

9. Absent a showing of good cause, a practitioner must complete all proctoring requirements within two years.

B. Completion of Proctoring

1. A practitioner shall remain subject to the proctoring requirement until the Medical Executive Committee:

   a. Has been furnished with a report from the chairperson of the division and/or department to which the practitioner is assigned including the types and numbers of cases observed, an evaluation of the applicant's performance, a statement that the applicant meets the qualifications for unsupervised exercise of specific clinical privileges, and a statement that the applicant has discharged all the responsibilities of Medical Staff membership;

   b. Has been furnished with a report from the chairperson of any other department(s) / division(s) in which the member has exercised clinical privileges describing the types and numbers of cases observed, an evaluation of the applicant's performance, and a statement that the member has satisfactorily demonstrated the ability to exercise these specific clinical privileges, and;

   c. Has determined that any relevant conditions which the Medical Executive Committee have imposed has been satisfied.

C. Failure to Complete Proctoring Requirements

1. If a practitioner fails to complete proctoring requirements due solely to the practitioner's failure to perform the required number or type of procedures, the Medical Executive Committee may, at its sole discretion, extend the time for proctoring for an additional period of up to six months, for show of good cause. If the Medical Executive Committee declines to so extend the time for proctoring, all such clinical privileges shall automatically expire and the provisions of Article VIII shall not apply. The practitioner may appeal the reasonableness of the automatic expiration, regarding the presence or absence of good cause, to the Medical Executive Committee.

2. If a practitioner fails to complete proctoring requirements because of quality of care concerns or any medical disciplinary cause or reason, the Medical Executive Committee has the discretion to extend the proctoring or to terminate the privileges in question. A termination of the clinical privileges in question will entitle the practitioner to the Hearing rights under Article VIII.

3. At the discretion of the Medical Executive Committee, a practitioner may be advanced from the Provisional status to another category of membership when the practitioner has successfully completed all basic proctoring requirements pursuant to current Medical Staff

proctoring requirements even if one or more privilege-specific proctoring requirements have not been completed.

5.5 Limitations on the Clinical Privileges of Limited Licensed Practitioners (Dentists and Podiatrists)

A. General Provisions Applying to Limited Licensed Practitioners

1. Admitting and other clinical privileges of Limited Licensed Practitioner may not exceed the scope of their licensure.

2. The scope and extent of privileges that a Limited Licensed Practitioner may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.

3. Surgical care rendered by Limited Licensed Practitioners shall be under the overall supervision of the chairperson of the department of surgery. Except as allowed below, a medical history and physical examination of the patient shall be made and recorded by a physician Medical Staff member who has clinical privileges to perform a history and physical before surgical or medical treatment shall be scheduled for performance, and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

4. Oral / Maxillofacial surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Medical Staff and Board of Directors through the privileging process.

5. Oral / Maxillofacial surgeons are defined as licensed dentists who have successfully completed a postgraduate program in oral surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education.

6. The dentist shall be responsible for the dental care of the patient, including the dental history and dental physical examination as well as all appropriate elements of the patient's record. Dentists may write orders within the scope of their license and consistent with the Rules and Regulations, and in compliance with the Hospital and Medical Staff Bylaws.

7. The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination as well as all appropriate elements of the patient's record. Podiatrists may perform the history and physical examination if granted such privileges by the Medical Staff. Podiatrists may write orders which are within the scope of their license, consistent with the Rules and Regulations, and in compliance with the Hospital and Medical Staff Bylaws.

B. Care Disputes Between Physicians and Limited Licensed Practitioners

1. The appropriate clinical department chairperson shall promptly resolve any dispute between a Limited Licensed Practitioner and a physician member regarding proposed treatment.

5.6 Anesthesia Services

A. The Medical Staff will establish, through policy or Rules, the criteria for determining the anesthesia service privileges to be granted to an individual practitioner and a procedure for applying the criteria to individuals requesting privileges.

5.7 Non-Privileged Physicians Ordering Outpatient Services

A. Qualified licensed practitioners who are not members of the Hospital's Medical Staff and/or do not possess privileges within the Hospital may order outpatient services that are within their scope of service to order.

5.8 History and Physical Privileges

A. History 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 have temporary privileges, acting within their scope of practice. The Medical Staff Rules and Regulations define the requirements for completing a History and Physical for every patient in compliance with accreditation and licensing standards, to include those found in 42 C.F.R. § 482(c)(5).

5.9 Consultations

A. The Rules and Regulations define the circumstances and criteria under which consultation or management by a physician or other qualified licensed practitioner is required.

5.10 Temporary Clinical Privileges

A. Requirement of Need and Definition of Circumstances

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

a. There is a specific need to provide an important patient care treatment or service that cannot be provided by a current member of the VPH Medical Staff, i.e., no physician has been granted such identical privileges, thus mandating an immediate authorization to practice for a limited period of time, or

b. When a new applicant with a complete application that raises no concerns and has been presented to the Medical Staff's Credentials Committee which has made a favorable recommendation regarding that applicant and is awaiting review and approval of the Medical Executive Committee and the Board of Directors. Such temporary privileges are only considered upon request following such action by the Credentials Committee and not automatically granted.

2. Subject to the provisions of Section 5.10, Subsection A above, temporary privileges may be granted in the following circumstances:

a. Care of a Specific Patient

1. Subject to Section 5.10, Subsection B below, temporary privileges may be granted for a specified period, not to exceed sixty days or the duration of the patient in question's Hospital stay, i.e., temporary privileges terminate at the time of discharge of the patient, to a physician, dentist, or podiatrist for the care of a specific patient. No individual shall be granted such privileges on more than two occasions per calendar year and shall not exceed 120 calendar days in a specific year.

b. Locum Tenens

1. Subject to Section 5.10, Subsection B below, temporary privileges may be granted for a specific period not to exceed six months, to a person serving as a

locum tenens for a current member of the Medical Staff. Such person may attend only patients of the member for whom he or she is providing coverage.

c. Pending Completion of the Credentialing Process

1. Subject to Section 5.10, Subsection B below, temporary privileges may be granted for a period of up to 120 days when a new applicant for Medical Staff membership and/or privileges is waiting for review and recommendation by the Medical Executive Committee and approval by the Board of Directors. The President / Chief Executive Officer may grant temporary privileges upon recommendation of either the applicable clinical department chairperson or the Chief of Staff if the applicant has successfully completed the credentialing verification process and has a favorable recommendation by the Credentials Committee and department chairperson.

B. Application and Review

1. Upon request for Temporary Privileges for Care of an application for Specific Patient with all required fees and supporting documentation, including responses to all requests for information, from a physician, dentist, or podiatrist who is authorized to practice in California, and who meets the requirements for need as described above in this Section the Board of Directors through the President / Chief Executive Officer or designee may grant temporary privileges to an individual who appears to have qualifications, ability and judgment consistent with Article II, but only after:

a. Primary source verification of licensure status, DEA registration, current competence relevant to the privileges requested, and insurance status is obtained;

b. Receipt of professional references (including current competencies);

c. Receipt of database profiles from AMA or AOA;

d. Queries to the National Practitioner Data Bank and Medical Board of California;

e. An OIG sanction report and GSA List query to ensure that the applicant is not an excluded provider;

f. Review of information and written or verbal recommendation has been obtained from the chairperson or designee of each department from which the applicant is requesting privileges;

g. The applicant’s file, including the recommendation of the clinical department chairperson or designee, is reviewed on behalf of the Medical Executive Committee by the Chief of Staff or designee;

h. The Chief of Staff or designee recommends and the Board of Directors, through the President / Chief Executive Officer, concurs with granting temporary privileges;

i. The verification of medical staff membership with privileges corresponding to the requested privileges at a hospital that is accredited by CMS or is Medicare deemed status, although exceptions may be made by the Chief of Staff or designee for good cause.

2. The omission of any information, response or recommendation specified in this Section shall preclude the granting of temporary privileges.

3. Temporary appointment and clinical privileges shall be automatically terminated at such time as the Medical Executive Committee recommends unfavorably with respect to the applicant's appointment to the staff and clinical privileges. At the Medical Executive Committee's discretion, temporary clinical privileges shall be modified to conform to the final recommendations of the Medical Executive Committee should the Medical Executive Committee recommend the applicant be granted different permanent privileges from the temporary privileges originally granted.

C. General Conditions

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

2. All temporary privileges are time limited and shall automatically terminate at the end of the designated period. The provisions of Article VIII shall not apply to such termination.

3. Requirements for proctoring may be imposed on all individuals granted temporary privileges on a case-by-case basis to be determined by the clinical department chairperson in collaboration with the Chief of Staff. Such requirements may be determined by the Chief of Staff or designee after consultation with the chairperson of any department to which the applicant is assigned. Temporary privileges shall be immediately terminated by the President / Chief Executive Officer upon written notice of any failure by the individual to comply with any proctorship requirements or other special conditions. Temporary privileges that are terminated because of a medical disciplinary cause or reason shall give rise to rights of appeal as described in Article VIII.

4. All persons requesting or receiving temporary privileges shall be bound by the Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital administrative policies.

5.11 Emergency Privileges

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

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

C. For the purpose of this Section, an emergency is defined as a condition in which serious or permanent harm might result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

5.12 Disaster Privileges

A. Disaster privileges may only be issued in the event that an emergency overwhelms the response capabilities of the Hospital and its emergency operations plan has been activated in response.

B. The President / Chief Executive Officer, or Chief of Staff, or their designee(s) have the sole discretion to, on a case-by-case basis to grant disaster privileges after establishing the qualifications of a practitioner upon presentation of a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

1. Patient healthcare organization picture identification card from a licensed healthcare organization in the United States of America, with an identifying professional designation

2. A current license to practice;

3. Primary source verification of the license;

4. 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 organization or group;

5. Identification that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances; or

6. Confirmation by a Licensed Independent Practitioner currently privileged by the Hospital or Medical Staff member(s) with personal knowledge of the voluntary practitioner's ability to act as a volunteer Licensed Independent Practitioner during a disaster.

C. Those practitioners granted disaster privileges shall be provided with an identification badge indicating their name, professional degree, and specialty. Practitioners with such disaster privileges serve under the supervision and direction of the Chief of Staff or his or her designee.

D. The Chief of Staff and the Medical Staff Services Department shall begin the verification process of the credentials of individuals who receive disaster privileges. The Chief of Staff or designee will determine within 72 hours of the practitioner's arrival if disaster privileges should continue. Due to extraordinary circumstances, if primary source verification of license cannot be completed within 72 hours of arrival, it is performed as soon as possible.

E. All disaster privileges are time limited and shall automatically terminate at such time as the Hospital's emergency operations plan is no longer in effect. Disaster privileges may also be terminated at any time by the Chief of Staff or the President / Chief Executive Officer or their designees. The provisions of Article VIII shall not apply to such termination.

F. Requirements for proctoring shall be imposed on individuals granted disaster privileges at the discretion of the Chief of Staff or designee or of the chairperson or designee of any department to which the practitioner has been assigned and as circumstances may allow.

5.13 Transport and Organ Harvesting Team Privileging

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

5.14 Clinical Privileges that Cross Specialty Lines

A. When a procedure is performed by specialists in different departments, the departments shall collaborate to develop equivalent privileging criteria, while recognizing that practice differences may exist. The Medical Executive Committee has the authority to resolve any significant conflicts or differences in the criteria developed.

5.15 Modification of Clinical Privileges or Clinical Department Assignment

A. On its own, upon recommendation of the departmental committee, or pursuant to a request under Section 4.7, the Medical Executive Committee may recommend a change in the clinical privileges or department assignment(s) of a member. The Medical 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 the procedures similar to those outlined in Section 5.3.

5.16 Lapse of Application Regarding Modification of Clinical Privileges or Clinical Department Assignment

A. If a Medical Staff member requesting a modification of clinical privileges or department assignments fails to furnish the information necessary to evaluate the request within 90 days, the request shall automatically lapse, and the applicant shall not be entitled to a Hearing as set forth in Article VIII.

5.17 Supervision of Advance Practice Professionals (APP's)

A. Physician members of the Medical Staff who have privileges to provide patient care may, within the scope of their license and practice, supervise and direct the exercise of practice prerogatives by APPs. The categories of APPs that may be supervised and their respective supervision requirements will be defined within each department and approved by the Interdisciplinary Practice Committee, the Medical Executive Committee, and the Board of Directors. This privilege to supervise APPs may be restricted, revoked, or otherwise modified by the Medical Executive Committee with resultant Hearing rights and reporting as applicable.

Article VI Advanced Practice Professional Staff

6.1 Qualifications of Advanced Practice Professionals

A. Advanced Practice Professionals (APP's) are not eligible for Medical Staff membership. They may be granted practice prerogatives and membership on the Advance Practice Professional Staff if they:

1. Hold a license, certificate or other credentials in a category of APP's that the Board of Directors (after securing Medical Executive Committee comments) has identified as eligible to apply for practice prerogatives;

2. Provide documentation that their experience, background, training, current competence, judgment, and ability are adequate to expect that any patient treated by the APP will receive care of the generally recognized professional level of quality established by the Medical Staff;

3. Are determined, on the basis of documented references, to adhere strictly to the lawful ethics of the practitioner's profession, to work cooperatively with others in the Hospital setting so as not to affect adversely patient care, and to be willing to commit to and regularly assist the Medical Staff in fulfilling its obligations related to patient care, within the areas of the practitioner's professional competence and credentials;

4. Agree to comply with these Bylaws, the Rules and Regulations, Policies and Procedures and applicable Hospital policies, as well as any approved standardized procedure or practice agreement, to the extent applicable to the APP;

5. Maintain professional liability insurance with a suitable insurer, with minimum limits ($1,000,000 / $3,000,000) as determined by the Medical Executive Committee; and

6.2 Eligible Categories

A. The Board of Directors shall determine, based upon comments of the Medical Executive Committee and such other information as it has before it, those categories of APP's that shall be eligible to exercise practice prerogatives in the Hospital, which, shall be set forth in the Rules and Regulations. Such APP's shall be subject to the supervision requirements developed in each department. An APP who does not have licensure or certification in an APP category identified as eligible for practice prerogatives may not apply for practice prerogatives but may submit a written request to the President / Chief Executive Officer, asking the Board of Directors to consider designating the appropriate category of APP's as eligible to apply for practice prerogatives. Upon receipt of such a request, the Board of Directors shall forward a copy of the request to the Medical Executive Committee for its recommendation and shall also request the recommendation of any affected department or division. The Board of Directors shall consider such request and the Medical Executive Committee's recommendation, as well as the recommendation of any affected department or division.

6.3 Clinical Department Assignment

A. Each APP shall be assigned to the department appropriate to his or her occupational or professional training and, unless otherwise specified in these Bylaws or the Rules, shall be subject to the terms and conditions similar to those specified for physicians as they may logically be applied to APP's and appropriately tailored to the particular APP.

6.4 General Prerogatives

A. The prerogatives which may be extended to an APP shall be defined in the Rules and Regulations and/or Hospital policies. Such prerogatives may include:

1. Serving on Hospital Committees and Departments

a. Service on Medical Staff, department, and Hospital committees and/or participation shall be by request of the Medical Staff. An APP may not serve as chairperson of Medical Staff committees.

2. Attendance at Meetings

a. An APP staff member may attend meetings of the department to which the APP is assigned, as permitted by the Rules, and may attend Hospital education programs in the APP's field of practice. An APP may not vote at department / division meetings.

3. Patient Care Services

a. Specified patient care services may be performed either independently or under the supervision or direction of a Medical Staff member and consistent with the practice prerogatives granted to the APP and within the scope of the APP's licensure or certification.

6.5 Practice Prerogatives

A. Range / Limitations / Conditions of Practice Prerogatives

1. APP's may exercise only those setting-specific practice prerogatives granted them by the Board of Directors. The range of practice prerogatives for which each APP may apply and any special limitations of conditions to the exercise of such practice prerogatives shall be based on recommendations of the Interdisciplinary Practice Committee, subject to approval by the Medical Executive Committee and the Board of Directors.

B. Procedure for Granting Practice Prerogatives

1. A Certified Registered Nurse Anesthetist (CRNA) is authorized to provide anesthesia services to patients within the scope of their licensure and training when acting under the order of a physician and does not require practice prerogatives be granted for this purpose. A CRNA is not authorized to render services to patients in the Hospital outside this capacity, and thus does not require a physician member to be assigned for direct supervision.

2. An APP whose scope of practice allows independent practice must apply and qualify for practice prerogatives and must designate a physician member of the Medical Staff who holds privileges to be responsible, to the extent necessary, for the general medical condition of patients for whom the APP proposes to render services in the Hospital.

3. An APP, other than a CRNA, whose scope of practice does not allow independent practice must apply and qualify for practice prerogatives and must provide services under the supervision of a physician member of the Medical Staff who qualifies for and holds privileges in accordance with the Bylaws and Rules and Regulations, to supervise and direct the exercise of practice prerogatives by the same category of APP as that of the applicant. An APP under this subsection may apply to work under the supervision of one Active Medical Staff member or, within the Medical Executive Committee's discretion, a group Medical Staff members so long as each of the Medical Staff members possesses privileges to supervise the APP or the category of APPs to which the applicant belongs. Whenever an APP will be supervised by more than one Active Staff member, such supervision must be in strict accordance with the Rules and Regulations.

4. APP applications for initial granting and renewal of practice prerogatives and APP staff membership shall be submitted to the Interdisciplinary Practice Committee. All such applications shall be processed in a parallel manner to that provided in Articles IV and V for Medical Staff members, except that the Interdisciplinary Practice Committee shall perform the function which would otherwise be performed by the Credentials Committee, unless otherwise specified in the Rules and Regulations.

C. Reapplication

1. Every two years, each APP on the APP Staff must reapply for renewed practice prerogatives.

D. Reapplication After Adverse Decisions Regarding Practice Prerogatives

1. Except as is provided under Section 6.7, an APP who (a) has received a final adverse decision regarding their application for practice prerogatives or (b) withdrew their application for practice prerogatives following an adverse recommendation by the Medical Executive Committee, or (c) after having been granted practice prerogatives has received a final adverse decision resulting in termination of practice prerogatives, or (d) has relinquished their practice prerogatives following issuance of a Medical Staff or Board of Directors' recommendation adverse to their practice prerogatives, shall not be eligible to reapply for

the practice prerogatives affected by such decision or recommendation for a period of at least 12 months from the date that the adverse decision became final, the application was withdrawn, or the APP relinquished their practice prerogatives.

6.6 Responsibilities

A. Each APP shall:

1. General

a. Continuously meet the qualifications, standards, and requirements set forth in these Bylaws (including Section 2.6, as modified to reflect the more limited practice of the APP), the Rules and Regulations, Policies and Procedures, and applicable Hospital policies, as well as any approved standardized procedure or practice agreement, to the extent applicable to the APP.

2. Within Area of Professional Competence

a. Retain appropriate responsibility within the APP's area of professional competence and as consistent with the prerogatives granted for the care and supervision of each patient in the Hospital for whom the APP is providing services.

3. Peer Review and Quality Improvement

a. Participate in peer review, utilization management, quality improvement, and in discharging such other functions as may be required from time to time.

6.7 Procedural Rights of Advanced Practice Practitioners

A. APP Staff shall not be entitled to those fair Hearing and Appeal rights as provided elsewhere in these Bylaws for Medical Staff members, except as required by law.

B. Termination, Suspension, or Restriction of Practice Prerogatives

1. General Procedures

a. At any time, the Chief of Staff, chairperson of the department or chief of the division to which the APP has been assigned may recommend to the Medical Executive Committee that an APP's practice prerogatives be terminated, suspended or restricted. After investigation (including, if appropriate, consultation with the Interdisciplinary Practice Committee), if the Medical Executive Committee (MEC) agrees that corrective action is appropriate, the MEC shall recommend specific corrective action to the Hospital's Board of Directors. A notification letter regarding the recommendation shall be sent by certified mail to the subject APP. The notification letter shall inform the APP of the recommendation and the circumstances giving rise to the recommendation.

b. Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an APP member to the Hearing rights set forth in Articles VII and VIII. However, an APP shall have the right to challenge any recommendation which would constitute grounds for a Hearing under Section 8.2 of the Bylaws (to the extent that such grounds are applicable by analogy to the APP), but only if the action would require reporting to the licensing body of the APP. Such a challenge may be initiated by filing a written request for a review with the Interdisciplinary Practice Committee within 15 days of receipt of the notification letter setting forth the specifics of the action or inaction challenged and detailing the remedy requested. Upon receipt of a request, the Interdisciplinary Practice

Committee, may afford the APP an opportunity for an interview concerning the grievance (the "APP Staff Review"). The APP Staff Review will not constitute a Hearing as defined by these Bylaws nor shall the procedure rules applicable to member Hearings apply; rather, the purpose of the APP Staff Review is to allow both the APP and the party recommending the action the opportunity to discuss the situation and to produce evidence in support of their respective positions. A record of the APP Staff Review shall be made.

c. Within 30 days following the APP Staff Review, the Interdisciplinary Practice Committee, based on the APP Staff Review and all other aspects of the investigation, shall make a final recommendation to the Medical Executive Committee. The APP may then request reconsideration by the Medical Executive Committee if the Interdisciplinary Practice Committee's recommendation is adverse, and may present additional written arguments relevant to the Interdisciplinary Practice Committee's recommendation. There is no right for the APP to personally appear before the Medical Executive Committee. After considering the APP's additional written arguments, if any, the Medical Executive Committee shall make a final decision on the Interdisciplinary Practice Committee's recommendation, which shall be communicated to the Board of Directors and, in writing, sent by certified mail to the subject APP. The final recommendation shall discuss the circumstances giving rise to the recommendation and any pertinent information from the APP Staff Review. The final decision will be made by the Board of Directors or a subcommittee thereof.

C. Summary Suspension

1. Notwithstanding Section 6.7(B), an APP's practice prerogatives may be immediately suspended or restricted where the failure to take such action may result in an imminent danger to the health of any individual. Such summary suspension or restriction may be imposed by the Chief of Staff, the MEC, or the chairperson of the department to which the APP has been assigned (or a designee). Unless otherwise stated, the summary suspension action shall become effective immediately upon imposition, and the person responsible for taking such action shall promptly give written notice of the action to the Board of Directors, the MEC, and the President / Chief Executive Officer. The notice shall also inform the practitioner of the right to file an APP Staff Review.

D. Automatic Suspension, Termination, or Restriction

1. Notwithstanding the provisions of Section 6.7, above, an APP's practice prerogatives shall automatically terminate, without review pursuant to Section 6.7 or any other Section of these Medical Staff Bylaws in the event:

a. The Medical Staff membership of the supervising physician is terminated.

b. The supervising physician no longer agrees to act as the supervising physician for any reason, or the relationship between the APP and the supervising physician is otherwise terminated, regardless of the reason thereof; or

c. The APP's certification or license, or other legal credential expires, is revoked, or is suspended.

d. Where the APP's practice prerogatives are terminated for reasons specified in (a) or (b), the APP may apply for reinstatement as soon as the APP has found another physician Medical Staff member who agrees to supervise the APP and has privileges to do so. In this case, the MEC may, at its discretion, expedite the reapplication process.

e. In the event the APP's certification or license is restricted, suspended, or made the subject of probation, the APP's practice prerogatives shall automatically be subject to the same restrictions, suspension, or conditions of probation.

f. Where the APP's practice prerogatives are automatically terminated, suspended or restricted pursuant to this subsection, the notice and interview procedures under Section 6.7 shall not apply and the APP shall have no right to an APP Staff Review, except within the discretion of the MEC, regarding any factual dispute over whether or not the circumstances giving rise to the automatic termination, suspension, or restriction actually exist.

E. Review of Category Decisions

1. The rights afforded by this Section shall not apply to any decision regarding whether a category of APP shall or shall not be eligible for practice prerogatives and the terms or conditions of such decision.

Article VII Corrective Action

7.1 General Provisions and Application of Article

A. The Medical Staff is responsible for overseeing the quality of medical care, treatment and services delivered at the Hospital. The following provisions are designed to achieve performance improvement through collegial peer review and educative measures whenever possible, but with recognition that, when circumstance warrant, the Medical Staff is responsible to embark on corrective measures and/or corrective action as necessary to achieve and assure quality of care and patient safety.

7.2 Criteria for Initiation

A. Any person may provide information, preferably in writing, to the Chief of Staff, any other Medical Staff officer, any Department Chairperson, the Chief Medical Officer, or the Chief Executive Officer about concerns regarding the conduct, performance, or competence of its members.

B. A request for an investigation or action against a member may be made by the Chief of Staff, a department chairperson, a member of the MEC, the Hospital's Chief Executive Officer, or the Board of Directors. Such a request can be made when reliable information indicates that the member may have exhibited acts, demeanor, or conduct, whether on or off the Hospital premises, that is or is reasonably likely to be:

1. Detrimental to patient safety or to the delivery of quality patient care within the Hospital;

2. Unethical, unprofessional, or illegal, including division of fees;

3. Contrary to the Medical Staff's Bylaws, Rules and Regulations, Policies and Procedures, Hospital policies, or the Hospital's compliance program (including items listed in Section 12.2);

4. Inconsistent with the performance standards of the Medical Staff, or below applicable professional standards, or;

5. Disruptive of Medical Staff or Hospital operations, or;

6. An improper use of Hospital resources.

C. The Chief of Staff or any other Medical Staff official may, instead of requesting an investigation, initiate or conduct such reviews as may be appropriate to his or her responsibilities under the Medical Staff's Bylaws, Rules and Regulations, or Policies and Procedures.

7.3 Investigation

A. Only the MEC is authorized to initiate an investigation unless the MEC does not take action upon or declines a request to initiate an investigation, in which case the Board of Directors may initiate an investigation on its own. An investigation does not include the usual activities of departments and other committees of the Medical Staff which lack the authority to take or recommend corrective action, including the usual quality assessment and improvement activities undertaken by the Medical Staff in compliance with the licensing and certification requirements for health facilities as set forth in Title 22 of the California Code of Regulations, the Physician Well-Being Committee, or preliminary deliberations or inquiries of the Medical Executive Committee or its representatives to determine whether to initiate an investigation, including an expedited initial review.

7.4 Expedited Initial Review

A. Whenever information suggests that corrective action may be warranted, the Chief of Staff or his or her designee and/or the CMO may, on behalf of the Medical Executive Committee, immediately research, inquire, and conduct whatever interviews may be indicated. The information developed during this initial review shall be presented to the Medical Executive Committee, which shall decide whether to initiate a formal corrective action investigation.

B. In cases of complaints of harassment or discrimination involving a patient, etc., an expedited initial review shall be conducted on behalf of the Medical Executive Committee by the Chief of Staff, the Chief of Staff's designee, or the CMO, together with representatives of administration, or by an attorney for the Hospital. In cases of complaints of harassment or discrimination where the alleged harasser is a Medical Staff member and the complainant is an employee, an expedited initial review shall be conducted by the Chief Medical Officer and the Hospital's human resources director or their designee, or by an attorney for the Hospital, who shall use best efforts to complete the expedited initial review within a timely manner. The Chief of Staff shall be kept apprised of the status of the initial review. The information gathered from an expedited initial review shall be referred to the Medical Executive Committee if it is determined that corrective action may be indicated against a Medical Staff member.

7.5 Process

A. A request for action or for an investigation under the auspices of the Medical Executive Committee must be supported by reference to specific activities or conduct alleged.

B. If the Medical Executive Committee concludes that an investigation is warranted, it shall determine how to proceed. The MEC may conduct the investigation itself, or may assign the task to an appropriate Medical Staff officer, Medical Staff department, or standing or ad hoc committee of the Medical Staff. The parties conducting the investigation shall not include partners, associates, or relatives of the individual being investigated or any individual who is in direct economic competition or who has a conflict of interest with the individual being investigated. The Medical Executive Committee in its discretion may appoint practitioners, review consultants, or agencies who are not members of the Medical Staff as temporary members of the Medical Staff to serve on or consult with a standing or ad hoc investigative committee.

C. The individual under investigation shall, at an appropriate time, 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 investigator or investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such an interview shall not constitute a Hearing, nor shall the procedural rules with respect to Hearings or appeals apply. At the conclusion of the investigation a written summary of the findings and recommendation(s) shall be forwarded to the Medical Executive Committee. Despite the status of any investigation, at all times the Medical Executive Committee shall have authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

7.6 Medical Executive Committee Action

A. As soon as practicable following the conclusion of the investigation, the Medical Executive Committee shall take action that may include, without limitation:

1. Determining that no corrective action is warranted (and if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, it will make a note in the member's credential file that the complaint was unsubstantiated).

2. Referring the member to the Physician Well-Being Committee for evaluation and follow up as appropriate.

3. Deferring action for a reasonable time.

4. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude department chairpersons from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such a letter is issued, the affected member may make a written response which shall be placed in the member's file pursuant to Section 13.9.

5. Taking special measures to monitor the member's exercise of privileges on a non-restrictive basis.

6. Recommending the imposition of terms of probation or special limitations on continued Medical Staff membership or exercise of clinical privileges including, without limitation, requirements for co-admission, mandatory consultation, or monitoring.

7. Recommending reduction of Medical Staff membership status or limitation of membership prerogatives; such actions may be time limited.

8. Recommending reduction, modification, suspension, or revocation of Medical Staff membership and/or clinical privileges; such actions may be time limited.

9. Imposing a suspension or restriction of clinical privileges and/or Medical Staff membership for a duration of 14 days or less, after giving the member an opportunity to be heard by the Medical Executive Committee where reasonably feasible.

10. Summarily suspending or restricting Medical Staff membership and/or clinical privileges.

11. Taking other actions deemed appropriate under the circumstances.

B. The Medical Executive Committee action shall be transmitted to the Board of Directors for information. Additionally, a determination will be made to establish whether the action is taken for any of the reasons required to be reported pursuant to Business and Professions Code Section 805 et seq.

7.7 Board of Directors Action

A. The Medical Staff acknowledges that the Board of Directors must act to protect the quality of medical care provided and the competency of its Medical Staff, and to ensure the responsible governance of the hospital in the event that the Medical Staff fails in any of its substantive duties or responsibilities. The Medical Executive Committee's (MEC's) action or recommendation following an investigation as described herein shall be presented to the Board of Directors at its next regularly scheduled meeting.

1. If the Medical Executive Committee has imposed or recommended corrective action as to which the affected practitioner may request a Hearing, the Board of Directors shall take no action on the matter until the practitioner has either waved or exhausted his or her Hearing rights.

2. If the practitioner invokes his Hearing and Appeal rights, the Board of Directors shall proceed as described in Article VIII.

3. If the Medical Executive Committee has taken or recommended corrective action and the practitioner has no rights of Hearing or appeal, or has waived such rights, and the Board of Directors questions or disagrees with the action of the Medical Executive Committee, the matter may be remanded back to the Medical Executive Committee for further consideration. If the decision of the Board of Directors is to take corrective action more severe than the action presented for the Board of Directors consideration, and the MEC declines to modify its action or fails to act in response to the Board of Director's direction, the practitioner shall be given an opportunity for a Hearing before the Board of Directors or a committee thereof. The procedures governing the Hearing shall be determined by the Board of Directors, in accordance with the member's rights under California law. The decision following the hearing shall be the final decision of the Hospital.

4. If the Medical Executive Committee decides not to conduct an additional investigation or otherwise initiate corrective action proceedings as set forth above, the matter shall be subject to review by the Board of Directors. The Board of Directors may affirm, reject, or modify the action or recommendation. The Board of Directors shall give great weight to the Medical Executive Committee's decision and initiate further action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the Medical Executive Committee and the Medical Executive Committee still has not acted. The decision shall become final if the Board of Directors affirms it or takes no action on it within a reasonable time after receiving the notice of decision.

7.8 Summary Restriction or Suspension

A. Criteria for Initiation

1. Whenever the conduct of a member (or other "licentiate" as defined by California law) is such that a failure to take action may result in an imminent danger to the life, health, and safety of any individual, the Chief of Staff, the Medical Executive Committee, the Hospital Chief Executive Officer (subject to the requirements in this Section), or the chairperson of the department or designee in which the member holds privileges, may summarily restrict or suspend the Medical Staff membership or clinical privileges of such member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the Board of Directors, the Medical Executive Committee, and the Hospital Chief Executive Officer. In addition, the affected Medical Staff member shall be provided with a written notice of the action which notice fully complies with the requirements of this Section. The summary restriction or suspension may be limited in duration and shall remain in effect

for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the department chairperson or by the Chief of Staff, considering where feasible the wishes of the patient in the choice of a substitute member.

2. Unless an investigation of the suspended practitioner is already underway at the time the summary suspension is imposed, that action shall automatically constitute a request for investigation or action pursuant to this Article. If the Medical Executive Committee imposed the summary suspension or restriction on its own initiative, it shall determine what, if any, investigation and further actions are warranted.

B. Written Notice of Summary Suspension

1. Within one working day of imposition of a summary suspension, the affected Medical Staff member shall be provided with verbal notice of such suspension, followed within three working days of imposition, a written notice of such suspension. This 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 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 8.3, which applies in all cases where the Medical Executive Committee does not immediately terminate the summary suspension. The notice under Section 8.3 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.

C. Medical Executive Committee Action

1. Within one week after a summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee shall be convened to review and consider the action. Upon request, the member shall attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any such meeting of the Medical Executive Committee, with or without the member, constitute a Hearing with the meaning of Article VIII, nor shall any procedural Hearing rules apply. The Medical 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 within two business days of the meeting.

    a. Unless the Medical Executive Committee promptly terminates the summary restriction or suspension, and if the summary suspension is reportable to the Medical Board of California, the member shall be entitled to the procedural rights afforded by Article VIII.

D. Initiation by the Board of Directors

1. If the Chief of Staff, members of the Medical Executive Committee and the department chairperson 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 through the Hospital President / Chief Executive Officer or designee may immediately suspend or restrict a member's privileges if a failure to take action may result in an imminent danger to the life, health and safety of any individual, provided that the Board of Directors or designee made reasonable attempts to contact the Chief of Staff or designee, members of the Medical Executive Committee and the department chairperson or designee before acting.

2. Such a suspension is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two business days, excluding weekends and holidays, the summary suspension shall terminate automatically. If the Medical Executive Committee does ratify the summary suspension, all other provisions under this Section 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 Medical Executive Committee for purposes of compliance with notice and Hearing requirements.

7.9 Automatic Suspension or Limitation

A. In the following instances, a member's membership and/or clinical privileges may be suspended, limited or terminated automatically as described below, and a review, if requested, shall be limited to the question of whether the grounds for automatic suspension as set forth below have occurred. The limitations described in this Section shall take effect automatically as of the date of the underlying action or event, regardless of whether the member provides notice thereof to the Medical Staff Services Department.

1. Medical Records

a. Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the Medical Executive Committee, by these Bylaws, the Rules and Regulations, Policies and Procedures, or by Hospital policies. Failure to comply shall result in suspension of admitting and related privileges; related privileges includes scheduling surgery, assisting in surgery, consulting on Hospital cases, and providing professional services within the Hospital for future patients. The suspension shall be imposed by the Chief of Staff, or his or her designee, after informing the member of delinquency for failure to complete medical records within such period, subject to the following:

1. A grace period may be allowed under compelling circumstances, such as illness;

2. The member whose privileges have been suspended for delinquent records may continue to care for patients in the Hospital at the time the suspension is imposed, and may admit patients in life-threatening situations with the approval of the member's department chairperson or the Chief of Staff;

3. The member shall remain responsible for his or her emergency on-call coverage obligations as scheduled and may exercise such clinical privileges only as may be required to fulfill such obligations.

b. A suspension related to completion of medical records shall continue until lifted by the Chief of Staff, or his or her designee.

c. The Chief of Staff or designee may also suspend a member's admitting and related privileges, as described above, where the member has removed any record from the Hospital without authorization. The suspension shall remain in place until the Chief of Staff or designee is satisfied that all records have been returned.

d. Members of the Medical Staff who exceed the maximum number of allowed suspension days per year will be required to pay a fine as set by the Medical Executive Committee, and will remain on suspension until the fine is satisfied. In addition, the Medical Executive Committee may require such members, at its discretion, to complete a designated course on medical record keeping within a designated reasonable

timeframe. Failure to complete such a course within the designated timeframe will constitute an automatic relinquishment of Medical Staff membership and privileges.

e. Repeated failures to complete medical records in a timely manner shall be one of the factors considered for changing the member's staff category and for denying reappointment, and shall be taken into consideration in connection with all other factors at the time of reappointment.

2. Licensure

a. Whenever a member's license or other legal credential authorizing practice in this State is:

1. Expired, revoked, or suspended, Medical Staff membership and clinical privileges shall be automatically revoked or suspended as of the date such action becomes effective.

2. Limited or restricted by the applicable licensing agency or certifying authority, any clinical privileges which the member has been granted at the Hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar matter as of the date such action becomes effective and throughout its term.

3. Placed on probation, 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.

3. Failure to Pay Dues or Assessments

a. Failure without good cause, as determined by the Medical Executive Committee, to pay dues or assessments imposed as per Article XIII within 30 days after written warning of delinquency shall be grounds for suspension of a member's membership and clinical privileges. If within three months and after two written warnings of the delinquency the member does not pay the required dues or assessments, the member's membership and privileges shall be automatically relinquished.

4. Professional Liability Insurance

a. If at any time a member's professional liability insurance coverage fails to be continuously maintained, or lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect (in whole or in part) for all of the member's clinical privileges, the member's affected clinical privileges shall be suspended automatically as of that date until the Medical Staff Services Department determines that it has received acceptable documentation of adequate professional liability insurance coverage. If acceptable proof of such coverage is not provided to the Medical Staff Services Department within 90 days of such lapse, then the member's clinical privileges and membership shall automatically terminate and be deemed as an automatic resignation.

5. Controlled Substances

a. Whenever a member's DEA certificate is:

1. Expired, 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.

2. Subject to probation, the member's right to prescribe medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

6. Failure to Comply with Government-Funded Healthcare Program Requirements

a. Whenever a member is excluded or disqualified from any federal health care program or otherwise becomes an Ineligible Person, the member's clinical privileges shall be automatically suspended as of the effective date of such disqualification or exclusion.

b. The Medical Executive Committee shall also be empowered to determine that compliance with certain specific government agency and professional review organization Rules or policies is essential to hospital and/or Medical Staff operations and that compliance with such requirements can be objectively determined. The Rules and Regulations may authorize the automatic suspension of a practitioner who fails to comply with such requirements. The suspension shall be effective until the practitioner complies with such requirements.

7. Failure to Satisfy Special Attendance Requirement

a. Members are expected to cooperate with Medical Staff committees and representatives in the discharge of their official functions. This includes responding promptly and appropriately to correspondence, providing requested information, and appearing at appropriately announced meetings regarding quality of care issues, utilization management issues, Medical Staff administrative issues, and other issues that may arise in the conduct of Medical Staff affairs.

b. Failure of a member without good cause to provide information or appear when requested by a Medical Staff committee or its representative as described in these Bylaws shall result in the suspension of all privileges. The MEC may, in addition to or in lieu of such a suspension, choose to take other appropriate action as it deems necessary. This special attendance requirement includes submitting to mental or physical examinations, as requested by the Medical Executive Committee, for the purpose of resolving issues of fitness to perform mental or physical functions associated with the practitioner's privileges or related issues of reasonable accommodation. The automatic suspension shall remain in effect until the practitioner has provided the requested information and/or satisfied the special attendance requirement which has been made by the Medical Staff committee and the member is expressly notified that it is rescinded.

8. Felonies and Misdemeanors

a. A conviction, plea of guilty, or plea of no contest shall result in an automatic relinquishment of Medical Staff membership and privileges if the matter pertains to a felony or misdemeanor involving any of the following: (a) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (b) Controlled substances; (c) Homicide or felony assault; (d) Sexual assault, battery, or rape; (e) Child pornography; (f) Moral turpitude; or (g) Child, dependent adult, or elder abuse. Such relinquishment shall become effective immediately upon such conviction (or plea of no contest) regardless of whether or not an appeal is taken or pending from said judgment.

b. Formal charges of any felony or misdemeanor that relate to any matter that could reasonably impact patient safety as determined by the Medical Executive Committee, to include all items listed above, may result in suspension of all Medical Staff privileges until the matter is resolved.

9. Failure to Provide Call Coverage

a. In the absence of extenuating circumstances, the failure to fulfill emergency call obligations as scheduled may be grounds for termination of the practitioner's membership and clinical privileges.

10. Failure to Complete Mandatory Orientation or Training

a. Failure, without good cause, as determined solely by the Medical Executive Committee, to complete in a timely manner any mandatory orientation or training required by the Hospital, the Medical Staff Bylaws and/or Rules and Regulations and Policies and Procedures, or the Medical Executive Committee, shall result in the automatic suspension of the member's Medical Staff privileges until such time as either the individual has successfully completed the required orientation or training or the practitioner's membership and privileges are automatically terminated. For the purposes of this Section, "mandatory training" does not include training ordered as part of an individual determination regarding a practitioner's competency, such as training ordered as part of an FPPE plan or as a corrective action.

11. Member Obligations

a. Members shall provide written notification to the Medical Staff Services Department of any item noted in Section 7.9 above within five calendar days of such action being taken. The member shall also promptly provide the Medical Staff Services Department with a written explanation of the basis for such actions, including copies of relevant documents. The Medical Executive Committee may request the member to provide additional information concerning the above-described actions or events, and a failure of the member to provide such information may extend the special actions listed above, even though the underlying limitation may have been removed.

Article VIII Hearings and Appellate Reviews

8.1 General Provisions

A. Intent

1. The intent of these Hearing and Appellate review procedures is to provide for a fair review of decisions that adversely affect practitioners (as described below in Section 8.2) and at the same time to protect the peer review participants from liability. It is further the intent to establish flexible procedures which do not create burdens that will discourage the Medical Staff and Board of Directors from carrying out peer review. Accordingly, discretion is granted to the Medical Staff and Board of Directors to create a hearing process which provides for the least burdensome level of formality in the process while still providing a fair review and to interpret these Bylaws in that light. The Medical Staff, Board of Directors, and their officers, committees and agents hereby constitute themselves as peer review bodies under the Federal Health Care Quality Improvement Act of 1986 and California Business and Professions Code Section 809 et seq., and claim all privileges and immunities afforded by the federal and state laws.

B. Exhaustion of Remedies

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

C. Intra-Organizational Remedies

1. The Hearing and Appeal rights established in these Bylaws are strictly judicial rather than legislative in structure and function. The Hearing committees have no authority to adopt new rules and standards, to modify existing rules and standards, or to resolve questions regarding the merits or substantive validity of Bylaws, Rules, Regulations, or Policies and Procedures. Challenges to the substantive validity of any Bylaw, Rule, Regulation, or Policy or Procedure shall be handled according to Section 8.17 below.

D. Definitions

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

a. "**Body whose decision prompted the Hearing**" refers to the Medical Executive Committee is all cases where the Medical Executive Committee or authorized Medical Staff departments, members or committees, took the action or rendered the decision which resulted in a Hearing being requested. It refers to the Board of Directors in all cases where the Board of Directors or its authorized officers, directors, or committees took the action or rendered the decision which resulted in a Hearing being requested.

b. "**Practitioner**", as used in this Article, refers to the practitioner who may request or has requested a Hearing pursuant to this Article.

c. "**Day**" means calendar day.

E. Substantial Compliance

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

F. Application of Article

1. For purposes of this Article, the term "member" may include "applicant" and those with temporary privileges, as it may be applicable under the circumstances, unless otherwise stated.

8.2 Grounds for a Hearing

A. Except as otherwise specified in applicable Bylaws, Rules, Regulations, or Policies and Procedures, any one of the following adverse actions or recommended actions shall be deemed grounds for a Hearing if taken for a medical disciplinary cause or reason (if not based on eligibility grounds) and which is reportable to the Medical Board of California under Business and Professions Code, Section 805, or the National Practitioner Data Bank.

1. Denial of Medical Staff membership, reappointment and/or clinical privileges, based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients;

2. Revocation of Medical Staff membership, based on professional competence or conduct which affects or could adversely affect the health or welfare of a patient or patients;

3. Revocation or reduction of clinical privileges, based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients;

4. Significant restriction of clinical privileges (except for proctoring incidental to Provisional status, new privileges, insufficient activity, or return from a leave of absence) for 30 or more days based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients;

5. Summary suspension or restriction of Medical Staff membership and/or clinical privileges for more than 14 days based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients, or;

6. Any other disciplinary action or recommendation that must be reported, by law, to the Medical Board of California, or the National Practitioner Data Bank.

7. Involuntary reduction or restriction of current clinical privileges for a cumulative total of 30 days or more in any 12-month period.

B. No actions or recommendations except those described above shall entitle the practitioner to request a Hearing.

8.3 Requests for a Hearing

A. Notice of Action or Recommendation

1. In all cases in which action has been taken or recommended as set forth in Section 7, the practitioner shall be given prompt written notice of the action or recommendation including the following information:

a. A description of the action or recommendation;

b. A brief statement of the reasons for the action or recommendation;

c. The right to request a Hearing within 30 days or as otherwise specified in these Bylaws;

d. A summary of the rights that would be granted at a Hearing pursuant to the Medical Staff Bylaws; and

e. A statement as to whether the action or recommendation must be reported to the Medical Board of California and/or the National Practitioner Data Bank.

B. Request for a Hearing

1. The member shall have 30 days following receipt of the notice of the action or recommendation within which to request a Hearing. The request shall be in writing addressed to the Medical Executive Committee with a copy to the Board of Directors within the time and manner described.

2. If the practitioner does not request a Hearing within the time and in the manner described, the practitioner shall be deemed to have waived any right to a Hearing and accepted the recommendation or action involved. Said action shall thereupon become the final action of the Medical Staff. The action or recommendation shall be presented for consideration by the

Board of Directors, which shall not be bound by it. If the Board of Directors ratifies the action or recommendation, it shall thereupon become the final action of the Hospital. However, if the Board of Directors, after consulting with the Medical Executive Committee, is inclined to take action against the practitioner that is more adverse than the action recommended by the Medical Staff, the practitioner shall be so notified and given an opportunity for a Hearing based on an adverse action by the Board of Directors, as provided herein.

8.4 Mediation

A. At any time, the Medical Staff may offer the practitioner the opportunity to mediate the dispute. The practitioner agrees that requesting mediation tolls all deadlines in this Article other than the deadline to request a Hearing within 30 days after receiving a notice of recommendation or action described above. There is no right to mediation granted by these Bylaws, however, and any such offer is solely at the discretion of the Medical Staff.

8.5 Hearing Procedure

A. Hearing Prompted by Board of Directors Action

1. If the Hearing is based upon an adverse action by the Board of Directors, the Chair of the Board of Directors shall fulfill the functions assigned in this Article to the Chief of Staff. The procedure may be modified as warranted under the circumstances, but the practitioner shall have all of the same rights to a fair Hearing.

B. Time and Place for Hearing

1. Upon receipt of a request for Hearing, the Chief of Staff shall schedule a hearing and, within 30 days from the date he or she received the request for a Hearing, give written notice to the practitioner of the time, place, and date of the Hearing. Unless extended by the parties or the Hearing Officer, the date of the commencement of the Hearing shall be not less than 30 days nor more than 60 days from the date of the written notice to the practitioner.

2. The MEC may elect, at its own discretion, to conduct any or all Hearings virtually by using assistive technology, as permitted by law.

C. Notice of Charges

1. Together with the Notice stating the place, time, and date of the Hearing, the Chief of Staff or designee on behalf of the Medical Executive Committee shall provide the reasons for the recommended action including the acts or omissions with which the practitioner is charged and a list of the charts in question, where applicable The Notice may be supplemented or amended at any time as needed prior to the issuance of the Judicial Review Committee's decision, provided the practitioner is afforded a fair and reasonable opportunity to respond.

D. Trier of Fact

1. Judicial Review Committee

a. When a Hearing is requested, the Chief of Staff shall appoint a Judicial Review Committee to serve as Trier of Fact which shall be composed of not less than three members of the Medical Staff who shall gain no direct financial benefit from the outcome and who have not acted as accusers, investigators, fact-finders, or initial decision-makers, and otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of

the Judicial Review Committee. Such appointment shall include designation of the chairperson. When feasible, the Judicial Review Committee shall include at least one member who has the same healing arts licensure and practices in the same specialty as the practitioner involved. Feasibility shall not be defined as requiring payment to serve on the Judicial Review Committee or seeking members outside of the Medical Staff.

2. Arbitrator

   a. As an alternative to a Judicial Review Committee, the Medical Executive Committee shall have the discretion to enter into an agreement with the practitioner involved to hold the Hearing before a mutually acceptable arbitrator or arbitrators who will serve as Trier of Fact. The arbitrator shall meet the same qualifications as the Hearing Officer, as detailed in this Section. The arbitrator shall carry out all the duties assigned to the Hearing Officer and to the Trier of Fact. If an arbitrator is appointed, no additional Trier of Fact or Hearing Officer shall be appointed, and all references in these Bylaws to the duties and responsibilities of the Trier of Fact, Judicial Review Committee, or Hearing Officer shall be read as the arbitrator's duties and responsibilities. If this alternative is used, the member and the Medical Executive Committee will select a mutually acceptable arbitrator. If the failure or refusal of the member to agree to an arbitrator makes it impracticable to commence the Hearing within the time frames set forth above, the time for commencement of the Hearing shall be extended to 30 days after an arbitrator is selected, or the Hearing will proceed with the formation of a Judicial Review Committee upon request of either party. Failure or refusal to exercise this discretion with regard to the use of an arbitrator shall not constitute a breach of the Medical Staff's responsibility to provide a fair Hearing.

3. A majority of the Judicial Review Committee must be present throughout the Hearing. In unusual circumstances when a Judicial Review Committee member must be absent from any part of the proceedings, he or she shall not be permitted to participate in the deliberations or the decision unless and until he or she has read the entire transcript of the portion of the Hearing from which he or she was absent.

4. The Trier of Fact shall have powers as are necessary to discharge its or his or her responsibilities.

E. The Hearing Officer

1. The President / Chief Executive Officer shall appoint a Hearing officer to preside at the Hearing. The Hearing officer shall be an attorney-at-law who is qualified to preside over a quasi-judicial Hearing, but attorneys from a firm regularly utilized by the Hospital or Medical Staff for legal advice regarding its affairs and activities shall not be eligible to serve as a 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 preside over the voir dire process and may question panel members directly, and shall make all rulings regarding service by the proposed Hearing panel members or the Hearing officer. The Hearing officer shall endeavor to assure that all participants in the Hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing officer shall be entitled to determine the order of or the procedure for presenting evidence and argument during the Hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence.

2. The Hearing officer's authority shall thus include, but not be limited to, making rulings with respect to requests and objections pertaining to the production of documents, requests for continuances, designation and exchange of proposed evidence, evidentiary disputes, witness issues including disputes regarding expert witnesses, and setting reasonable schedules for timing and/or completion of all matters related to the Hearing.

3. At the commencement of the Hearing, the Hearing officer may also apprise the Judicial Review Committee of its right to terminate the Hearing due to the member's failure to cooperate with the Hearing process, but shall not independently make that determination or otherwise recommend such a termination at any other time. 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, including but not limited to, limiting the scope of examination and cross-examination and setting fair and reasonable time limits on either side's presentation it its case.

4. 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 office shall not be entitled to vote.

5. In all matters, the Hearing officer shall act reasonably under the circumstances and in compliance with applicable legal principles. In making rulings, the Hearing officer shall endeavor to promote a less formal, rather than more formal, Hearing process and also to promote the swiftest possible resolution of the matter, consistent with the standards of fairness set forth in these Bylaws. The Hearing officer shall have authority to interpose any objections and to initiate rulings necessary to ensure a fair and efficient process.

F. Voir Dire

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

G. Representation

1. The Hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, or character. Neither party may be represented in any phase of the Hearing by an attorney-at-law unless the Medical Executive Committee agrees to allow both parties to be represented by legal counsel. In any event, the body whose decision prompted the Hearing shall not be represented by an attorney-at-law if the practitioner is not so represented. The foregoing shall not be deemed to deprive any party of its right to be represented by legal counsel for the purpose of preparing for the Hearing. When attorneys are not allowed, the practitioner and the body whose decision prompted the Hearing may be represented at the Hearing only by a practitioner licensed to practice in the State of California who is not also an attorney-at-law.

H. Failure to Appear or Proceed

1. Failure without good cause of the member to personally attend and proceed at a Hearing in an efficient and orderly manner or serious and persistent misconduct or failure to cooperate in the hearing process shall be grounds for termination of the hearing as determined by the Judicial Review Committee. Such conduct by the practitioner shall be deemed to constitute a waiver of any hearing rights and acceptance of the recommendation(s) or action(s) taken by the Medical Executive Committee.

I. Postponements and Extensions

1. Once a timely request for a Hearing is initiated, postponements and extensions of the time beyond those permitted in these Bylaws may be permitted by the Hearing officer on the showing of good cause or upon agreement of the parties. The Medical Executive Committee shall exercise ongoing oversight over the Hearing to ensure the timely resolution of issues. 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 Medical Executive Committee failed to provide information in a reasonable time or consented to the delay.

8.6 Discovery

A. Rights of Inspection and Copying

1. The member shall have the right to inspect and copy documents and other evidence upon which the charges are based, as well as all other evidence relevant to the charges. The Medical Executive committee may 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. 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.

B. Limits on Discovery

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

C. Ruling on Discovery Disputes

1. The Hearing officer shall rule on requests for access to information and may impose any safeguards for the protection of the peer review process and that justice requires. In so doing, the Hearing officer shall consider:

a. Whether the information sought may be introduced to support or defend against the charges;

b. The exculpatory or inculpatory nature of the information sought, if any;

c. The burden imposed on the party in possession of the information sought, if access if granted; and

d. Any previous requests for access to information submitted or resisted by the parties to the same proceeding.

D. Pre-Hearing Document Exchange

1. The parties must exchange all documents that will be introduced at the Hearing. The documents must be exchanged at least ten days prior to the Hearing. Failure to comply with this rule is good cause for the Hearing officer to grant a continuance, or to limit the introduction of any documents not provided to the other party in a timely manner.

2. The member shall have the right to receive at least 10 days prior to the Hearing a copy of the exhibits expected to be presented to the Trier of Fact demonstrating the basis of the charges. The failure to provide exhibits to the other party within 10 days of the Hearing shall constitute good cause for a continuance.

3. The Medical Executive Committee may object to the introduction of evidence that was not provided during an appointment, reappointment or privilege application review or during corrective action despite the requests of the peer review body for such information. The information will be barred from the hearing by the Hearing Officer unless the practitioner can prove he or she previously acted diligently and could not have submitted the information prior to the hearing.

E. Witness Lists

1. If either side to the Hearing requests in writing a list of witnesses, within 15 days of such request, and in no event less than 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 expected to give testimony or evidence in support of that party at the Hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. Failure to disclose the identity of a witness at least ten days prior to the Hearing date at which the witness is to appear shall constitute good cause for a continuance.

8.7 Procedural Disputes

A. It shall be the duty of the parties to exercise reasonable diligence in notifying the Hearing officer of any pending or anticipated procedural disputes as far in advance of the scheduled Hearing as possible, in order that decisions concerning such matters may be made in advance of the Hearing. Objections to any pre-Hearing decisions may be succinctly made at the Hearing.

B. The parties shall be entitled to file motions or otherwise request rulings as deemed necessary to give full effect to rights established by the Bylaws and to resolve such procedural matters as the Hearing officer determines may be properly resolved outside the presence of the full Judicial Review Committee. All such motions or requests, the arguments presented by both parties, and rulings thereon shall be reflected in the Hearing record in a manner deemed appropriate by the Hearing officer.

8.8 Record of Hearing

A. A shorthand reporter shall be present to make a record of the Hearing proceedings, and the pre-Hearing proceedings if deemed appropriate by the Hearing officer. The cost of attendance of the shorthand reporter shall be borne by the Hospital, but the cost of preparing a transcript, if any, or of a copy if the transcript has already been prepared, 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 under oath administered by a person lawfully authorized to administer such oath.

8.9 Attendance

A. Except as permitted by the Hearing officer for good cause, only members of the Judicial Review Committee, the Hearing officer, the member and his or her representative, the representative and the designees of the Medical Staff which may include the Chief of Staff and the chairperson of the member's department, the Medical Staff Services Department Director or his or her designee and the court reporter, shall be permitted to attend the Hearing in its entirety (excluding deliberations).

8.10 Rights of the Parties

A. 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 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 Medical Executive Committee and examined as if under cross-examination. The Hearing officer shall rule upon the validity of any challenges of witnesses or exhibits presented by the parties to the Hearing. The Hearing officer shall also have the discretion to ask questions of witnesses if he or she deems it appropriate for purposes of clarification or efficiency. The Judicial Review Committee may question witnesses or request additional witnesses if it deems such action appropriate. As the Judicial Review Committee lacks the power of subpoena, however, the attendance of requested witnesses is not compulsory.

8.11 Rules of Evidence

A. Judicial rules of evidence and procedure relating to the conduct of a Hearing regarding the 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 relying in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. However, findings may not be based upon uncorroborated hearsay. At its discretion, the Judicial Review Committee may request or permit both sides to file written arguments.

8.12 Burdens of Presenting Evidence and Proof

A. At the Hearing the Medical Executive Committee or body whose decision prompted the hearing shall have the initial duty to present evidence which supports its recommendation or action. The practitioner shall be obligated to present evidence in response.

B. An applicant shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, of the applicant's qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning the practitioner's current qualifications. 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 Medical 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. The term reasonable and warranted means within the range of reasonable and warranted alternatives open to the Medical Executive Committee, under the circumstances, and not necessarily the only measure or best action that could have been taken or formulated in the opinion of the Trier of Fact.

8.13 Adjournment and Conclusion

A. After consultation with the chair of the Judicial Review Committee, the Hearing officer may adjourn and reconvene the Hearing 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 Medical 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, and the conclusion of deliberations, the Hearing will be closed.

8.14 Basis for Decision

A. 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.

8.15 Decision of the Judicial Review Committee

A. Within 30 days after the 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 Medical Executive Committee. A copy of said decision shall be forwarded to the Administrator, the Board of Directors, and 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 The decision of the Judicial Review Committee is subject to such rights of appeal or review as described in these Bylaws.

8.16 Appeal

A. Time for Appeal

1. Within ten days after receipt of the decision of the Judicial Review Committee, either the member or the Medical 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 requested 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 proceeding.

2. It shall be the obligation of the party requesting appellate review to produce the record of the Judicial Review Committee proceedings. If the record is not produced within 30 days, appellate rights shall be deemed waived by the party requesting same.

3. In the event of a waiver of appellate rights by a practitioner, if the Board of Directors is inclined to take action which is more adverse than that taken or recommended by the Medical Executive Committee, the Board of Directors must consult with the Medical Executive Committee before taking such action. If after such consultation the Board of Directors is still inclined to take such action, then the practitioner shall be given an opportunity to be heard before a final decision is made. Said opportunity shall not involve additional evidentiary proceedings if the action under consideration by the Board of Directors is based on the factual findings or conclusions of the Judicial Review Committee.

B. Grounds for Appeal

1. A written request for an appeal shall include an identification of the grounds of appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the Hearing shall be:

    a. Substantial noncompliance with the procedures required by these Bylaws, or applicable law, which has created demonstrable prejudice; or

    b. The decision was not supported by substantial evidence based upon the Hearing record or such additional information as may be permitted pursuant to this Section; or

    c. The Judicial Review Committee's failure to sustain an action or recommendation of the Medical Executive Committee that, based on the evidence, was reasonable and warranted.

C. Time, Place, and Notice

1. If an appellate review is to be conducted, the appeal board shall, within 30 days after receipt of a notice of appeal, schedule a review date and cause each side to be given notice of time, place, and date of the appellate review. The appellate review shall not commence less than 30 or more than 60 days from the date of 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 may commence as soon as the arrangements may reasonably be made, not to exceed 15 days from the date of the notice. The time for appellate review may be extended by the appeal board for good cause.

D. Appeal Board

1. 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 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 assisting the Hearing panel or served as Hearing officer.

E. Appeal Procedure

1. 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 Committee for taking of further evidence and for decision. The appeal board shall also have discretion to remand the matter to the Judicial Review Committee for the taking of further evidence. Each party shall have the right to be represented by legal counsel or any other representative designated by that party in connection with the appeal to present a written statement in support of that party's position on appeal and to personally appear and make oral argument. The appeal board shall present to the Board of Directors its written recommendations as to whether the Board of Directors shall affirm, reverse or modify the Judicial Review Committee decision, or remand the matter to the Judicial review Committee for further review and decision.

F. Decision

1. Within 30 days after the conclusion of the appellate review proceedings, the Board of Directors shall render a decision. The Board of Directors may affirm, reverse or modify the decision of the Judicial Review Committee, but their decision must be supported by substantial evidence following a fair Hearing. The Board of Directors decision shall constitute the final decision of the Hospital.

2. Should the Board of Directors determine that the Judicial Review Committee decision is not supported by substantial evidence or that a fair procedure has not been afforded, it may remand the matter to the Judicial Review Committee for reconsideration, stating the purpose of the referral. If the matter is remanded to the Judicial Review Committee for further review and recommendation, the committee shall promptly conduct its review and make its recommendations to the Board of Directors. This further review and the time required to report back shall not exceed 30 days in duration except as the parties may otherwise agree or for good cause as jointly determined by the chairperson of the Board of Directors and the Judicial Review Committee.

3. The decision of the Board of Directors 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 Medical Executive and Credentials committees, the subject of the Hearing, and the Administrator.

8.17 Right to One Hearing

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

8.18 Exhaustion of Remedies

A. If an adverse action is taken or recommended, the member must exhaust the administrative remedies afforded by these Bylaws before resorting to legal action.

8.19 Exceptions to Hearing Rights

A. Exclusive Contracts

1. The procedural rights provided under this Section shall not apply in situations where a practitioner’s application for Medical Staff membership and privileges was denied or whose privileges were reduced or terminated as a result of a decision by the Hospital to close or continue closure of a department or service pursuant to an exclusive contract, or to transfer an existing exclusive contract, or as a result of action by the holder of such an exclusive contract.

B. Validity of Bylaws, Rules / Regulations and/or Policy

1. No Hearing provided for in this Article shall be utilized to make determinations as to the merits or substantive validity of any Medical Staff Bylaw, Rule, Regulation, or Policy or Procedure. Where a practitioner is adversely affected by the application of a Medical Staff Bylaw, Rule, Regulation, or Policy or Procedure, the practitioner’s sole remedy is to seek review of such Bylaw, Rule, Regulation or Policy or Procedure initially by the Medical Executive Committee. The Medical Executive Committee may in its discretion consider the request according to such procedures as it deems appropriate. If the practitioner is

dissatisfied with the action of the Medical Executive Committee, the practitioner may request review by the Board of Directors, which shall have discretion whether to conduct a review according to such procedures as it deemed appropriate. The Board of Directors shall consult with the Medical Executive Committee before taking final action regarding the Bylaw, Rule, Regulation, Policy or Procedure involved. This procedure must be utilized prior to any legal action.

C. Automatic Suspension or Limitation of Clinical Privileges

1. No Hearing is required when a member's license or legal credential to practice has expired, been revoked or suspended as set forth in Section 7.9. Any automatic suspension or limitation initiated pursuant to Section 7.9 does not invoke Hearing rights as described in these Bylaws.

D. Clinical Department Formation or Elimination

1. A Medical Staff clinical department can be formed or eliminated by the Board of Directors only following a review and recommendation by the Medical Executive Committee regarding the appropriateness of the clinical department's elimination or formation. The Board of Directors shall consider the recommendations of the Medical Executive Committee prior to making a final determination regarding formation or elimination.

2. The Medical Staff member(s) whose privileges may be reduced or terminated by department formation or elimination are not afforded Hearing rights pursuant to Article VIII.

Article IX Officers and Members-at-Large

9.1 Officers of the Medical Staff

A. Identification

1. The Officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff (who also serves the role and function of Secretary-Treasurer), and the Immediate Past Chief of Staff. Only individuals meeting the qualifications and who are nominated and elected as expressly provided in these Bylaws shall be the Officers of the Medical Staff with all powers and duties vested herein. The right of the Medical Staff to select and remove Medical Staff Officers is inviolate and shall not be interfered with or restricted in any manner.

B. Qualifications

1. All Medical Staff Officers shall:

a. Be members of the Active Staff who are licensed as physicians and surgeons at the time of their nomination and election and must remain members of the Active Staff in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved;

b. Understand the purposes and functions of the Medical Staff and demonstrate willingness to assure that patient welfare always takes precedence over other concerns;

c. Work with and motivate others to achieve the objectives of the Medical Staff and Hospital and understand and be willing to work toward attaining the Hospital's lawful and reasonable policies and requirements;

d. Verbally disclose all previously undisclosed actual or potential conflicts of interest in the course of each Medical Staff meeting or other event where such a disclosure may be relevant. Any potential conflicts so disclosed shall be resolved as set forth in Section 13.2. All nominees for election or appointment to Medical Staff leadership positions (including those nominated by petition of the Medical Staff) shall, at least 20 calendar days prior to the date the election is to be held or the appointment is to be announced, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. The Medical Executive Committee shall evaluate the significance of such disclosures and discuss any significant conflicts with the nominee. If a nominee with a significant conflict remains on the ballot, the nature of his or her conflict shall be disclosed in writing and circulated with the ballot.

C. Nominations of Chief of Staff, Vice Chief of Staff, and Members-at-Large of the Medical Executive Committee

1. Medical Staff elections shall occur every other calendar year, in even numbered years. A nominating committee shall be appointed by the Medical Executive Committee in July of the year of the election. The nominating committee shall consist of the Immediate Past Chief of Staff, current Chief of Staff who shall serve as the chairperson, two voting members of the Medical Executive Committee appointed by the Chief of Staff, and two Active Staff members who are not currently members of the Medical Executive Committee recommended by the Chief of Staff and approved by the Medical Executive Committee. The nominating committee shall meet within 14 business days of its formation and approval by the Medical Executive Committee. The nominating committee shall formally request names of potential candidates from members of the Medical Staff at least 30 days prior to the September Medical Executive Committee meeting. Such a request shall be made electronically to each Medical Staff member. The nominating committee shall consider any names so received along with its own list of potential candidates and select a reasonable number of nominees to appear on the ballot. The nominations of the committee shall be reported to the Medical Executive Committee who will approve a preliminary list of nominees for the ballot at its September meeting and shall be delivered by email to members of the Medical Staff within five days after Medical Executive Committee approval. Such mailing to the Active Staff members shall also provide instructions as provided for below as to the method for nominating additional candidates for these leadership positions. The Hospital shall have no right to approve the slate of candidates or otherwise participate in the activities of the nominating committee.

2. Further nominations may be made for any Office by any voting member of the Medical Staff, provided that the name of the candidate is submitted in writing to the chairperson of the nominating committee, the nomination is endorsed by the signature of at least 10% of other members who are eligible to vote, and it bears the candidate’s written consent. These nominations shall be delivered to the chairperson of the Medical Executive Committee as soon as reasonably practicable, but prior to the October Medical Executive Committee meeting, which must be held at least 15 days after the September meeting.

3. At the October Medical Executive Committee meeting, a final ballot will be approved consisting of the list of nominees approved at the prior meeting and any additional nominees who meet the requirements set forth in Section 9.1.

D. Election

1. The final ballot for Medical Staff Officers and/or Members-at-Large shall be sent electronically to all members of the Active Medical Staff within ten business days of Medical

Executive Committee approval. Voting shall be by secret electronic ballot. The ballot shall list the nominees in alphabetical order. Only ballots electronically submitted and received prior to 4:00 PM on the fifteenth business day following the ballot electronic transmittal date shall be counted.

2. A nominee for Chief of Staff and Vice Chief of Staff shall be elected upon receiving a majority of the valid votes cast. If no candidate for the Office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the Medical Executive Committee by majority vote shall decide the election by secret written ballot at its next meeting or at a special meeting called for that purpose.

3. Nominees for the four Member-at-Large positions shall be elected based upon a plurality of votes, i.e., those four candidates receiving the highest number of votes cast among the overall field of candidates will be determined to have been elected to fill the vacant positions.

4. Any complaint concerning the election process shall be submitted in writing to the Medical Executive Committee via the current Chief of Staff and/or the Medical Staff Services Department within five calendar days after the election. Any subsequent action taken by or decision made by the Medical Executive Committee on the matter shall be final and binding.

E. Installation of Officers

1. The Chief of Staff shall be sworn in by the outgoing Chief of Staff at the conclusion of the last General Staff meeting prior to the beginning of the first year of his or her term. The following oath shall be said:

   a. *I, _____, do solemnly swear to faithfully perform the duties of the Chief of the Medical Staff of Valley Presbyterian Hospital. I further swear to uphold, protect, and defend the Bylaws, and Rules and Regulations of the Medical Staff to the best of my ability.*

2. All elected and appointed Officers, department chairpersons, committee chairpersons, and committee members shall assume the duties and responsibilities of their offices as of the first day of the calendar year following the installation of Officers. If a member of the Medical Executive Committee is appointed due to a vacancy in office, those duties and responsibilities will be assumed immediately and swearing-in of a Chief of Staff in such circumstances may be performed by the Immediate Past Chief of Staff.

F. Term of Elected Office

1. Each Officer and Member-at-Large of the Medical Executive Committee shall serve a two-year term, commencing on the first day of the Medical Staff year following election. Each Officer and Member-at-Large shall serve in Office until the end of that term, or else until a successor is elected, unless the Officer or Member-at-Large shall sooner resign or be removed from Office. At the end of the Chief of Staff's term, he or she shall automatically assume the Office of Immediate Past Chief of Staff. No Officer may be elected to two successive terms. Members-at-Large shall be eligible to be elected to no more than two successive terms.

G. Recall of Officers and Members-at-Large of the Medical Executive Committee

1. Any Medical Staff Officer and Member-at-Large may be removed from Office for valid cause, including, but not limited to: gross neglect or misfeasance in Office, serious acts of

moral turpitude, the development of a clear conflict of interest that cannot be resolved or reasonably managed or failure to discharge satisfactorily the duties of Office, including the following:

a. Intentionally failing to comply with the Medical Staff Bylaws, Rules, and/or policies;

b. Consistently failing to perform the duties in Section 9.2;

c. Conduct detrimental to the interests of the Medical Staff or the Hospital;

d. Development of any condition that renders the individual incapable of fulfilling the duties of that Office; or

e. Failure to continuously meet the qualifications for the Office or position.

2. Recall of a Medical Staff Officer or Member-at-Large may be initiated by the Medical Executive Committee or shall be initiated by petition signed by at least one-third of the members of the Medical Staff eligible to vote for Officers and Members-at-Large. Recall shall be considered at a special meeting of the Medical Executive Committee called for that purpose. Recall shall require a two-thirds vote of Medical Executive Committee members eligible to vote.

H. Vacancies in Elected Office

1. Vacancies in Office occur upon the death or disability, resignation, removal of the Officer or Member-at-Large, by filling a vacancy in another elected Office, or by the Officers' or Members'-at-Large loss of membership in the Medical Staff. Vacancies, other than that of the Chief of Staff, shall be filled by appointment by the Medical Executive Committee until the next regular election. If there is a vacancy in the Office of the Chief of Staff, then the Vice Chief of Staff shall serve out the remaining term. The Medical Executive Committee shall then appoint a Vice Chief of Staff to serve in that Office until the next regular election. If there is a vacancy in the Office of the Immediate Past Chief of Staff, whenever practicable the appointed member shall have served as Chief of Staff in the past.

9.2 Duties of Officers of the Medical Staff and Members-at-Large of the Medical Executive Committee

A. Chief of Staff

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

a. Serving as a member of the Board of Directors if so authorized, and consulting with the Board of Directors periodically on matters related to the quality of care provided to patients of the Hospital;

b. Interacting with Administration in all matters of mutual concern within the Hospital;

c. Representing the views and policies of the Medical Staff at each Board of Directors meeting and to the President / Chief Executive Officer;

d. Serving on liaison committees with the Board of Directors and Administration as assigned;

e. Being a spokesperson for the Medical Staff in external professional and public relations;

f. Serving as liaison between the Medical Staff and outside licensing or accreditation agencies;

g. Enforcing these Bylaws, Rules and Regulations, and Policies and Procedures, and implementing sanctions where indicated, and promoting compliance with procedural safeguards;

h. Serving as chairperson of the Medical Executive Committee;

i. Calling, presiding at, and being responsible for the agenda of all general Medical Staff meetings;

j. 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;

k. Appointing, in consultation with the Medical Executive Committee, committee members for all standing committees other than the Medical Executive Committee, except where otherwise provided by these Bylaws and, except where otherwise indicated, designating the chairperson of these committees;

l. Appointing, in consultation with the Medical Executive Committee, Medical Staff members to serve on a Joint Conference Committee for the Board of Directors and Medical Staff when so requested by the chairperson of the Board.

m. Performing such other functions as may be assigned to the Chief of Staff by these Bylaws, the Medical Staff, or by the Medical Executive Committee.

B. Immediate Past Chief of Staff

1. The Immediate Past Chief of Staff shall be a member of the Medical Executive Committee and the Board of Directors if so authorized and shall perform such duties as may be assigned by the Chief of Staff or delegated by these Bylaws, or by the Medical Executive Committee.

C. Vice Chief of Staff

1. The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice Chief of Staff shall be a member of the Medical Executive Committee and the Board of Directors if so authorized, and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws, or by the Medical Executive Committee. Any reference to “Secretary-Treasurer,” including in other governing documents, refers to the Vice Chief of Staff.

2. The duties shall include but not be limited to:

a. Maintaining a roster of members;

b. Ensuring that accurate and complete minutes are kept of all Medical Executive Committee, special, and general Medical Staff meetings;

c. Calling meetings on the order of the Chief of Staff or Medical Executive Committee;

d. Attending to all appropriate correspondence and notices on behalf of the Medical Staff;

e. Receiving and safeguarding all funds of the Medical Staff, preparing an annual proposed budget of anticipated income and expenditures, for approval by the Medical Executive Committee, preparing on a quarterly basis a financial statement in accordance with generally accepted accounting principles, and reporting accurate financial reports to the Medical Executive Committee and annually to the Medical Staff;

f. Serving as chairperson of the Quality Committee;

g. Being responsible for supervising, counting, recording, and reporting all votes at regular or special General Staff meetings, whether by voice, show of hands, or written ballots. The Vice Chief of Staff shall also supervise mailing, collection, safekeeping, and the opening and recording of all written Bylaws ballots or written ballots of any question submitted by the Medical Executive Committee to staff members by mail ballot.

h. 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 the Medical Executive Committee.

D. Members-at-Large of the Medical Executive Committee

1. The Members-at-Large of the Medical Executive Committee, of which there will be four, shall serve on the Medical Executive Committee for two-year terms and shall perform such other duties as may be assigned by the Chief of Staff or the Medical Executive Committee. Their term commences on January 1 of the year following the election. A Member-at-Large shall not hold a position as a Medical Staff Officer or Department Chair at the same time they hold the position of Member-At-Large on the Medical Executive Committee.

Article X Clinical Departments and Divisions

10.1 Organization of Clinical Departments and Divisions

A. The Medical Staff shall be organized in clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a chairperson selected and entrusted with the authority, duties, and responsibilities specified in this Section. A department may be further divided, as appropriate, into divisions which shall have a division chief selected and entrusted with the authority, duties, and responsibilities specified in this Section. When appropriate, the Medical Executive Committee may recommend to the Medical Staff the creation, elimination, modification, or combination of departments or divisions.

10.2 Identification of Clinical Departments and Divisions

A. The current departments and divisions are:

1. Department of Anesthesiology

2. Department of Emergency Medical Services

3. Department of Medicine

a. Division of Cardiology

4. Department of Obstetrics and Gynecology

5. Department of Pathology

6. Department of Radiology

7. Department of Pediatrics

8. Department of Surgery

10.3 Assignments to Clinical Departments and Divisions

A. Each member shall be assigned membership to one clinical department; and if appropriate, the member may be assigned to one division. A member may also be granted clinical privileges in other departments / divisions.

10.4 Duties of Clinical Departments

A. Subject to approval by the Medical Executive Committee, each department shall perform the functions assigned to it by the department chairperson. The duties of each department shall include:

1. Meeting regularly, and as often as necessary for the purpose of conducting patient care reviews and analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. The department shall routinely collect both general and practitioner-specific information about important aspects of patient care provided in the department, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work is subject to such review is a member of that department;

2. Recommending to the Medical Executive Committee criteria with regard to the granting of clinical privileges and the performance of specified services within the department;

3. Evaluating and making appropriate recommendations regarding the qualifications of applicants seeking membership or renewal of membership and clinical privileges within the department ; and

4. Conducting, participating in, and making recommendations regarding continuing education programs pertinent to clinical practice;

5. Reviewing and evaluating department adherence to (a) Medical Staff Policies and Procedures, and (b) sound principles of clinical practice.

6. Coordinating patient care provided by the department’s members with nursing and ancillary patient care services;

7. Submitting written reports to the Medical Executive Committee concerning: (a) the department’s review and evaluation activities, actions taken thereon, and the results of such actions; and (2) recommendations for maintaining and improving the quality of care provided in the department and the Hospital;

8. Establishing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols;

9. Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve are identified;

10. Accounting to the Medical Executive Committee for all professional and Medical Staff administrative activities within the department;

11. Formulating recommendations for Rules and Regulations related to their department reasonably necessary for the proper discharge of its responsibilities.

10.5 Duties of Divisions

A. Subject to approval of the Medical Executive Committee, each division shall perform the functions assigned to it by the department chairperson. Members of the division will meet as often as necessary. The duties of each division may include, without limitation:

1. Performing retrospective patient care reviews;

2. Evaluating patient care practices;

3. Recommending to the department criteria for the granting of clinical privileges and the performance of specified services within the division.

4. Evaluating and making appropriate recommendations regarding the qualifications of applicants seeking membership or renewal of membership and clinical privileges within that division;

5. Serving as educational and administrative functional units;

6. Transmitting regular reports to the department chairperson of its assigned functions.

10.6 Clinical Department Chairperson

A. Qualifications

1. Each clinical department will have a chairperson and vice chairperson who shall be a physician member of the Medical Staff qualified by licensure, training, experience, and demonstrated ability in at least one of the clinical areas covered by the department.

2. If the department is considered closed by an exclusive contract per Section 13.11 and there are no members of the Active Medical Staff within the department considered suitable and willing to act as chairperson or vice chairperson, those positions may be filled by members of the Provisional staff and must be ratified by a majority vote of the Medical Executive Committee prior to taking Office. Otherwise, the chairperson or vice chairperson must be a member of the Active Medical Staff.

3. Department chairpersons and vice chairpersons shall be certified by an appropriate specialty board or must demonstrate comparable competence.

4. A department chairperson or vice chairperson may not hold a position as Chief of Staff, Vice Chief of Staff, Immediate Past Chief of Staff, or Member-at-Large, on the Medical Executive Committee while serving as a department chairperson.

B. Selection

1. The selection of clinical department chairpersons and vice chairpersons shall be made by their own department. Procedures for selection may be outlined in the Rules and Regulations and will adhere to the conflict of interest requirements set forth in these Bylaws.

C. Term of Office

1. Each department chairperson and vice chairperson shall serve a two-year term of Office which coincides with the Medical Staff year or until their successors are chosen, unless they shall sooner resign, be removed from Office, or lose their Medical Staff membership or clinical privileges in that department. Department chairpersons and vice chairpersons shall be eligible to be elected to two successive terms.

D. Removal from Office

1. After election and ratification, removal of a department chairperson or vice chairperson or division chief from Office may occur after a two-thirds vote of the Medical Executive Committee and a two-thirds vote of the department or division members eligible to vote who cast votes.

E. Duties of Clinical Department Chairpersons

1. Each department chairperson shall act as presiding officer at all department meetings and shall have the following authority, duties, and responsibilities. The vice chairperson, in the absence of the chairperson, shall assume all duties and authority of the chairperson and shall otherwise perform such duties as may be assigned. The duties of the department chairperson are to:

a. Represent their department at the Credentials and Medical Executive committees and transmit a recommendation concerning practitioner membership and classification, renewal of membership, criteria for clinical privileges, monitoring of specified services, and corrective action with respect to persons with clinical privileges in the department;

b. Transmit to the Credentials Committee recommendations regarding specific clinical privileges for each Medical Staff member holding or requesting clinical privileges in the department both at the time of appointment and reappointment;

c. Recommend to the Credentials Committee and Medical Executive Committee and oversee proctoring programs to be utilized at the time of appointment or when practitioners are requesting new privileges in the department;

d. Recommend to the Medical Executive Committee the criteria for membership, clinical privileges, and proctoring related to the department;

e. Make recommendations to the Medical Executive Committee regarding policies necessary for the proper discharge of department responsibilities;

f. Direct and supervise all administrative (unless otherwise specified) and clinical activities within the department and report on such activities as necessary to the appropriate Medical Staff committees and/or Medical Executive Committee including cooperating with the nursing service and the Hospital administration in matters such as personnel, supplies, special regulations, standing orders and techniques;

g. Direct and supervise committees established by the department as well as specific programs for the planned, systematic surveillance of the professional performance of all individuals who have delineated clinical privileges in the department. Programs developed shall include the continuous assessment and improvement of the quality of care, treatment, and services as well as peer review and other quality control programs;

h. Transmit to the Medical Executive Committee any recommendations regarding a request for investigation or recommendations for correction action regarding any person holding clinical privileges in the department;

i. Provide programs to assure the continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the department;

j. Serve as a member of the Medical Executive Committee;

k. Assess and recommend to the relevant Hospital authority off-site resources for needed patient care, treatment, and services not provided by the department or the organization;

l. Coordinate and integrate interdepartmental and intradepartmental services;

m. Integrate the department or service into the primary functions of the organization;

n. Recommend a sufficient number of qualified and competent persons to provide care, treatment, and services in the department;

o. Make recommendations regarding the qualifications and competence of department or service personnel who are not Licensed Independent Practitioners and who provide patient care, treatment, and services;

p. Provide, arrange for, or oversee orientation and continuing education of all persons in the department;

q. Recommend the space and other resources needed by the department;

r. Endeavor to enforce the Medical Staff Bylaws, Rules and Regulations, and Policies and Procedures within the department;

s. Implement within the department appropriate actions taken by the Medical Executive Committee; and

t. Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff or the Medical Executive Committee.

F. Vacancies

1. If the position of clinical department chairperson becomes vacant, the vacancy shall be filled by the department vice chairperson.

10.7 Clinical Department Vice Chairperson

A. Qualifications

1. The qualifications for the department vice chairperson shall be the same as those of the clinical department chairperson as set forth in Section 10.6.

B. Selection

1. The selection of the department vice chairperson shall occur pursuant to Section 10.6.

C. Term of Office

1. The term of office for the department vice chairperson shall be the same as that of the clinical department chairperson as set forth in Section 10.6.

D. Removal from Office

1. The removal of the department vice chairperson shall occur in the same manner as set forth for removal of the clinical department chairperson, as described in Section 10.6.

E. Duties

1. The clinical department vice chairperson shall assume all duties and authority of the clinical department chairperson in the absence of the clinical department chairperson and shall perform other duties as assigned by the clinical department chairperson, delegated by the Bylaws, Rules and Regulations, Policies and Procedures, or as directed by the Medical Executive Committee.

F. Vacancies

1. If the position of department vice chairperson becomes vacant, the department chairperson will appoint a vice chairperson to fill the vacancy for the remainder of the current term. Such an appointment requires ratification by a majority vote of the Medical Executive Committee.

10.8 Division Chiefs

A. Qualifications

1. Each division shall have a chief who shall be a member of the division, and shall be qualified by training, experience, and demonstrated current ability in the clinical area covered by the division.

2. If the division is considered closed by an exclusive contract as per Section 13.11 and there are no members of the active Medical Staff within the division considered suitable and willing to act as chief, that position may be filled by a member of the provisional staff and must be ratified by a majority vote of the MEC prior to taking office. Otherwise the chief must be a member of the active Medical Staff.

B. Selection

1. The selection of division chiefs shall be made by each division, subject to approval of the Medical Executive Committee. Procedures for selection may be outlined in the Rules and Regulations and will adhere to the conflict of interest requirements set forth in these Bylaws. Vacancies due to any reason shall be filled for the unexpired term through appointment by the department chairperson.

C. Term of Office

1. Each division chief shall serve a two-year term which coincides with the Medical Staff year or until a successor is chosen unless the division chief shall sooner resign or be removed from the office or lose Medical Staff membership or clinical privileges in that division. Division chiefs shall be eligible to succeed themselves.

D. Removal from Office

1. A division chief may be removed as described in Section 10.6.

E. Duties

1. Each division chief shall:

a. Act as presiding officer at division meetings;

b. Assist in the development and implementation, in cooperation with the department chairperson, of programs to carry out the quality review and evaluation and monitoring functions assigned to the division;

c. Evaluate the clinical work performed in the division;

d. Conduct investigations and submit reports and recommendations to the department chairperson regarding the clinical privileges to be exercised within the division by members of or applicants to the Medical Staff; and

e. Perform such other duties commensurate with the Office as may from time to time be reasonably requested by the department chairperson, the Chief of Staff, or the Medical Executive Committee.

Article XI Committees

11.1 Designation

A. Medical Staff committees shall include but not be limited to, the Medical Staff meeting as a committee of the whole, meetings of departments and divisions, meetings of committees established under this Article, meetings of committees established in the Rules and Regulations, and meetings of special or ad hoc committees created by the Medical Executive Committee or by departments. The standing committees of the Medical Staff other than the Medical Executive Committee are designated in the Rules and Regulations. All Medical Staff committees shall be responsible to the Medical Executive Committee. Any meeting or activities related to the business of Medical Staff committees shall be considered Medical Staff committee proceedings and shall be entitled to the protections and immunities afforded to peer review committees under state and federal law.

1. Meetings

a. Provisions and rules regarding Medical Staff meetings are described in the Rules and Regulations. Committee members must comply at all times with conflict of interest requirements as described in these Bylaws.

11.2 Medical Executive Committee

A. Composition

1. The Medical Executive Committee will include:

a. Officers (with vote):

1. The Chief of Staff.

2. The Vice Chief of Staff.

3. The Immediate Past Chief of Staff.

b. Department chairpersons (with vote):

1. Anesthesiology.

2. Emergency Medical Services.

3. Medicine.

4. Obstetrics and Gynecology.

5. Pathology.

6. Pediatrics.

7. Radiology.

8. Surgery.

c. In the absence of a department chairperson, the vice chairperson of a department shall attend the Medical Executive Committee and may vote in his or her place.

d. Four Members-at-Large (with vote).

e. Non-voting members:

1. Hospital President / Chief Executive Officer, or designee;

2. Chief Nursing Officer;

3. Chief Medical Officer;

4. Chief Operating Officer;

5. Chief Information Officer;

6. Chief Medical Information Officer;

7. Chair of Bylaws Committee;

8. Chair of Credentials Committee.

B. Duties

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

a. Representing and acting on behalf of the Organized Medical Staff between meetings of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

b. Making recommendations to the Board of Directors related to Medical Staff membership, the structure of the Organized Medical Staff, the process used to review credentials and delineate privileges, the delineation of privileges for practitioners privileged through the Medical Staff process, and the Medical Executive Committee's

review of and actions on reports of Medical Staff committees, departments, and other assigned activity groups.

c. Evaluating and continuously improving the medical care rendered to patients in the Hospital;

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, departments, divisions, and assigned activity groups;

f. Developing and adopting appropriate Policies and Procedures in order to implement these Bylaws;

g. Recommending actions to the Board of Directors on matters of a medico-administrative nature;

h. Fulfilling the Medical Staff organization's accountability to the Board of Directors for the medical care rendered to patients through implementation of the Hospital's quality assessment / performance improvement plan;

i. 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 membership and renewals of membership, assignments to departments, clinical privileges, and corrective action;

j. 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;

k. Assisting in the obtaining and maintenance of accreditation as well as various Hospital certifications or designations, which shall include providing recommendations to the Hospital on the selection of the accreditation organization and structure of the survey process. The Board of Directors shall give great weight to the recommendation of the Medical Executive Committee;

l. Recommending to the relevant Hospital authority off-site sources needed for clinical patient care services that are provided by the Hospital, taking into account the quality-related aspects of contracts for patient care services with these off-site sources;

m. Conducting such other functions as are necessary for the effective operations of the Medical Staff;

n. Reporting to the Medical Staff at each general staff meeting;

o. Taking reasonable steps to develop continuing education activities and programs for the Medical Staff;

p. Participating in the development of Hospital policy, practice, and planning;

q. Reviewing and recommending all forms proposed for inclusion in the permanent medical record;

r. Affirmatively implementing, enforcing, and safeguarding the self-governance rights of the Medical Staff to the fullest extent permitted by law, such rights of the Medical Staff including, but not limited to, the following:

1. Initiating, developing, and adopting Medical Staff Bylaws, Rules and Regulations, and amendments thereto, subject to approval by the Hospital Board of Directors, which approval shall not be unreasonably withheld.

2. Selecting and removing Medical Staff Officers;

3. Assessing Medical Staff dues and utilizing the Medical Staff dues as appropriate for the purposes of the Medical Staff;

4. The ability to retain and be represented by independent legal counsel at the expense of the Medical Staff;

5. Establishing in Medical Staff Bylaws, Rules and Regulations, criteria and standards for Medical Staff privileges, and for enforcing those criteria and standards;

6. Establishing in Medical Staff Bylaws, Rules and Regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review, and other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff and its committees and departments and review and analysis of patient medical records.

7. Taking such action as appropriate to enforce these Bylaws regarding the prohibition against retaliation directed towards a member.

s. Enforcing the Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital Policies and Procedures in the best interest of patient care and of the Hospital, with regard to all persons who hold appointment to the Medical Staff;

t. 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;

u. Reviewing the quality and appropriateness of services provided by contract physicians;

v. Reviewing and approving the designation of the Hospital's Authorized Representative for National Practitioner Data Bank purposes;

w. Assisting the Hospital in the development and maintenance of methods for the protection and care of patients and others in the event of internal or external disaster;

x. Assigning a representative from the Medical Staff to participate in any Hospital deliberations affecting the discharge of Medical Staff responsibilities;

y. Establishing a mechanism for dispute resolution between Medical Staff members (including Limited Licensed Practitioners) involving the care of a patient;

z. Providing leadership in activities related to patient safety; and

aa. Participating in the process of analyzing and improving patient satisfaction.

ab. Seeking out the views of the Medical Staff on all appropriate issues.

ac. Conveying accurately to the Board of Directors the views of the Medical Staff on all issues, including those relating to safety and quality.

C. Meetings and Recommendations

1. The Medical Executive Committee shall meet as often as necessary but at least ten times annually and maintain a record of its proceedings and actions. Special meetings of the Medical Executive Committee may be called at any time by the Chief of Staff.

2. Reports of activities and records relating to the Medical Executive Committee's functions shall be submitted in writing to the Board of Directors with a copy to the President / Chief Executive Officer. The Chief of Staff shall be available to meet with the Board of Directors or its applicable committee or designee on any recommendation that the Medical Executive Committee may make.

D. Quorum

1. A quorum for the Medical Executive Committee shall be 50% of the members eligible to vote.

E. Removal

1. A Medical Executive Committee member can be removed from the committee prior to the end of their term only if the Medical Staff acts to remove that member from their position. Removal of Officers and Members-at-Large is described in Section 9. The removal of department chairpersons is described in Section 10.

11.3 Joint Conference Committee

A. Composition

1. When necessary to be formed, the Joint Conference Committee shall be composed of three members of the Medical Executive Committee (to be selected by the Chief of Staff), and three members of the Board of Directors (to be selected by the Chairman of the Board). The Chief Executive Officer will be an ex-officio member without voting privileges. The members of the Medical Staff should be composed of Medical Staff Officers unless the Chief of Staff has reason to exclude any of those Officers.

B. Duties

1. The Joint Conference Committee shall provide for medico-administrative liaison with the Board of Directors, the Chief Executive Officer, and the Medical Staff relative to matters of Hospital policy and practice. Its primary function should be to serve as a forum for discussion of matters pertaining to efficient and effective patient care. The Joint Conference Committee shall serve as the body to handle disputes between the Medical Staff and Board of Directors, and shall meet and confer in good faith to resolve such disputes.

C. Meetings

1. The Joint Conference Committee shall meet as requested by the Chairman of the Board of Directors or Chief of Staff and shall transmit written reports of its activities to the Executive Committees of both the Board of Directors and the Medical Staff.

Article XII Confidentiality, Immunity, and Releases

12.1 Authorization and Conditions

A. By applying for and/or exercising clinical privileges within this Hospital, an applicant or practitioner:

1. 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 or practitioner's professional ability, qualifications and professionalism;

2. Authorizes persons and organizations to provide information, including the release of records and documents, concerning the applicant or practitioner to the Medical Staff;

3. Agrees to be bound by the provisions of this Article and to waive any and all legal claims against any representative of the Medical Staff or the Hospital, and all third parties who provide information to the Hospital or Medical Staff concerning the applicant or practitioner, for acts performed in connection with evaluating the applicant or practitioner's qualifications who would be immune from liability under this Article, to the fullest extent permitted by law; and

4. Acknowledges receiving a copy (or having access to) a copy of these Bylaws and the Rules, and agrees to be bound by the terms thereof, as they may be amended from time to time, and acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges at this Hospital.

12.2 Confidentiality of Information

A. Protected Health Information

1. Upon Appointment and Reappointment to the Medical Staff, practitioners will be required to sign a confidentiality agreement and associated documents regarding medical records confidentiality. This confidentiality agreement includes access to the Hospital's information system and should affirm the practitioner's commitment to protection of the confidentiality and security of patient health information in keeping with Federal and State privacy laws.

2. The Board of Directors and its representatives will have the right to have access to such information for purposes of meeting the Board's responsibilities for quality of care in the Hospital. Access to patient records by Medical Staff shall be limited to use for the provision of patient care, payment, and operations of the Hospital; to include activities such as quality management, peer review, utilization review, and other authorized activities.

3. An alleged breach of confidentiality pursuant to actions of a Medical Staff member shall be investigated by the Medical Executive Committee and corrective action taken when appropriate.

B. Medical Staff Quality Improvement / Peer Review Information

1. Medical Staff, department, division or committee minutes, files, and records, including information regarding any applicant, member or other individual exercising clinical privileges, shall be considered Medical Staff minutes or records and, to the fullest extent permitted by law, shall be confidential and protected from discovery pursuant to California Evidence Code 1157 and other relevant provisions of California law. Such records will be

disclosed only in the furtherance of credentialing/peer review and performance improvement activities, and only in accordance with these Bylaws and the law.

2. 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 requirements that confidentiality is maintained. By serving on a department, division, Medical Staff or Hospital committee, a Medical Staff member pledges that he or she will not waive the privilege of confidentiality respecting any committee on which he or she serves, except as expressly required by law.

3. Access to such records shall be given the Board of Directors or its appointed representatives, and the Chief Executive Officer, in order to discharge their lawful obligations and responsibilities. Such records shall be maintained by that body as confidential.

4. Dissemination of such information and records shall only be made where expressly required by law, or pursuant to officially adopted policies of the Medical Staff or, where no officially adopted policy exists, only with the express approval of the Medical Executive Committee.

C. Breach of Confidentiality

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

12.3 Immunity from Liability

A. For Action Taken

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

B. For Providing Information

1. Each representative of the Medical Staff and Hospital and all third parties shall be immune, to the fullest extent permitted by law, from liability to any applicant, member or former member, or other individual who did or does exercise clinical privileges at the Hospital, for damages or other relief by reason of providing any information concerning such person in connection with any evaluation of such person’s competence, conduct, qualifications, performance, or quality of patient care.

12.4 Activities and Information Covered

A. 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:

1. Applications for membership, renewal of membership, and clinical privileges;

2. Correction action;

3. Hearings and appellate reviews;

4. Utilization reviews;

5. Other department, division, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

6. The actions of peer review organizations, medical boards and other entities which engage in the monitoring or evaluation of professional competence or conduct, including queries and reports to the National Practitioner Data Bank, Medical Board of California, specialty boards, peer review organizations and other professional or health care related entities and similar queries and reports.

12.5 Releases

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

12.6 Indemnification and Related Issues

A. Indemnification

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

2. In the event the Hospital shall fail timely to defend, contest or otherwise protect the Medical Staff against such claim or claims, after receipt of notice within a reasonable time under the circumstances for the Hospital to provide a full defense, the Medical Staff shall have the right to do so, including without limitation, the right to make any compromise or settlement thereof, and to recover from the Hospital all attorney's fees, reimbursements and other expenses and losses as a result thereof, provided, however, that the Medical Staff shall not take such action without first giving the Hospital reasonable opportunity to defend, contest or otherwise protect the Medical Staff against such claim.

B. Settlement

1. Except as otherwise provided, the Medical Staff shall not settle any claim without the Hospital's prior written consent. The Hospital shall not settle any claim in any manner, which would impose any obligation on the Medical Staff, which is not covered by indemnification hereunder without the duly authorized written consent of the Chief of Staff acting on behalf of the Medical Executive Committee. Neither the Hospital nor the Medical Staff shall unreasonably withhold their consent to any proposed settlement.

C. Rights Not Exclusive

1. The rights provided hereunder shall not be deemed exclusive of any other rights to which the Medical Staff may be entitled under any liability insurance, or any agreement, resolution or otherwise. The protection afforded to the Medical Staff hereunder is intended to supplement the other protections presently available to the Medical Staff under statutory law, the liability insurance or otherwise, and all of such protections are intended to be cumulative. Nothing herein shall be deemed to diminish or otherwise restrict the Medical Staff's right to reimbursement under the liability insurance, or indemnification under statutory law, agreements, resolutions, or otherwise.

D. Enforcement and Conditions

1. The Hospital's indemnity obligations hereunder shall be applicable only when the Hospital's Board of Directors determines in good faith (which determination must be made within a reasonable time after receiving Notice of a Claim) that the acts at issue were performed in good faith, in a manner reasonably believed to be in the best interests of the Hospital (including but not limited to, patient care) and, in the case of a criminal proceeding, were performed by persons having no reasonable cause to believe that the acts were unlawful.

2. If the Hospital's Board of Directors determines in good faith that the acts at issue do not meet the conditions set forth in this Section, and the Medical Executive Committee disagrees with this determination, the Hospital and Medical Staff shall resolve the matter pursuant to the procedure in this Section.

3. The Hospital's indemnity obligations hereunder are subject to the Hospital's express reservation of its right to be reimbursed (for all costs paid by the Hospital under this Section) by the party on whose behalf a payment was made by the Hospital. In the event that a court or a referee determines that the party does not qualify for indemnity under the terms of this Section.

E. No Duplication of Payments

1. The Hospital shall not be liable under this Section to make any payment in connection with any claim made against the Medical Staff to the extent the Medical Staff has otherwise actually received payment (under any liability insurance or otherwise) of the amounts otherwise indemnifiable hereunder.

F. Partial Indemnification

1. If the Medical Staff is entitled under any provisions of this Section to indemnification by the Hospital for some or a portion of the expenses and losses but not, however, for the total amount thereof, the Hospital shall nevertheless indemnify the Medical Staff for the portion of such expenses and losses to which the Medical Staff is entitled to indemnification.

G. Dispute Resolution

1. The Hospital and Medical Staff will meet as a Joint Conference Committee and confer in good faith to resolve any problem or dispute that may arise regarding the parties' duties. In the event that any problem or dispute that may arise is not satisfactorily resolved by discussion between the parties, the parties agree that their choice of legal remedy is that either party may request that the matter be heard by a referee from the Los Angeles County Superior Court, pursuant to California Code of Civil Procedure Sections 638, et seq. The Hospital and Medical Staff, in such case, shall agree upon a single referee who shall then try all issues, whether of fact or law, and report a finding and judgment thereon and issue any legal and equitable relief appropriate under the circumstances of the controversy before the referee. The decision of the referee will be final and binding on the parties. Any such referee selected shall be considered a temporary judge appointed pursuant to Article 6, Section 21 of the California Constitution.

H. Subrogation

1. In the event of any payment in connection with proceedings relevant to this Section, the Hospital shall be subrogated, to the extent of such payment, to all of the rights of recovery of the Medical Staff, who shall execute all documents required and shall do everything that may be reasonably necessary to secure such subrogation rights, including the execution of such documents necessary to enable the Hospital effectively to bring suit to enforce such rights.

12.7 Cumulative Effect

A. Provisions in these Bylaws and in Medical Staff application forms relating to authorizations, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

Article XIII General Provisions

13.1 Rules and Regulations and Policies and Procedures

A. The Medical Executive Committee shall initiate and adopt general Rules and Regulations and Policies and Procedures as it may deem necessary for the proper conduct of its work and shall periodically review and revise its Rules and Regulation to comply with current Medical Staff practice. The mechanism described herein shall be the sole method of the initiation, adoption, amendment, or repeal of the Rules and Regulations and Policies and Procedures. Such Rules and Regulations and Policies and Procedures 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.

1. Effect

a. Adherence to the Bylaws, Rules and Regulations, Policies and Procedures and Hospital policies as are properly initiated and adopted is required of all applicants for Medical Staff membership and all practitioners holding clinical privileges at the Hospital, including Medical Staff members, those holding temporary privileges, and APP Staff members holding clinical privileges or working under practice prerogatives. The Rules and Regulations shall be deemed an integral part of these Bylaws.

2. Revision

a. Any Active Staff physician, dentist or podiatrist may suggest changes to the Rules and Regulations or Medical Staff policies to the Medical Executive Committee or the Bylaws Committee. The Bylaws Committee may suggest such changes as a result of

its responsibilities to periodically review the Rules and Regulations. Regardless of the origin of the proposal(s), the proposed changes shall be considered by the Bylaws Committee, which may include adoption, amendment, or repeal of the Rules and Regulations and Policies and Procedures. That committee shall review and recommend to the Medical Executive Committee the relevant actions. After review and revision(s), if any, by the Medical Executive Committee, they will be forwarded to the Board of Directors for their review and approval. Such Rules and Regulations and Policies and Procedures shall become effective upon approval of the Board of Directors, which approval shall not be withheld unreasonably, and will automatically occur after 60 days if no action is taken.

B. Conflict Resolution

1. If there is a conflict between these Bylaws and the Rules and Regulations, these Bylaws shall prevail. If there is a conflict between Rules and Regulations and Policies and Procedures, the document which has most recently been reviewed and approved by the Medical Executive Committee shall prevail.

2. In the event of any ambiguity in the Medical Staff Bylaws, Rules and Regulations or Policies and Procedures, or should there be any question of interpretation, the Medical Executive Committee shall have the authority to resolve it, except in the case of a dispute between the Medical Executive Committee and the Board of Directors regarding an ambiguity or question of interpretation in which case the Medical Executive Committee and the Board of Directors shall have the joint responsibility to resolve it.

13.2 Conflict of Interest

A. A conflict of interest arises when there is a divergence between an individual's private interests and his or her professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by those interests. A conflict of interest depends on the situation and not on the character of the individual. The fact that an individual practices in the same specialty as a practitioner who is being reviewed does not by itself automatically create a conflict of interest. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No staff member has a right to compel a determination that a conflict exists. The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict. These Bylaws shall be the unique and exclusive mechanism for discerning and acting upon conflicts of interest applicable to Medical Staff members. Only those Medical Staff members who also serve on the Board of Directors may be required to adhere to a disclosure and conflict of interest policy, if any, of the Board of Directors. Medical Staff members who fail to comply with all provisions of these Bylaws concerning actual or potential conflicts of interest shall be subject to corrective action under these Bylaws, including but not limited to removal from a Medical Staff position.

B. Disclosure

1. In order to encourage unbiased, responsible management and decision making, all Medical Staff leaders, including Officers, department chairpersons, division chiefs, Medical Staff representatives, and Medical Staff members serving on committees shall comply with the disclosure of interest and conflict of interest requirements as relevant to the position held and the circumstances, consistent with these Bylaws.

2. No member may exercise any leadership role unless or until the member completes the Disclosure of Interest form approved by the Medical Executive Committee as consistent with these Bylaws.

    a. All nominees for election or appointment to Medical Staff Offices, department chairmanships, or the Medical Executive Committee shall, within 10 days of their nomination or 10 days prior to their appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. Nominated physicians who do not complete the required conflict of interest statement within ten days of their nomination shall be removed from the election ballot.

    b. This form shall be updated by such members within 30 days of the occurrence of any changes relating to statements on that form.

    c. This form shall be available for viewing by any member of the Medical Staff, but may only be used for bona fide Medical Staff purposes and not for individual or personal use, nor may the information be shared with non-Medical Staff members.

3. Members holding any leadership or committee role must disclose their potential conflict of interest relevant to the subject under discussion when they address a Medical Staff body or prior to voting upon the subject where a potential conflict of interest exists.

4. The disclosure of an interest, as set forth in these Bylaws, does not automatically mean that an actual conflict of interest exists. Whether a disclosed interest constitutes a conflict is determined as set forth herein.

C. Recusal

1. A recused member shall not be counted in determining the quorum for that vote but may answer questions or otherwise provide information about the matter after disclosing the conflict. A recused member must not be present for the remainder of the deliberations or the vote.

2. Not all disclosures of a potential conflict of interest require the member’s abstention or recusal, however, a member may abstain from voting on any issue. A member shall recuse themself if the member reasonably believes that the member’s ability to render a fair and independent decision is or may be affected by a conflict of interest.

3. In any instance where a member has or reasonably could be perceived to have a conflict of interest or bias in any matter involving another Medical Staff member, or in any instance where any such individual or committee member brought the complaint against that staff member, such individual or member with a conflict shall recuse and shall be excused from any meeting during that time.

4. A department of committee chairperson shall have a duty to delegate review of applications for appointment, reappointment or clinical privileges, or questions that may arise to a vice chairperson or other member of the committee, if the chairperson has a conflict of interest with the individual under review, or could be reasonably perceived to be biased.

5. If the recusal of an Officer or committee member affects the quorum necessary to transact business or applicable functions, the Chief of Staff shall appoint an Active Staff member

without a conflict to act on the matter(s) as a temporary replacement for the recused individual.

D. Dispute Resolution

1. Any department or committee member with knowledge of the matter may call to the attention of the committee chairperson the existence of a potential or perceived conflict of interest or bias on the part of any committee member.

2. Any dispute over the existence of bias or a conflict of interest shall be resolved by the chairperson. If there remains a dispute regarding conflict of interest or bias, and the member does not voluntarily recuse themself, then the matter will be decided by the other voting members of the committee. In this case the member shall leave the room while the potential conflict of interest is discussed and voted upon. If by majority vote it is determined that a conflict of interest exists, the chairperson will excuse the member from the meeting.

13.3 Dues and/or Assessments

A. The Medical Executive Committee shall have the power to determine the amount of annual dues or assessments, if any, for each category of Medical Staff membership and based on other criteria for its members and applicants, and to determine the manner of expenditure of such funds received.

13.4 Medical Staff Funds

A. Medical Staff funds, regardless from what source (i.e., Medical Staff, Hospital) shall be under the sole control of the Medical Staff. All Medical Staff members may at all reasonable times inspect all bank statements and quarterly financial statements.

B. Hospital-Provided Funds Deposited to the Medical Staff Fund

1. Funds may be deposited in the Medical Staff account from the Hospital to assure the Medical Staff the financial ability to solely administer those functions required under the Bylaws.

C. Compensation of Medical Staff Officers

1. Medical Staff Officers should be compensated for their work spent representing and leading the Medical Staff. Such compensation shall come from the Medical Staff bank account, for which the Medical Staff has sole responsibility. The payment to the individual physicians should be in the form and amount determined by the Medical Executive Committee (MEC). Payment to each physician under this provision shall be unrelated to referrals, and shall be contingent upon each physician’s proper performance of those duties. The evaluation and determination of the quality of that performance is in the sole determination of the MEC.

D. Compensation of Other Medical Staff Leaders

1. The Medical Staff also may elect to compensate Medical Staff Leaders who are not Officers for work performed pursuant to their duties as department chairpersons and vice chairpersons, committee chairpersons, and other duties performed on behalf of the Medical Staff as determined by the MEC. Unless a separate contract with the Hospital exists through which a committee chairperson or other Medical Staff Leader is compensated, such compensation shall come from the Medical Staff bank account, for which the Medical Staff has sole responsibility, and the amount and form of such

compensation shall be determined by the MEC. The amounts and forms of compensation must comply with any applicable federal or state laws regarding physician compensation, shall be unrelated to referrals and shall not jeopardize the nonprofit tax-exempt status of the Hospital. If the Hospital provides any funds to the Medical Staff specifically earmarked for such compensation, the Hospital shall have the authority to review any compensation arrangement to determine its compliance with state and federal laws, as well as any impact it may have on the nonprofit tax-exempt status of the Hospital, and shall have the authority to approve or withhold approval of the compensation arrangement. Compensation is contingent on the Medical Staff Leader's fulfillment of his or her duties, which shall be determined by the MEC.

13.5 Construction of Terms and Headings

A. 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. Terms that imply gender are to be disregarded as such and do not exclude any persons form the effects of these Bylaws.

13.6 Authority to Act and Delegation

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

B. The authority and responsibilities vested in any Officer, member or committee of the Medical Staff in these Bylaws shall not be delegated to, or otherwise exercised by, any member of the Administrative staff or any person or entity outside of the Medical Staff, unless the Medical Staff explicitly authorizes such delegation or exercise of authority.

13.7 Division of Fees

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

13.8 Notices

A. Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing and properly sealed, and shall be sent through the United States Postal Service, first-class postage prepaid. An alternative delivery mechanism may be used if it is reliable, expeditious, and if evidence of its use is obtained, including email. Notices to a member, applicant or other party shall be sent to the addressee at the address as it last appears in the official records of the Medical Staff or the Hospital.

B. Notice to the Medical Staff or Officers or committees thereof, shall be addressed as follows when mailed:

1. Name and proper title of addressee, if known or applicable.
   Name of department, division, or committee
   c/o Director of Medical Staff Services
   Valley Presbyterian Hospital
   15107 Vanowen St.
   Van Nuys, CA 91405

13.9 Individual Member Credential Files

A. Adverse Information

1. The following information shall be automatically uploaded to a Medical Staff member or Advanced Practice Clinician individual electronic credentials file:

    a. Letters of reprimand issued by the Medical Executive Committee and/or clinical department chairperson.

    b. Notices of reduction, revocation or suspension of privileges.

    c. Notification of discipline action from outside sources.

    d. Medical Staff or APP Staff health information pertinent to the safe exercise of individual clinical privileges.

    e. Performance improvement and peer review information and correspondence from internal and outside sources.

    f. Redacted narratives from the Hospital's event reporting system, including but not limited to any matters of unprofessional conduct.

    g. Notes prepared or approved by Medical Staff Officers, department chairpersons, or committee chairpersons from informal conferences.

B. Letters of Reprimand

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

    a. Only the Medical Executive Committee shall have the authority to issue a Letter of Reprimand and place the Letter of Reprimand into the practitioner's credentials file.

    b. If the Medical Executive Committee authorizes the issuance of a Letter of Reprimand and insertion of a Letter of Reprimand into the practitioner's credential file, the practitioner shall be notified of this action and may respond.

    c. Notice to the practitioner shall include a copy of the Letter of Reprimand, which will be inserted into the practitioner's credentials file.

C. Opportunity to Request Correction

1. When an individual has received notice of insertion of a Letter of Reprimand into his or her credentials file, the practitioner may address to the Medical Executive Committee a written request for correction or deletion of information contained in the Letter of Reprimand. Such request shall include a statement of the basis for the action requested.

2. The Medical Executive Committee shall review such a request within a reasonable time and determine after such review whether or not to make the correction or deletion requested by the practitioner.

3. The member shall be notified in writing of the decision of the Medical Executive Committee in this matter.

4. In any case, the practitioner shall have the right to add to his or her own credentials file, upon written request to the Medical Executive Committee, a statement responding to the information contained in the Letter of Reprimand.

D. Review of Adverse Information

1. 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 clinical department chairperson, as part of his or her reappraisal function, shall review any adverse information in the credentials file pertaining to a member.

b. Following this review, the clinical department chairperson shall determine whether documentation in the file warrants further action.

c. With respect to such adverse information, the clinical department chairperson shall recommend to the Medical Executive Committee if he or she feels further action is warranted.

13.10 Confidentiality of the Credentials File

A. Information contained in the credentials file of any member may be disclosed with the member's consent or as otherwise set forth in these Bylaws

B. A Medical Staff member or APP Staff member exercising clinical privileges or practice prerogatives shall be granted access to his or her own credentials file, subject to the following provisions:

1. A request for access must be submitted in writing to the Chief of Staff via the Medical Staff Services Department Director or designee.

2. The individual may review, and receive a copy of, only those documents provided by the individual him or herself or addressed personally to that individual. A summary of all other information, including peer review committee findings, letters of reference, proctoring reports, complaints and other documents, shall be provided to the individual, in writing, by the designated Officer of the Medical Staff through the Medical Staff Services Department. Such summary shall disclose the substance, but not the source, of the information summarized.

3. The review by the individual shall take place in the Medical Staff Services Department, during normal work hours, with an Officer or designee of the Medical Staff and a Medical Staff Management Coordinator present.

13.11 The Medical Staff Role in Exclusive Contracting and in Establishing or Modifying Clinical Departments and/or Services

A. Definitions

1. For the purpose of this Section, the following definitions shall apply:

a. "**Clinical departments / services**" means those departments or services in which a relationship, contractually or otherwise, may exist between a member(s) of the Medical Staff and the Hospital to provide specified services.

b. To "**close**" or "**closure**" means to make exclusive arrangements with or restrict access to a department or service to specific members of the Medical Staff.

c. "**Open**" means to allow access to all appropriately trained and privileged members of the Medical Staff.

d. "**Terminate**" means to eliminate a department or service.

e. "**Transfer**" means to replace one physician or physician group with another.

B. Criteria for Review

1. In appropriate circumstances, the Board of Directors, following consultation with the Medical Executive Committee and following appropriate notice and opportunity for interested parties to be heard, may make a decision pertaining to the closure, termination, opening or transfer of individual departments or services. The Medical Executive Committee, will consider whether the action will:

a. Enhance or maintain the quality of care.

b. Improve or maintain the efficiency of care.

c. Improve or maintain coverage and utilization.

d. Promote compliance with regulations, laws, and accreditation standards.

e. Resolve irreconcilable differences among those who utilize the department or service which adversely affects quality of care.

C. Exclusive Contracts and Rights of Individual Physicians

1. The procedural rights provided under these Bylaws do not apply to a practitioner whose application for Medical Staff membership and privileges was denied, not accepted due to failure to qualify, or whose privileges were terminated on the basis that the privileges he or she seeks are granted only pursuant to an exclusive contract.

2. If the Hospital closes or continues closure of a department or service pursuant to an exclusive contract in accordance with the requirements of these Bylaws, then a member who either is not the party to such contract or who is not affiliated with the party to such a contract shall be prohibited from exercising privileges which are the subject of such exclusive contract. To the degree termination of certain specific privileges, but not all privileges, of a Medical Staff member are warranted by an exclusive contract, whether in the same or different specialty within the Hospital as covered by the exclusive contract, other privileges of that member that are not affected by the institution of the exclusive contract shall remain granted and unchanged. Those specific privileges of a member that are terminated because of the institution of an exclusive contract must be stricken from the list of approved privileges maintained by the Medical Staff for that member.

13.12 Forms

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

13.13 Medical Staff Representation by Legal Counsel

A. Upon the authorization of the Medical Staff, or of the Medical Executive Committee acting on its behalf, the Medical Staff may retain and be represented by independent legal counsel who, to the extent practicable, shall not be employed by a law firm representing the Hospital. The Medical Staff shall enter into a written engagement letter with the individual selected to be independent legal counsel affirming that the Medical Staff, not the Hospital, is the counsel's client, that the counsel represents solely the interests of the Medical Staff, and that the attorney-client privilege of confidentiality applicable to all communications between the counsel and the Medical Staff is held solely by the Medical Staff, regardless of whether the Medical Staff or a third party pays the counsel's fees. In the event the counsel is paid for by a third party, the counsel shall also provide a written assurance to the Medical Staff that there will be no interference by the third party with the counsel's independence of professional judgment or with the attorney-client relationship, as required by State Bar of California Rules of Professional Conduct, Rule 3-310.

Article XIV Adoption and Amendment of Bylaws

14.1 Procedure

A. Origination

1. Upon request of the Medical Executive Committee, or the Medical Staff Bylaws Committee after approval of the Medical Executive Committee, or upon written petition signed by at least 20% of the members of the Active Medical Staff who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these Bylaws.

B. Notification

1. The notice with the proposed change(s) shall be emailed to all Active Staff members eligible to vote and shall bear the heading in bold print – **Notice of Proposed Change(s) of the Bylaws**, and shall include the exact wording of the existing language, if any, and the proposed change(s). Medical Staff members may submit arguments for or against the proposed change(s), electronically or in writing, to the Chairperson of the Bylaws Committee in care of the Medical Staff Services Department within 15 business days of the date the electronic email notice was mailed.

C. Ballots

1. Within ten business days after the deadline date for receipt of any arguments for or against the proposed changes, an email will be sent to all Active Staff members containing:

a. The wording of the proposed change(s);

b. The exact wording of the existing bylaw(s);

c. A ballot.

2. The email shall specify the time and manner in which the ballot shall be returned, which shall in no event be later than 15 days from the date the ballot was transmitted, addressed to the member at his or her email address as it appears in the records of the Medical Staff.

14.2 Action on Bylaws Change

A. Action upon a change in the Bylaws shall require a majority of affirmative votes of returned ballots, emailed to Active Staff members. Ballots must be returned to the Medical Staff Services Department within 15 business days from the date the ballots were emailed. Action on changes to the Medical Staff Bylaws by the Medical Staff will be deemed to have occurred after the tabulation of ballots is completed.

14.3 Approval

A. Bylaws changes adopted by the Medical Staff shall become effective following approval by the Board of Directors, which approval shall not be withheld unreasonably. If approval is withheld the reasons for doing so shall be specified by the Board of Directors in writing, and shall be forwarded to the Chief of Staff, the Medical Executive Committee, and the Bylaws Committee.

14.4 Exclusivity

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

14.5 Effect of the Bylaws

A. Upon adoption and approval as provided in these Bylaws, in consideration of the mutual promises and agreements contained in these Bylaws, the Hospital and the Medical Staff, intending to be legally bound, agree that these Bylaws shall constitute part of the contractual relationship existing between the Hospital and the Medical Staff members, both individually and collectively.

B. These Bylaws may not be unilaterally amended or repealed by the Medical Staff or Board of Directors.

C. No Medical Staff governing document (Bylaws, Rules, or Policies and Procedures) and no Hospital corporate bylaws or other hospital governing document shall include any provision purporting to allow unilateral amendment or repeal of the Medical Staff Bylaws or other Medical Staff governing documents.

D. Hospital corporate bylaws, policy, rules or other Hospital requirements that conflict with Medical Staff Bylaws provisions, Rules, Regulations and/or Policies and Procedures, shall not be given effect and shall not be applied to the Medical Staff or its individual members.

E. Any purported addition, amendment or repeal of these Medical Staff Bylaws that does not conform to the mechanisms herein are automatically null and void.

14.6 Successor in Interest / Affiliations

A. 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 the new bylaws are approved, the existing bylaws of each institution will remain in effect.

B. Affiliations

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

14.7 Review

A. These Bylaws shall be reviewed regularly and revisions made according to the described amendment procedure above.

Approvals

October 18, 2021	Medical Executive Committee approved proposed revisions to Bylaws
November 5, 2021	Proposed revisions to Bylaws emailed to Active Staff for Comment Period
November 30, 2021	Proposed revisions to Bylaws emailed to Active Staff for vote
December 21, 2021	Voting period concluded majority voted in favor or proposed revisions
December 29, 2021	Board of Directors approved proposed revisions to Bylaws

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