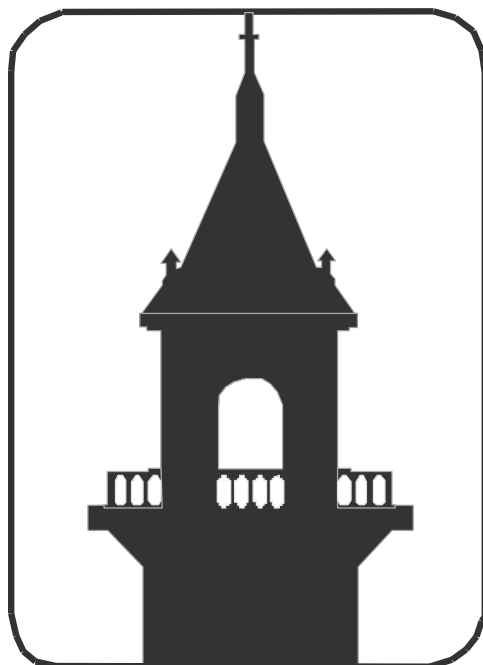


DESERT REGIONAL MEDICAL CENTER

MEDICAL STAFF

BYLAWS



ADOPTED: MAY 1993

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DRMC MEDICAL STAFF BYLAWS

1. ARTICLE I - PURPOSES AND TERMS

1.1 PURPOSES OF THE BYLAWS

These bylaws are adopted in order to provide for the organization of the medical staff of Desert Regional Medical Center and to provide a framework for self-government in order to permit the medical staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. These bylaws provide the professional and legal structure for medical staff operations, organized medical staff relations with the governing board, and relations with applicants to and members of the medical staff. The organized medical staff both enforces and complies with these medical staff bylaws. The organized Medical Staff will make every possible effort to comply with pertinent Federal, State and County laws and revisions will be made as needed in a timely manner.

1.2 DEFINITIONS

- 1.2.1. **ADMINISTRATOR** means the chief executive officer of the hospital.
- 1.2.2. **AUTHORIZED REPRESENTATIVE** or **HOSPITAL'S AUTHORIZED REPRESENTATIVE** means the individual designated by the hospital and approved by the medical executive committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these Bylaws.
- 1.2.3. **GOVERNING BOARD** means the governing body of the hospital.
- 1.2.4. **CHIEF OF STAFF** means the chief officer of the medical staff elected by members of the medical staff.
- 1.2.5. **CLINICAL PRIVILEGES** or **PRIVILEGES** means the permission granted to medical staff members to provide patient care and include unrestricted access to those hospital resources (including equipment, facilities and hospital personnel) which are necessary to effectively exercise those privileges.
- 1.2.6. **HOSPITAL** means Desert Regional Medical Center.
- 1.2.7. **IN GOOD STANDING** means a member is currently not under suspension or serving with any limitation of voting or other prerogatives imposed by operation of the bylaws, rules and regulations or policy of the medical staff.
- 1.2.8. **INVESTIGATION** means a process specifically instigated by the medical executive committee to determine the validity, if any, to a concern or complaint raised against a member of the medical staff, and does not include activity of the medical staff aid committee.

- 1.2.9. MEDICAL EXECUTIVE COMMITTEE (MEC) means the executive committee of the medical staff which shall constitute the governing body of the medical staff as described in these bylaws.
- 1.2.10. MEDICAL STAFF or STAFF means those physicians (MD or DO or their equivalent) as defined in Section 2.2.2.1, dentists and podiatrists who have been granted recognition as members of the medical staff pursuant to the terms of these bylaws.
- 1.2.11. MEDICAL STAFF YEAR means the period from July 1 to June 30.
- 1.2.12. MEMBER means, unless otherwise expressly limited, any physician (MD or DO or their equivalent) as defined in Section 2.2.2.1, dentist, podiatrist, or clinical psychologist holding a current license to practice within the scope of that license who is a member of the medical staff.
- 1.2.13. PHYSICIAN means an individual with an MD or DO degree or the equivalent degree (i.e., foreign) as recognized by the Medical Board of California (MBC) or the Board of Osteopathic Examiners (BOE), who is licensed by either the MBC or the BOE.
- 1.2.14. DEPARTMENT means a clinical service. This term may be used interchangeably.
- 1.2.15. NAME The name of this organization is the Medical Staff of Desert Regional Medical Center.
- 1.2.16. PEER is a Medical Staff member who through education, experience or a combination is capable of reviewing the care provided by a Medical Staff member, and can render a determination regarding the appropriateness of care provided.

2. ARTICLE II – MEMBERSHIP

2.1. NATURE OF MEMBERSHIP

No physician, dentist, 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. They may be granted temporary privileges in accordance with the procedures set forth in these bylaws. Appointment to the medical staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these bylaws.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2.1 GENERAL QUALIFICATIONS

Only physicians, dentists and podiatrists shall be deemed to possess basic qualifications for membership in the medical staff, except for the retired staff categories in which case these criteria shall only apply as deemed individually applicable by the medical staff, and who

- 2.2.1.1. document their (1) current licensure, (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and (5) current adequate physical and mental health status, so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;
- 2.2.1.2 are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care, (3) to keep as confidential, as required by law, all information or records received in the physician-patient relationship, and (4) to be willing to participate in and properly discharge those responsibilities determined by the medical staff;
- 2.2.1.3. maintain in force professional liability insurance in not less than the minimum amounts, if any, as from time to time may be jointly determined by the medical executive committee.
- 2.2.1.4. are certified or are progressing towards specialty certification by (1) boards which are duly organized and recognized by an American Board of Medical Specialties member board or the Bureau of Osteopathic Specialists, the American Board of Oral & Maxillofacial Surgery, the American Board of Dentistry and Pediatric Dentistry, the American Board of Podiatric Surgery, or the American Board of Podiatric Orthopedic and Primary Podiatric Medicine, Applicants/Re-applicants who are progressing toward board certification must become board certified within five years of the initial granting of medical staff membership, unless extended for good cause by the medical executive committee.
- 2.2.1.5. are current members of the medical staff who were not board certified as of date of adoption of this amendment (Jan. 18, 2007), may be considered for renewal of medical staff membership if they can document sufficient training and otherwise meet the requirements of medical staff membership.

2.2.2. PARTICULAR QUALIFICATIONS

2.2.2.1. Physicians. An applicant for physician membership in the medical staff, except for the emeritus 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 Board of Osteopathic Examiners of the State of California. For the purpose of this section, "or their equivalent" shall mean any degree (i.e., foreign) recognized by the Medical Board of California or the Board of Osteopathic Examiners.

2.2.2.2. Limited License Practitioners.

2.2.2.2.1. Dentists. An applicant for dental membership in the medical staff, except for the emeritus staff, must hold a DDS or equivalent degree and a valid and unsuspended certificate to practice dentistry issued by the Board of Dental Examiners of California.

2.2.2.2.2. Podiatrists. An applicant for podiatric membership on the medical staff, except for the emeritus staff, must hold a DPM degree and a valid and unsuspended certificate to practice podiatry issued by the Medical Board of California.

2.3 EFFECT OF OTHER AFFILIATIONS

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

2.4 NONDISCRIMINATION

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

2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

2.5.1. Except for the emeritus and retired staff, the ongoing responsibilities of each member of the medical staff include:

2.5.2. providing patients with the quality of care meeting the professional standards of the medical staff of this hospital;

- 2.5.3. abiding by the medical staff bylaws, medical staff rules and regulations, and policies;
- 2.5.4. discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of medical staff membership, including committee assignments;
- 2.5.5. preparing and completing in timely fashion medical records for all the patients to whom the member provides care in the hospital;
- 2.5.6. aiding in any medical staff approved educational programs for medical students, interns, resident physicians, resident dentists, staff physicians and dentists, nurses and other personnel;
- 2.5.7. working cooperatively with members, nurses, hospital administration and others so as not to adversely affect patient care;
- 2.5.8. making appropriate arrangements for coverage of that member's patients as determined by the medical staff;
- 2.5.9. refusing to engage in improper inducements for patient referral;
- 2.5.10. participating in continuing education programs as determined by the medical staff;
- 2.5.11. participating voluntarily in such emergency service coverage or consultation panels as may be determined by the medical staff;
- 2.5.12. discharging such other staff obligations as may be lawfully established from time to time by the medical staff or medical executive committee; and
- 2.5.13. providing information to and/or testifying on behalf of the medical staff or an accused practitioner regarding any matter under an investigation pursuant to paragraph 6.1.3, and those which are the subject of a hearing pursuant to Article VII.

2.6 VOLUNTARY PARTICIPATION ON EMERGENCY DEPARTMENT BACKUP CALL PANELS

Participation on the emergency department backup call panel shall be voluntary. Neither the appointment nor reappointment to the medical staff shall in any way be contingent on an applicant's willingness to participate on the emergency department's backup call panel.

- 2.6.1 All provisional staff members shall participate in the Emergency Department on-call panel during the first two years of membership if there is a designated need.

2.7 HARASSMENT PROHIBITED

- 2.7.1. Harassment by a medical staff member against any individual (e.g., against another medical staff member, house staff, hospital employee or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation shall not be tolerated.
- 2.7.2. “Sexual harassment” is unwelcome verbal or physical conduct of a sexual or gender-based nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters).
- 2.7.3. Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual’s employment or creates and/or perpetuates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.
- 2.7.4. All allegations of sexual harassment shall be immediately investigated by the medical staff and, if confirmed, will result in appropriate corrective action, from reprimands up to and including termination of medical staff privileges or membership, if warranted by the facts.

3. ARTICLE III - CATEGORIES OF MEMBERSHIP

3.1 CATEGORIES

The categories of the medical staff shall include the following: active, courtesy, consulting, provisional, emeritus, participating, resident/fellow, telemedicine, and administrative. At appointment and each time of reappointment, the member’s staff category shall be determined.

3.2 ACTIVE STAFF

3.2.1. QUALIFICATIONS

The active staff shall consist of members who:

- 3.2.1.1. meet the general qualifications for membership set forth in Section 2.2;

- 3.2.1.2. have offices or residences which, in the opinion of the medical executive committee, are located closely enough to the hospital to provide appropriate continuity of quality care;
- 3.2.1.3. regularly care for patients in this hospital or are regularly involved in medical staff functions, as determined by the medical staff rules and regulations; and
- 3.2.1.4. except for good cause shown as determined by the medical staff, have satisfactorily completed their designated term in the provisional staff category.

3.2.2 PREROGATIVES

Except as otherwise provided, the prerogatives of an active medical staff member shall be to:

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

3.3. THE COURTESY MEDICAL STAFF

3.3.1. QUALIFICATIONS

The courtesy medical staff shall consist of members who:

- 3.3.1.1. meet the general qualifications set forth in Sections 3.2.1.1 and 3.2.1.2.
- 3.3.1.2. do not regularly care for patients or are not regularly involved in medical staff functions as determined by the medical staff rules and regulations;
- 3.3.1.3. are members in good standing of the active or associate medical staff of another California licensed hospital, although exceptions to this requirement may be made by the medical executive committee for good cause; and
- 3.3.1.4. have satisfactorily completed appointment in the provisional category.

3.3.2. PREROGATIVES

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

- 3.3.2.1. admit patients to the hospital with the limitations of Section 3.3.1.2 and exercise such clinical privileges as are granted pursuant to Article V; and
- 3.3.2.2. attend in a non-voting capacity meetings of the medical staff and the department of which the individual is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

Courtesy staff members shall not be eligible to hold office in the medical staff.

3.4. THE CONSULTING MEDICAL STAFF

3.4.1. QUALIFICATIONS

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

- 3.4.1.1. are not otherwise members of the medical staff and meet the general qualifications set forth in Section 2.2, except that this requirement shall not preclude an out-of-state practitioner from appointment as may be permitted by law if that practitioner is otherwise deemed qualified by the medical executive committee;
- 3.4.1.2. possess adequate clinical and professional expertise;
- 3.4.1.3. are willing and able to come to the hospital on schedule or promptly respond when called to render clinical services within their area of competence;
- 3.4.1.4. are members of the active or associate medical staff of another hospital licensed by California or another state, although exceptions to this requirement may be made by the medical executive committee for good cause.

3.4.2. PREROGATIVES

The consulting medical staff member shall be entitled to:

- 3.4.2.1. exercise such clinical privileges as are granted pursuant to Article V; and
- 3.4.2.2. Consulting staff members shall not be eligible to hold office in the medical staff organization, but may serve on committees.

3.5 PROVISIONAL STAFF

3.5.1. QUALIFICATIONS

The provisional staff shall consist of members who:

- 3.5.1.1 meet the general medical staff membership qualifications set forth in Sections 3.2.1.1., 3.2.1.2. and 3.4.1.1-3.4.1.4 ; and
- 3.5.1.2. immediately prior to their application and appointment were not members (or were no longer members) in good standing of this medical staff.

3.5.2. PREROGATIVES

The provisional staff member shall be entitled to:

- 3.5.2.1. admit patients and exercise such clinical privileges as are granted pursuant to Article V; and
- 3.5.2.2. attend meetings of the medical staff and the department of which that person is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.
- 3.5.2.3. At the end of one (1) year, they may, once proctoring is completed and upon satisfactory review by their assigned department and the Credentials Committee, be considered by the Medical Executive committee for promotion to Courtesy or Active Staff membership. If an initial appointee fails to complete initial proctoring within the first eighteen (18) months, the physician will be reminded that they have an additional six (6) months to complete the initial proctoring. If the physician fails to meet this requirement within six (6) months, the physician will be considered a voluntary resignation from staff.
- 3.5.2.4. Provisional staff members shall not be eligible to hold office in the medical staff organization, but may serve on committees.

3.5.3. OBSERVATION OF PROVISIONAL STAFF MEMBER

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

The results of the observation shall be communicated by the department chair to the credentials committee.

3.5.4. TERM OF PROVISIONAL STAFF STATUS

A member shall remain in the provisional staff for a period of 1 to 2 years, unless that status is extended by the medical executive committee for an additional period of up to 6 months upon a determination of good cause, which determination shall not be subject to review pursuant to Articles VI or VII.

3.5.5. ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS

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

3.5.5.2. In all other cases, the appropriate department shall advise the credentials committee which shall make its report to the medical executive committee which, in turn, shall make its recommendation to the governing board regarding a modification or termination of clinical privileges or termination of medical staff membership.

3.5.6. EMERGENCY DEPARTMENT ON-CALL DUTIES

All provisional staff members shall participate whenever applicable in the Emergency Department On-Call panel for the first two years of membership as determined by the Department Chair.

3.6 EMERITUS, AND PARTICIPATING STAFF

3.6.1. QUALIFICATIONS

3.6.1.1. The Emeritus Staff - The emeritus staff shall consist of members who have retired from active practice and, at the time of their retirement, were members in good standing of the active medical staff for a period of at least 10 continuous years, and who continue to adhere to appropriate professional and ethical standards.

3.6.1.2. The Participating Staff - The participating staff shall consist of physicians, dentists, podiatrists who do not actively practice at the hospital but are an important resource for medical staff educational activities.

3.6.2. PREROGATIVES

Emeritus and participating staff members are not eligible to admit patients to the hospital or to exercise clinical privileges in the hospital, or to vote or hold office in this medical staff organization, but they may serve on committees with or without vote at the discretion of the medical executive committee. They may attend staff and department meetings, including open committee meetings and educational programs.

3.7. ADMINISTRATIVE STAFF

3.7.1. QUALIFICATIONS

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

3.7.2. PREROGATIVES

The administrative staff shall be entitled to:

- 3.7.2.1. Attend meetings of the medical staff and various departments, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except to the extent the right to vote is specified at the time of appointment.
- 3.7.2.2. Administrative staff members shall not be eligible to hold office in the medical staff organization, admit patients or exercise clinical privileges.
- 3.7.2.3. Administrative Medical Staff shall be eligible to serve on Medical Staff committees and shall be eligible to vote if serving as Chair, otherwise they serve ex-officio.
- 3.7.2.4. Members of the Administrative Medical Staff shall be required to attend Medical Staff meetings in accordance with the Bylaws and shall be required to pay Medical Staff dues.

3.8. RESIDENT/FELLOW MEDICAL STAFF

3.8.1. QUALIFICATIONS

Resident medical staff membership shall be held by post-doctoral trainees (residents and fellows) in training programs of teaching institutions who are not eligible for another staff category and who are either licensed or registered with the appropriate State of California licensing board. All resident medical staff members must obtain a license to practice medicine within the State of California when eligible. The Resident/Fellow Medical Staff shall be in good standing at an accredited teaching program with a license to practice medicine in California

under the supervision of a Medical Staff member in good standing of same Department.

3.8.2. PREROGATIVES

- 3.8.2.1. The Resident/Fellow Medical Staff shall be in good standing at an accredited teaching program with a license to practice medicine in California under the supervision of a Medical Staff member in good standing of same Department.
- 3.8.2.2. All medical care provided by resident medical staff is under the supervision of members of the active, courtesy or consulting staff. Such care shall be in accordance with the provision of a program approved by and in conformity with the Accreditation council on Graduate Medical Education of the American Medical Association, the American Osteopathic Association, or the American Dental Association's Commission Dental Accreditation. Residents must be supervised by teaching staff in such a way that the trainee assumes progressively increasing responsibility for patient care according to their level of training, ability and experience.
- 3.8.2.3 Appointment. Appointment to the resident medical staff shall be for one year and may be renewed annually. Resident medical staff membership may not be considered as the observational period required to be completed by provisional staff. Resident medical staff membership terminates with termination from the training program. Appointment to the Resident/Fellow Medical Staff goes through Graduate Medical Education Committee and then to the Medical Executive Committee and Governing Board.

3.9 TELEMEDICINE STAFF

3.9.1. QUALIFICATIONS

- 3.9.1.1. Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Diagnosis and treatment of a patient may be performed via a telemedicine link.
- 3.9.1.2. Telemedicine Practitioner are any licensed and appropriately credentialed practitioner who prescribes, renders a diagnosis or otherwise provides clinical treatment recommendations to a patient who has expressly applied for and been granted Telemedicine privileges.

3.9.2. PREROGATIVES

Every practitioner providing direct clinical services including but not limited to telemedicine services at this hospital shall be entitled to exercise only those privileges specifically granted to them by the governing board. The privileges

must be within the scope of the license authorizing the practitioner to practice in California. Regardless of the privileges granted, each practitioner must obtain consultation when necessary for the safety of his patients or when required by these bylaws, the medical staff and departmental rules and regulations and other policies of the medical staff and the hospital. Telemedicine staff are exempt from meeting attendance.

3.10 LIMITATION OF PREROGATIVES

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

3.11 GENERAL EXCEPTIONS TO PREROGATIVES

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

3.11.1 shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the chair of the meeting, subject to final decision by the medical executive committee; and

3.11.2 shall exercise clinical privileges only within the scope of their licensure and as set forth in Section 5.4.

3.12 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the credentials committee, or pursuant to a request by a member under Section 4.6.1.2, or upon direction of the governing board as set forth in Section 6.1.6, the medical executive committee may recommend a change in the medical staff category of a member consistent with the requirements of the bylaws.

3.13 AFFILIATE STAFF MEMBER

A licensed physician who wishes to continue their association with the Medical Staff of Desert Regional Medical Center who does not meet the requirements for verification of their credentials based on inadequate activity at Desert Regional Medical Center or any other accredited hospital may choose this category. They may participate in the care of patients on whom they provide outpatient care who are admitted to the hospital by visiting the patient, reviewing the medical record and discussing the care of the patient with the admitting physician, other practitioners or a consultant. They may become involved in discussions about discharge planning in order to maintain contact and care of their patient as an outpatient. They do not have privileges to admit, write orders or request consultants. They can not do the admission H&P but they can provide information for the medical record which would be of assistance to the admitting physician or consultants.

Requirements for reappointment. Active medical license, malpractice certificate.

4. ARTICLE IV - APPOINTMENT AND REAPPOINTMENT

(Including Telemedicine Services)

4.1. GENERAL

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

4.2. BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement, or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. To the extent consistent with law, this burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the medical executive committee which may select the examining physician. The applicant may select the examining physician from an outside panel of three physicians chosen by the medical executive committee.

4.3. APPOINTMENT AUTHORITY

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

4.4. DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these bylaws, initial appointments to the medical staff shall be for a period up to 2 years. Reappointments shall be for a period of up to two medical staff years.

4.5 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

4.5.1 APPLICATION FORM

An application form shall be developed by the medical executive committee. The form shall require detailed information which shall include, but not be limited to, information concerning:

- 4.5.1.1. the applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA registration, and continuing medical education information related to the clinical privileges to be exercised by the applicant;
- 4.5.1.2. peer references familiar with the applicant's professional competence and ethical character;
- 4.5.1.3. requests for membership categories, departments, and clinical privileges;
- 4.5.1.4. past or pending professional disciplinary action, voluntary or involuntary denial, revocation, suspension, reduction or relinquishment of medical staff membership or privileges or any licensure or registration, and related matters. For the purposes of this section, voluntary actions shall only include those taken while under investigation for possible incompetence of improper professional conduct, or breach of contract, or in return for such an investigation not being conducted;
- 4.5.1.5. current physical and mental health status;
- 4.5.1.6. final judgments or settlements made against the applicant in professional liability cases, and any filed and served cases pending;
- 4.5.1.7. professional liability coverage; and
- 4.5.1.8. any past, pending or current exclusion from a federal or state health care program.

Each application for initial appointment to the medical staff shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. When an applicant requests an application form, that person shall be given a copy (in hard-copy or electronic format) of these bylaws, the medical staff rules and regulations, and, as deemed appropriate by the medical executive committee, copies or summaries of any other applicable medical staff policies relating to clinical practice in the hospital.

4.5.2 EFFECT OF APPLICATION

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

- 4.5.2.1. signifies willingness to appear for interviews in regard to the application;
- 4.5.2.2. 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;
- 4.5.2.3. consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;
- 4.5.2.4. 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;
- 4.5.2.5. 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;
- 4.5.2.6. consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the hospital or medical staff may have, and releases the medical staff and hospital from liability for so doing to the fullest extent permitted by law;
- 4.5.2.7. if a requirement then exists for medical staff dues, acknowledges responsibility for timely payment;
- 4.5.2.8. agrees to provide for continuous quality care for patients;
- 4.5.2.9. pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing for the continuous care of the applicant's patients, seeking consultation whenever necessary, refraining from failing to disclose to patients when another surgeon will be performing the surgery, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners; and
- 4.5.2.10 pledges to be bound by the medical staff bylaws, rules and regulations, and policies.

4.5.3. VERIFICATION OF INFORMATION

The Medical Staff Services Department, upon receipt of an initial application, shall establish a formal credential file, including all of the information in the

application packet. The Medical Staff Services Department shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The hospital's authorized representative shall query the National Practitioner Data Bank regarding the applicant or member and submit any resulting information to the Credentials Committee for inclusion in the applicant or member's credentials file. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain the required information. When collection and verification is accomplished, all such information shall be transmitted to the appropriate department(s) and the Credentials Committee.

4.5.4. DEPARTMENT ACTION

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

4.5.5. CREDENTIALS COMMITTEE ACTION

The credentials committee/or designated representative shall review the application, evaluate and verify the supporting documentation, the department chair's report and recommendations, and other relevant information. The credentials committee may elect to interview the applicant and seek additional information. As soon as practicable, the credentials committee shall transmit to the medical executive committee a written report and its recommendations as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The committee may also recommend that the medical executive committee defer action on the application.

4.5.6. MEDICAL EXECUTIVE COMMITTEE ACTION

At its next regular meeting after receipt of the credentials committee report and recommendation, or as soon thereafter as is practicable, the medical executive committee shall consider the report and any other relevant information. The medical executive committee may request additional information, return the matter to the credentials committee for further investigation, and/or elect to interview the applicant. The medical executive committee shall immediately forward transmittal to the governing board, or in cases eligible for expedited processing, the committee duly appointed by the board to handle expedited cases,

a written report and recommendation as to medical staff appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The committee may also defer action on the application. The reasons for each recommendation shall be stated.

4.5.7. EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

4.5.7.1. Favorable Recommendation: When the recommendation of the medical executive committee is favorable to the applicant, it shall be immediately forwarded, together with supporting documentation, to the governing board or, in cases eligible for expedited processing, applicable committee duly appointed by the Board to handle expedited calls.

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

4.5.8. ACTION ON THE APPLICATION

The governing board or, in cases eligible for expedited processing, the duly appointed committee of the board, may accept the recommendation of the medical executive committee or may refer the matter back to the medical executive committee for further consideration, stating the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. The following procedures shall apply with respect to action on the application:

4.5.8.1. If the medical executive committee issues a favorable recommendation, the governing board or its duly appointed committee in cases eligible for expedited processing shall affirm the recommendation of the medical executive committee if the medical executive committee's decision is supported by substantial evidence.

4.5.8.2. If the governing board concurs in that recommendation, the decision of the board shall be deemed final action.

4.5.8.3. If the tentative final action of the governing board is unfavorable, the administrator shall give the applicant written notice of the tentative adverse recommendation and the applicant shall be entitled to the procedural rights set forth in Article VII. If procedural rights are waived by the applicant, the decision of the governing board shall be deemed final action.

4.5.8.4. In cases eligible for expedited processing, if the duly appointed committee and the Board concur in that recommendation, the positive decision shall be ratified by the governing board at its next regularly scheduled meeting. The ratification by the board shall be deemed final.

If the committee's decision is adverse to the applicant, or the Board fails to ratify the committee's decision, the matter shall be referred back to the medical executive committee for evaluation.

4.5.8.5. In the event the recommendation of the medical executive committee, or any significant part of it, is unfavorable to the applicant the procedural rights set forth in Article VII shall apply.

4.5.8.5.1. If procedural rights are waived by the applicant, the recommendations of the medical executive committee shall be forwarded to the governing board for final action, which shall affirm the recommendation of the medical executive committee if the medical executive committee's decision is supported by substantial evidence.

4.5.8.5.2. If the applicant requests a hearing following the adverse medical executive committee recommendation pursuant to Section 4.5.8.5 or an adverse governing board tentative final action pursuant to 4.5.8.3, the governing board shall take final action only after the applicant has exhausted all procedural rights as established by Article VII. After exhaustion of the procedures set forth in Article VII, the board shall make a final decision and shall affirm the decision of the judicial review committee if the judicial review committee's decision is supported by substantial evidence, following a fair procedure. The board's decision shall be in writing and shall specify the reasons for the action taken.

4.5.8.6. Applicants are ineligible for expedited processing if, at the time of appointment, any of the following has occurred:

4.5.8.6.1. The applicant submits an incomplete application.

4.5.8.6.2. The medical executive committee makes a final recommendation that is adverse or with limitation.

4.5.8.6.3. There is a current challenge or previously successful challenge to licensure.

4.5.8.6.4. The applicant has received an involuntary termination of medical staff membership at another organization.

4.5.8.6.5. The applicant has received involuntary limitation, reduction, denial, or loss of medical privileges.

4.5.8.6.6. There has been a final judgment adverse to the applicant in a professional liability action.

4.5.9. NOTICE OF FINAL DECISION

4.5.9.1. Notice of the final decision shall be given to the chief of staff, the medical executive and the credentials committees, the chair of each department concerned, the applicant, and the administrator.

4.5.9.2. A decision and notice to appoint or reappoint shall include, if applicable: (1) the staff category to which the applicant is appointed; (2) the department to which that person is assigned; (3) the clinical privileges granted; and (4) any special conditions attached to the appointment.

4.5.10. REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the medical staff for a period of 2 years. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

4.5.11. TIMELY PROCESSING OF APPLICATIONS

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

4.5.11.1. evaluation, review, and verification of application and all supporting documents by the medical staff office: 7 days from receipt of all necessary documentation;

4.5.11.2. review and recommendation by department(s): 7 days after receipt of all necessary documentation from the medical staff office;

4.5.11.3. review and recommendation by credentials committee: 7 days after receipt of all necessary documentation from the department(s);

4.5.11.4. review and recommendation by executive committee: 30 days after receipt of all necessary documentation from the credentials committee or at the next scheduled meeting; and

4.5.11.5. final action: 180 days after receipt of all necessary documentation by the medical staff office, 30 days in expedited cases, or 7 days after conclusion of hearings.

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

4.6.1. APPLICATION

4.6.1.1. At least 4 months prior to the expiration date of the current staff appointment (except for temporary appointments), a reapplication form developed by the medical executive committee shall be mailed or delivered to the member. Providers are expected to return the completed reappointment application within 45 days of receipt. If the provider fails to return the application within the first 45 day period, a second request will be sent via certified mail. If the provider fails to submit a completed reappointment application within the second 45 day period, a final notice will be sent to the provider via certified mail stating they will be deemed to have voluntarily resigned membership and privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 4.5.1, as well as other relevant matters. Upon receipt of the application, the information shall be processed as set forth commencing at Section 4.5.3.

4.6.1.2. A medical staff member who seeks a change in medical staff status or modification of clinical privileges may submit such a request at any time upon a form developed by the medical executive committee, except that such application may not be filed within 12 months of the time a similar request has been denied.

4.6.2. EFFECT OF APPLICATION

The effect of an application for reappointment or modification of staff status or privileges is the same as that set forth in Section 4.5.2.

4.6.3. STANDARDS AND PROCEDURE FOR REVIEW

When a staff member submits the first application for reappointment, and every two years thereafter, or when the member submits an application for modification of staff status or clinical privileges, the member shall be subject to an in-depth review generally following the procedures set forth in Sections 4.5.3 through 4.5.11.

4.6.4. FAILURE TO FILE REAPPOINTMENT APPLICATION

If the member fails to submit a completed application for reappointment within 45 days past the date it was due, the member shall be deemed to have resigned membership in the medical staff. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article VII shall not apply.

4.7. LEAVE OF ABSENCE

4.7.1. LEAVE STATUS

At the discretion of the medical executive committee, a medical staff member may obtain a voluntary leave of absence from the staff upon submitting a written request to the medical executive committee stating the approximate period of leave desired, which may not exceed 18 months. During the period of the leave, the member shall not exercise clinical privileges at the hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the medical staff.

4.7.2. REAPPOINTMENT DURING LEAVE OF ABSENCE

If a member will be eligible for reappointment during a requested leave of absence, that member will be responsible for submission of a completed reappointment application pursuant to Section 4.6.1.1.

4.7.3. TERMINATION OF LEAVE

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, if the executive committee so requests. The staff member shall submit satisfactory status of his/her health for the termination of a medical leave. The medical executive committee shall make a recommendation concerning the reinstatement of the member's privileges and prerogatives, and the procedure provided in Sections 4.1 through 4.5.11 shall be followed.

4.7.4. FAILURE TO REQUEST REINSTATEMENT

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

4.7.5. MEDICAL LEAVE OF ABSENCE

The medical executive committee shall determine the circumstances under which a particular medical staff member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. In the discretion of the medical executive committee, unless accompanied by a

reportable restriction of privileges, the leave shall be deemed a “medical leave” which is not granted for a medical disciplinary cause or reason.

4.7.6. MILITARY LEAVE OF ABSENCE

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the medical executive committee. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions of Sections 4.7.3 and 4.7.4, as determined by the medical executive committee.

5. ARTICLE V - CLINICAL PRIVILEGES

5.1. EXERCISE OF PRIVILEGES

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

5.2. DELINEATION OF PRIVILEGES IN GENERAL

5.2.1. REQUESTS

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

5.2.2. BASIS FOR PRIVILEGES DETERMINATION

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

especially other institutions and health care settings where a member exercises clinical privileges.

5.3. PROCTORING

5.3.1. GENERAL PROVISIONS

Except as otherwise determined by the medical executive committee, all initial appointees to the medical staff and all members granted new clinical privileges shall be subject to a period of proctoring. Each appointee or recipient of new clinical privileges shall be assigned to a department where performance on an appropriate number of cases as established by the medical executive committee, or the department as designee of the medical executive committee, shall be observed by the chair of the department, or the chair's designee, during the period of proctoring specified in the department's rules and regulations, to determine suitability to continue to exercise the clinical privileges granted in that department. The exercise of clinical privileges in any other department shall also be subject to direct observation by that department's chair or the chair's designee. The member shall remain subject to such proctoring until the medical executive committee has been furnished with:

- 5.3.1.1. a report signed by the chair of the department(s) to which the member is assigned describing the types and numbers of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made; and
- 5.3.1.2. a report signed by the chair of the other department(s) in which the appointee may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the applicant's performance and a statement that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments.

5.3.2 FAILURE TO MEET PROCTORING REQUIREMENTS

If an initial appointee fails within the time of provisional membership to meet the requirements of Section 3.5.2.3, the physician may be granted an additional 6 months to complete the initial proctoring at the discretion of the Credentials Committee with approval from the Medical Executive Committee. If the physician fails to meet this requirement within six (6) months, the physician will be considered a voluntary resignation from staff.

If a member exercising new clinical privileges fails to meet requirements of Section 5.3.1 within the time allowed by the department, those specific clinical privileges shall automatically terminate. The timeframe is not to exceed twelve (12) months.

5.4. CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

5.4.1. ADMISSIONS

- 5.4.1.1. Except as provided by section 5.4.1.2, when dentists, oral surgeons and podiatrists who are members of the medical staff, co-admit patients, a physician member of the medical staff must conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry and podiatry), and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice.
- 5.4.1.2. Oral and maxillofacial surgeons who have successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Office of Education and have been determined by the medical staff to be competent to do so, may perform a history and physical examination and determine the ability of their patient to undergo surgical procedures the oral and maxillofacial surgeon proposes to perform. Completion of a history and physical by a qualified oral and maxillofacial surgeon under this section shall satisfy the appraisal portion of the requirements of section 5.4.2, below. For patients with existing medical conditions or abnormal findings beyond the surgical indications, a physician member of the medical staff must conduct or directly supervise the admitting history and physical examination, except the portion related to oral and maxillofacial surgery, and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the oral and maxillofacial surgeon's lawful scope of practice.

5.4.2. MEDICAL APPRAISAL

All patients admitted for care in a hospital by a dentist, oral and maxillofacial surgeon or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and the dentist, oral and maxillofacial surgeon or podiatrist shall seek consultation with a physician member to determine the patient's medical status and need for medical evaluation whenever the patient's clinical status indicates the presence of a medical problem. Where a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate department(s).

5.5. TEMPORARY CLINICAL PRIVILEGES

Temporary privileges are allowed under two circumstances only: to address a patient care need and to finalize a pending application.

5.5.1. PATIENT CARE NEEDS

5.5.1.1. Care of Specific Patient

Temporary clinical privileges may be granted where good cause exists to allow a physician, dentist, podiatrist, clinical psychologist to provide care to a specific patient (but not more than 5 during a calendar year) provided that the procedure described in Section 5.5.4 has been completed.

5.5.1.2. Locum Tenens

Temporary clinical privileges may be granted to a person serving as a Locum Tenens for a current member of the medical staff, provided that the procedure described in Section 5.5.4 has been completed. Such person may attend only patients of the member(s) for whom that person is providing coverage, for a period not to exceed 120 days, unless the medical executive committee recommends a longer period for good cause.

5.5.2. PENDING APPLICATION FOR PERMANENT MEDICAL STAFF MEMBERSHIP

Temporary clinical privileges may be granted while that person's application for permanent medical staff membership and privileges are pending, provided that the procedure described in Section 5.5.4.1.2 has been completed, and that the applicant has no current or previously successful challenge to professional licensure or registration, no involuntary termination of medical staff membership at any other organization, and no involuntary limitation, reduction, denial or loss of clinical privileges. Such persons may only attend patients for a period not to exceed 120 days.

5.5.3. TEMPORARY MEMBERSHIP AND TEMPORARY PRIVILEGES NOT CO-EXTENSIVE

Temporary members of the medical staff pursuant to Section 6.1.3 are not, by virtue of such membership, granted temporary clinical privileges.

5.5.4. APPLICATION AND REVIEW

5.5.4.1. "Upon receipt of a completed application and supporting documentation from a physician, dentist, podiatrist, authorized to practice in California, the chief executive officer on the recommendation of either the applicable clinical department chairperson or the chief of staff, may grant temporary privileges to a member who appears to have qualifications, ability and judgment consistent with Section 2.2.1., but only:

- 5.5.4.1.1. With respect to applications by a Locum Tenens, or to fulfill an important patient care need, after verification of current licensure and current competence; or
- 5.5.4.1.2. With respect to a new applicant awaiting review and approval of the medical staff executive committee and the governing body in compliance with the requirements in Section 5.5.3, after the following has been completed:
 - 5.5.4.1.2.1. the National Practitioner Data Bank report regarding the applicant for temporary privileges has been received and evaluated and current California licensure has been verified.
 - 5.5.4.1.2.2. the appropriate department chair has interviewed the applicant and has contacted at least one person who
 - 5.5.4.1.2.2.1. has recently worked with the applicant;
 - 5.5.4.1.2.2.2. has directly observed the applicant's professional performance over a reasonable time; and
 - 5.5.4.1.2.2.3. provides reliable information regarding the applicant's current professional competence to perform the privileges requested, ethical character, and ability to work well with others so as not to adversely affect patient care, or other criteria required by medical staff bylaws.
 - 5.5.4.1.3. the applicant's file, including the recommendation of the department chair of the applicable department when available, or the chief of staff in all other cases, is forwarded to the credentials committee and the medical executive committee.
 - 5.5.4.1.4. the medical executive committee through the chief of staff, after reviewing the applicant's file and attached materials, recommends granting temporary privileges.
- 5.5.4.2. If the applicant requests temporary privileges in more than one department, interviews may be conducted and written concurrence shall first be obtained from the appropriate department chairs and forwarded to the credentials committee. In the event of a disagreement between the chief executive officer or his or her designee and the medical executive

committee regarding the granting of temporary clinical privileges, the matter shall be resolved as set forth in Section 4.5.8.

5.5.5. GENERAL CONDITIONS

5.5.5.1. If granted temporary privileges, the applicant shall act under the supervision of the department chair to which the applicant has been assigned, and shall ensure that the chair, or the chair's designee, is kept closely informed as to the applicant's activities within the hospital.

5.5.5.2. Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended under Articles VI and/or VII of these bylaws or unless affirmatively renewed following the procedure as set forth in Section 5.5. As necessary, the appropriate department chair or, in the chair's absence, the chair of the medical executive committee, shall assign a member of the medical staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement medical staff member.

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

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

5.6. EMERGENCY PRIVILEGES

5.6.1. In the case of an emergency involving a particular patient, any member of the medical staff, to the degree permitted by the scope of the applicant's license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of the patient or to save the patient from serious harm provided that the care provided is within the scope of the individual's license. The member shall make every reasonable effort to communicate promptly with the department chair concerning the need for emergency care and assistance by members of the medical staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the department chair with respect to further care of the patient at the hospital.

5.6.2. In the event of an emergency under Section 5.6.1, any person shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to qualified members of the medical staff when it becomes reasonably available.

- 5.6.3. Emergency privileges under Section 5.6.1 shall not be used to force members to serve on emergency department call panels providing services for which they do not hold delineated clinical privileges.
- 5.6.4. In the case of a disaster in which the emergency management plan has been activated and the hospital is unable to handle the immediate patient needs, the Chief of Staff, or in the absence of the Chief of Staff, the Chief of Staff-Elect, may grant emergency privileges. In the absence of the Chief of Staff and Chief of Staff-Elect and Department Chair(s), the Chief Executive Officer or the CEO's designee of the Hospital may grant the privileges of this section. The grant of privileges under this section shall be on a case-by-case basis at the sole discretion of the individual authorized to grant such privileges.
- 5.6.5. The verification process of the credentials and privileges of individuals who receive emergency privileges under this section shall be developed in advance of a disaster situation. This process shall begin as soon as the immediate disaster situation is under control, and is completed within 72 hours from time the volunteer practitioner presents to the organization, and shall meet the following requirements in order to fulfill important patient care needs:
 - 5.6.5.1. The medical staff identifies in writing the individual(s) responsible for granting emergency privileges.
 - 5.6.5.2. The medical staff describes in writing the responsibilities of the individual(s) responsible for granting emergency privileges.
 - 5.6.5.3. The medical staff describes in writing a mechanism to manage the activities of individuals who receive emergency privileges. There is a mechanism to allow staff to readily identify these individuals.
 - 5.6.5.4. The medical staff addresses the verification process as a high priority. The medical staff has a mechanism to ensure that the verification process of the credentials and privileges of individuals who receive emergency privileges begins as soon as the immediate situation is under control. This privileging process is identical to the process established under the medical staff bylaws for granting temporary privileges to fulfill an important patient care need.
 - 5.6.5.5. The chief executive officer or president of the medical staff or his or her designee(s) may grant emergency privileges upon presentation of any of the following:
 - 5.6.5.5.1. A current picture hospital ID card.
 - 5.6.5.5.2. A current license to practice and a valid picture ID issued by a state, federal, or regulatory agency.
 - 5.6.5.5.3. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).

5.6.5.5.4. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity.

5.6.5.5.5. Presentation by current hospital or medical staff member(s) with personal knowledge regarding practitioner's identity.

5.7. MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

On its own, upon recommendation of the credentials committee, or pursuant to a request under Section 4.6.1.2, the medical executive committee may recommend a change in the clinical privileges or department assignment(s) of a member. The executive committee may also recommend that the granting of additional privileges to a current medical staff member be made subject to monitoring in accordance with procedures similar to those outlined in Section 5.3.1.

5.8. LAPSE OF APPLICATION

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

6. ARTICLE VI - CORRECTIVE ACTION

6.1 CORRECTIVE ACTION

6.1.1 CRITERIA FOR INITIATION

Any person may provide information to the medical staff about the conduct, performance, or competence of its members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the hospital; (2) unethical; (3) contrary to the medical staff bylaws and rules or regulations; or (4) below applicable professional standards, a request for an investigation or action against such member may be initiated by the chief of staff, a department chair, or the medical executive committee.

6.1.2 INITIATION

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

6.1.3 INVESTIGATION

If the medical executive committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The medical executive committee may conduct the investigation itself, or may assign the task to an appropriate medical staff officer, medical staff department, or standing or ad hoc committee of the medical staff. The medical executive committee in its discretion may appoint practitioners who are not members of the medical staff as temporary members of the medical staff for the sole purpose of serving on a standing or ad hoc committee, and not for the purpose of granting these practitioners temporary clinical privileges under Section 5.5, should circumstances warrant. If the investigation is delegated to an officer of committee other than the medical executive committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the medical executive committee as soon as practicable. The report may include recommendations for appropriate corrective action. The member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a "hearing" as that term is used in Article VII, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the medical executive committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

6.1.4 EXECUTIVE COMMITTEE ACTION

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

- 6.1.4.1. determining no corrective action be taken and, if the executive committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's file;
- 6.1.4.2. deferring action for a reasonable time where circumstances warrant;
- 6.1.4.3. issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude department heads from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file;
- 6.1.4.4. recommending the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical

privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring;

6.1.4.5. recommending reduction, modification, suspension or revocation of clinical privileges;

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

6.1.4.7. recommending suspension, revocation or probation of medical staff membership; and

6.1.4.8. taking other actions deemed appropriate under the circumstances.

6.1.5 SUBSEQUENT ACTION

6.1.5.1 If corrective action as set forth in Section 7.2.1-7.2.11 is recommended by the medical executive committee, that recommendation shall be transmitted to the governing board.

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

6.1.6 INITIATION BY GOVERNING BOARD

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

6.2 SUMMARY RESTRICTION OR SUSPENSION

6.2.1 CRITERIA FOR INITIATION

Whenever a member's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient, prospective patient, or other person. A physician also may be summarily suspended based on a finding of imminent harm to prospective patients—it is not necessary to identify a specific patient. The chief of staff, the medical executive committee, or the head of the department or designee in which the member holds privileges may summarily restrict or suspend the medical staff membership or

clinical privileges of such member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the governing board, the medical executive committee and the administrator. In addition, the affected medical staff member shall be provided with a written notice of the action which notice fully complies with the requirements of Section 6.2.2 below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the department chair or by the chief of staff, considering where feasible, the wishes of the patient in the choice of a substitute member.

6.2.2 WRITTEN NOTICE OF SUMMARY SUSPENSION

Within one working day of imposition of a summary suspension, the affected medical staff member shall be provided with written notice of such suspension. This initial written notice shall include a statement of facts demonstrating that the suspension was necessary because failure to suspend or restrict the practitioner's privileges summarily could reasonably result in an imminent danger to the health of an individual. The statement of facts provided in this initial notice shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for, but is in addition to, the notice required under Section 7.3.1 (which applies in all cases where the medical executive committee does not immediately terminate the summary suspension). The notice under Section 7.3.1 may supplement the initial notice provided under this section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

6.2.3. MEDICAL EXECUTIVE COMMITTEE ACTION

Within one week after such summary restriction or suspension has been imposed, a meeting of the medical executive committee or a subcommittee appointed by the chief of staff shall be convened to review and consider the action. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the medical executive committee may impose, although in no event shall any meeting of the medical executive committee, with or without the member, constitute a "hearing" within the meaning of Article VII, nor shall any procedural 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 working days of the meeting.

6.2.4. PROCEDURAL RIGHTS

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

- 6.2.4.1. Any affected practitioner shall have the right to challenge imposition of the summary suspension, particularly on the issue of whether or not the facts stated in the notice present a reasonable possibility of “imminent danger” to an individual. Initially, the practitioner may present this challenge to the medical executive committee at the meeting held within one week of imposition of the suspension. If the medical executive committee’s decision is to continue the summary suspension, then any practitioner who has properly requested a hearing under the medical staff bylaws may request that the hearing be bifurcated, with the first part of the hearing being devoted exclusively to procedural matters, including the propriety of summary suspension. Along with any other appropriate requests for rulings, the affected practitioner may request that the hearing officer or hearing panel stay the summary suspension, pending the final outcome of the hearing and any appeal.
- 6.2.4.2. At the conclusion of the procedural portion of the hearing, the hearing officer or hearing panel shall issue a written opinion on the issues raised, including whether or not the facts stated in the written notice to the affected practitioner adequately support a determination that failure to summarily restrict or suspend could reasonably result in “imminent danger” to an individual. Such written opinion shall be transmitted to both the affected practitioner and the medical executive committee within one week of the date of the procedural hearing.
- 6.2.4.3. If the hearing officer’s or hearing panel’s determination is that the facts stated in the notice required by Section 6.2.2 do not support a reasonable determination that failure to summarily restrict or suspend the practitioner’s privileges could result in imminent danger, the summary suspension shall be immediately stayed pending the outcome of the hearing and any appeal.
- 6.2.4.4. If the hearing officer or hearing panel determines that the facts stated in the notice required by Section 6.2.2 support a reasonable determination that summary suspension was necessary to avoid imminent danger to an individual, the summary suspension shall remain in effect pending conclusion of the hearing and any appellate review.

6.2.5. INITIATION BY GOVERNING BOARD

- 6.2.5.1. If the chief of staff, members of the medical executive committee and the head of the department (or designee) in which the member holds privileges are not available to summarily restrict or suspend the member’s membership or clinical privileges, the governing board (or designee) may immediately suspend a member’s privileges if a failure to suspend those privileges is likely to result in an imminent danger to the health of any person, provided that the governing board (or designee) made reasonable attempts to contact the chief of staff, members of the medical executive committee and the head of the department (or designee) before the suspension.

- 6.2.5.2. 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 working 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 Section 6.2 of these bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the medical executive committee for purposes of compliance with notice and hearing requirements.

6.3 AUTOMATIC SUSPENSION OR LIMITATION

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

6.3.1 LICENSURE

- 6.3.1.1 Revocation and Suspension: Whenever a member's license or other legal credential authorizing practice in this state is revoked or suspended, medical staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.
- 6.3.1.2 Restriction: Whenever a member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the member has been granted at the hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
- 6.3.1.3 Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.
- 6.3.1.4 Failure to maintain current medical license shall be grounds for automatic suspension of a members' clinical privileges, and if within 90 days the member does not provide current medical license, the member's membership shall be automatically terminated.

6.3.2 CONTROLLED SUBSTANCES

- 6.3.2.1 Whenever a member's DEA certificate is revoked, limited, or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

6.3.2.2 Probation: Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

6.3.3 MEDICAL RECORDS

6.3.3.1 Members of the medical staff are required to complete medical records within fourteen (14) days of patient discharge. Exceptions to this are the H&P (history and physical) and Operative reports which must be completed within 24 hours. Any practitioner with undictated H&P or operative reports shall receive a courtesy call or fax from Health Information Management (HIM) Department. Any practitioner with undictated H&P or operative reports shall automatically be placed on limited suspension after seventy-two (72) hours. Bona fide vacation or illness may constitute an excuse subject to approval by the medical executive committee. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, shall be imposed by the chief of staff or their designee, after notice of delinquency for failure to complete medical records within such period. The suspension shall continue until lifted by the chief of staff or his or her designee, or upon completion of the medical records.

For the purpose of this Section, "related privileges" means scheduling surgery, assisting in surgery, consulting on hospital cases, administering anesthesia and providing professional services within the hospital for all future patients. A physician on limited suspension may not assume care of a patient admitted by another member of the Medical Staff.

Exception: Suspension does not apply to admissions to the Skilled Nursing Facility or coverage on the DRMC emergency department call panel.

6.3.3.2 If after an additional thirty (30) consecutive days the physician is still on suspension, he/she may be required to make a mandatory appearance at the next Medical Executive Committee meeting to explain the prolonged suspension. If the physician does not have an excused absence from attending the meeting, the medical executive committee will take appropriate action. If the suspension is not corrected by the following Medical Executive Committee meeting, then the physician's membership and privileges will be completely suspended from any and all professional services within the hospital. If this delinquency is not corrected by the following Medical Executive Committee meeting then the physician's membership and privileges will be terminated. This action is not reportable to the California Medical Board, as patient care is not involved.

6.3.3.3 Content – The record shall include, as appropriate, identification data, complaint, personal history, family history, history of present illness, physical examination, special reports (e.g. consultations, clinical

laboratory, nuclear medicine and radiology, etc.), provisional diagnosis, medical or surgical provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, and discharge summary (to include final diagnosis, condition on discharge, clinical resume, and autopsy report when performed).

6.3.3.4 Admission History and Physical (H&P)

6.3.3.4.1 An H&P must be on the chart or electronic health record within 24 hours after admission or prior to any procedure. The H&P is the responsibility of the admitting physician or other qualified health care provider. If there is an error on the Hospital Admitting Sheet then it should be corrected and there should be an entry into the record that states who the admitting physician is as soon as possible. The admitting health care provider cannot be changed to a physician who is on suspension at the time of the admission. The H&P report shall be dictated, typed or written and include all pertinent positive and negative findings resulting from an inventory of systems. Any practitioner with undictated H&P shall receive a courtesy call or fax from Health Information Management. Any practitioner with undictated H&P shall be automatically suspended after seventy-two (72) hours.

6.3.3.4.2 An H&P can only be performed by a Practitioner that has privileges at this hospital and is responsible for the patient.

6.3.3.4.3 An H&P can be dictated, typed or written up to thirty (30) days prior to admission, outpatient or inpatient, of the patient. An addendum documenting whether there are any changes to the history and physical condition of the patient is required within twenty-four (24) hours of admission but always before the performance of any procedures. Additionally, when an H&P is completed within the 30 days before admission, it is required that an updated medical record entry documenting an examination for any changes in the patient's condition is placed in the patient's medical record within twenty-four (24) hours after admission, but, in all cases involving surgery or a procedure requiring anesthesia services, prior to the surgery or procedure. The examination must be conducted by a practitioner who is credentialed and privileged by the hospital's medical staff to perform an H&P.

6.3.3.5. History and Physical for Surgery with Moderate or Deep Sedation

6.3.3.5.1. There must be a complete H&P work-up on the chart of every patient prior to surgery before anesthesia begins, except in emergencies. If this has been dictated, but not yet recorded in the patient's chart, there must be a statement that

H&P has been dictated and a note in the chart as to a reason for admission by the practitioner who admitted the patient.

- 6.3.3.5.2. In case of an emergency, the practitioner shall make a note regarding the patient's condition prior to surgery.
- 6.3.3.5.3. An H&P performed within thirty (30) days prior to the surgery is acceptable if: Patient for whom moderate or deep sedation contemplated (any procedure deemed high risk) receives a pre-sedation or pre-anesthesia assessment within the twenty-four (24) time frame prior to surgery. The patient must be re-evaluated and examined immediately before moderate or deep sedation use or anesthesia induction.
- 6.3.3.6. Progress Notes – Progress notes shall be written or dictated by the attending physician or his/her covering physician on a daily basis, including newborns, giving a pertinent, chronological report of the patient's course in the hospital and should reflect an assessment of the patient's status from his/her visit with the patient on that day, any change in condition and the results of treatment. If the patient is not in the room at the time of the visit the progress note should reflect that fact. Progress notes are required two (2) times a week for hospice, three (3) times a week for acute rehab and every five (5) days for SNF, and are not required in an admission solely for a pediatric pneumogram. A discharge summary may be substituted for the final progress note.
- 6.3.3.7. Operative Report – A comprehensive operative note shall be entered in the medical record immediately after surgery to provide pertinent information for use by an individual who is required to attend the patient. Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports shall be in printed form or dictated immediately following surgery for outpatients as well as inpatients and the report promptly signed by the surgeon and made a part of the patient's current medical record. Any practitioner with undictated operative reports twenty-four (24) hours following the time of the operation will receive a courtesy call from Health Information Management. Any practitioner with undictated operative reports seventy-two (72) hours following the time of the operation shall be automatically suspended from operative privileges as outlined in the Medical Staff Bylaws.
- 6.3.3.8. Intensive Care Unit (ICU) transfer note. If a patient is in the ICU for three (3) hospital days or more, then a transfer note must be written or dictated within 24 hours of the time the patient is transferred out of the ICU. This summary should include procedures done in the ICU and the diagnoses at the time of the transfer. The exception is when the primary physician in the ICU is also the primary physician for the patient on the ward until discharge.

- 6.3.3.9. Discharge Summary – A discharge summary shall be dictated on all medical records of patients hospitalized over forty-eight(48) hours by the physician or his/her designee, as long as it is countersigned by the physician. A final progress note may be submitted for the discharge summary in the case of patients hospitalized less than forty-eight (48) hours. Neither is required in an admission solely for a pediatric pneumogram. The discharge summary or final progress note should concisely recapitulate the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient upon discharge, and any specific instructions given to the patient and/or the family.
- 6.3.3.10. Date and Time of Entry – All orders must be dated and timed.
- 6.3.3.11. Abbreviations – See the Administrative Policy & Procedure: Abbreviations and Symbols for standard abbreviations utilized in the facility and particularly in the patient’s medical record. Final diagnosis and procedures shall be recorded in full in the final progress notes of the medical record, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner within fourteen (14) days of discharge of all patients. The attending practitioner has the responsibility to establish the final diagnoses, including the recording or diagnoses and procedures from consultants on the case.
- 6.3.3.12. Authentication – All clinical entries in the patient’s medical record shall be accurately dated and authenticated by the responsible practitioner. Authentication means to establish authorship by written signature, or identifiable initials. At the discretion of the supervising physician, Allied Health Practitioners do not need to authenticate dictated reports if the supervisory physician signs the report. An electronic signature is acceptable after the physician has gone to Medical Records and signed his security access form.
- 6.3.3.13. Errors and Omissions – Errors are properly corrected by drawing a single line through the mistake, writing the word “error” near it, and recording the correct information. This entry needs to be signed, dated, and timed. Omissions in the record entered at a later date shall be added in the next available space. The words “late entry” with the current time, date, signature, and an explanation of the reason for the late entry shall be documented.
- 6.3.3.14. Release of Information – Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.
- 6.3.3.15. Removal of Record – Records may be removed from the hospital’s jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. All records are the property of the hospital and shall not otherwise be taken away without the permission of the Chief

Executive Officer of the Hospital or his/her designee. In the case of readmission or a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of charts from the hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee of the Medical Staff.

- 6.3.3.16. Access to Medical Records – Members of the Medical Staff shall have access to the medical records of all his/her patients. Medical Staff members who are engaged in peer review activities or Quality Improvement activities shall be granted appropriate access to medical records. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the President of the Medical Staff and Hospital Administrative Policies. Subject to the discretion of the Chief Executive Officer or his/her designee, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.
- 6.3.3.17. Permanent File – A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the President of the Medical Staff or designee.
- 6.3.3.18. Order Sheet – A practitioner’s routine orders, which applicable to a given patient, shall be reproduced in detail on the order sheet of the patient’s record, dated, and times, and signed by the practitioner.
- 6.3.3.19. Incomplete Medical Records – All medical records, including progress notes, cancer staging forms on newly diagnosed cancer cases, final diagnosis, and clinical resume, and counter signatures on verbal and phone orders shall be completed within fourteen (14) days following discharge of the patient from the hospital. Medical Staff members who do not complete records within fourteen (14) days of discharge will receive an automatic temporary suspension of privileges as outlined in the Medical Staff Bylaws. The Health Information Management Department will be responsible for notifying the President of the Medical Staff or Department Chair about records lacking clear indication or arguments about the responsibility of which practitioner is responsible for a particular part of the medical record. In the event that the document in question is the discharge summary then the following considerations will be made a) The admitting physician is responsible for the discharge summary unless there is a clear statement in the medical record about transfer of care, b) if the purpose of the admission is to perform a surgery then the operating surgeon is responsible for the

discharge summary, c) if the patient is admitted to the hospitalist service the hospitalist who discharges the patient shall be responsible for the discharge summary.

6.3.4 FAILURE TO PAY DUES/ASSESSMENTS

Failure without good cause as determined by the medical executive committee, to pay dues or assessments, as required under Section 14.2, within 60 days, shall be ground for automatic suspension of a member's clinical privileges, and if within three months after written warnings of the delinquency the member does not pay the required dues or assessments, the member's membership shall be automatically terminated.

6.3.5 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance shall be grounds for automatic suspension of a member's clinical privileges, and if within 90 days after written warnings of the delinquency the member does not provide evidence of required professional liability insurance, the member's membership shall be automatically terminated.

6.3.6 PEER REVIEW

Failure without good cause as determined by the medical executive committee, to respond in writing to written requests by the Peer Review Committee within the time frame specified in the policies of the Peer Review Committee, shall be grounds for automatic suspension of a member's clinical privileges until such a time as the Peer Review Committee has received the specified written response.

6.3.7 OUTSIDE ACTIONS

If any other hospital has initiated an action against your medical staff privileges, or if the Medical Board has filed an accusation against your license this must be reported to the Medical Staff Office within 10 days of action. Summary suspensions must be reported immediately.

7. ARTICLE VII - HEARINGS AND APPELLATE REVIEWS

7.1. GENERAL PROVISIONS

7.1.1. EXHAUSTION OF REMEDIES

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

7.1.2. APPLICATION OF ARTICLE

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

7.1.3. TMELY COMPLETION OF PROCESS

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

7.1.4. FINAL ACTION

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

7.2. GROUNDS FOR HEARING

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

- 7.2.1. denial of medical staff membership;
- 7.2.2. denial of requested advancement in staff membership status, or category;
- 7.2.3. denial of medical staff reappointment;
- 7.2.4. demotion to lower medical staff category or membership status;
- 7.2.5. suspension of staff membership;
- 7.2.6. revocation of medical staff membership;
- 7.2.7. denial of requested clinical privileges;
- 7.2.8. involuntary reduction of current clinical privileges;
- 7.2.9. suspension of clinical privileges;
- 7.2.10. termination of all clinical privileges; or
- 7.2.11. involuntary imposition of significant consultation or monitoring requirements (excluding monitoring incidental to provisional status and Section 5.3.)

7.3. REQUESTS FOR HEARING

7.3.1. NOTICE OF ACTION OR PROPOSED ACTION

- 7.3.1.1. In all cases in which action has been taken or a recommendation made as set forth in Section 7.2, the chief of staff or designee on behalf of the medical executive committee shall give the member prompt written notice of (1) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the
- 7.3.1.2. Medical Board of California and/or to the National Practitioner Data Bank if required; (2) the reasons for the proposed action including the acts or omissions with which the member is charged; (3) the right to request a hearing pursuant to Section 7.3.2, and that such hearing must be requested within 30 days; and (4) a summary of the rights granted in the hearing pursuant to the medical staff bylaws. If the recommendation or final proposed action is reportable to the Medical Board of California and/or to the National Practitioner Data Bank, the written notice shall state the proposed text of the report(s).

7.3.2. REQUEST FOR HEARING

The member shall have 30 days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the medical executive committee with a copy to the governing board. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

7.3.3. TIME AND PLACE FOR HEARING

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

7.3.4. NOTICE OF HEARING

Together with the notice stating the place, time and date of the hearing, which date shall not be less than 30 days after the date of the notice unless waived by a member under summary suspension, the chief of staff or designee on behalf of the medical executive committee shall provide the reasons for the recommended action, including the acts or omissions with which the member is charged, a list of

the charts in question, where applicable, and a list of the witnesses (if any) expected to testify at the hearing on behalf of the medical executive committee. The content of this list is subject to update pursuant to Section 7.4.1.

7.3.5. JUDICIAL REVIEW COMMITTEE

When a hearing is requested, the medical executive committee shall recommend the appointment of a judicial review committee. The judicial review committee shall be composed of not less than three (3) members of the medical staff. The judicial review committee members shall gain no direct financial benefit from the outcome, and shall not have acted as accusers, investigators, fact finders, initial decision makers or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the medical staff from serving as a member of the judicial review committee. A judicial review committee may be appointed from the active medical staff, other staff categories or practitioners who are not members of the medical staff. Such appointment shall include designation of the chair. Membership on a judicial review committee shall consist of one member who shall have the same healing arts licensure as the accused, and may include an individual practicing the same specialty as the member. All other members shall have M.D. or D.O. degrees or their equivalent as defined in Section 2.2.2.1.

7.3.6. FAILURE TO APPEAR OR PROCEED

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

7.3.7. POSTPONEMENTS AND EXTENSIONS

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

7.4. HEARING PROCEDURE

7.4.1. PREHEARING PROCEDURE

7.4.1.1. 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 anticipated to give testimony or evidence in support of that party at the hearing. The member shall have the right to inspect and copy documents or other evidence upon which the charges are based, as well as all other evidence relevant to the charges. The member shall also have the right to receive at least 30 days prior to the hearing a copy of the evidence forming the basis of the

charges which is reasonably necessary to enable the member to prepare a defense, including all evidence which was considered by the medical executive committee in determining whether to proceed with the adverse action, and any exculpatory evidence in the possession of the hospital or medical staff. The member and the medical executive committee shall have the right to receive all evidence which will be made available to the Judicial Review Committee. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least ten days before the commencement of the hearing shall constitute good cause for a continuance.

- 7.4.1.2. The medical executive committee shall have the right to inspect and copy at its expense any documents or other evidence relevant to the charges which the member possesses or controls as soon as practicable after receiving the request.
- 7.4.1.3. The failure by either party to provide access to this information at least 30 days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the member under review.
- 7.4.1.4. The hearing officer shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the hearing officer shall consider:
 - 7.4.1.4.1. whether the information sought may be introduced to support or defend the charges;
 - 7.4.1.4.2. the exculpatory or inculpatory nature of the information sought, if any;
 - 7.4.1.4.3. the burden imposed on the party in possession of the information sought, if access is granted; and
 - 7.4.1.4.4. any previous requests for access to information submitted or resisted by the parties to the same proceeding.
- 7.4.1.5. The member shall be entitled to a reasonable opportunity to question and challenge the impartiality of judicial review committee members and the hearing officer. Challenges to the impartiality of any judicial review committee member or the hearing officer shall be ruled on by the hearing officer.
- 7.4.1.6. It shall be the duty of the member and the medical executive committee or its designee to exercise reasonable diligence in notifying the chair of the judicial review committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order

that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

7.4.2. REPRESENTATION

7.4.2.1. The hearings provided for in these bylaws are for the purpose of intraprofessional resolution of matters bearing on professional conduct, professional competency, or character.

7.4.2.2. The member shall be entitled to be accompanied by and represented at the hearing by an individual of the member's choosing who is not also an attorney at law, and the medical executive committee shall appoint a representative who is not an attorney to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions. Neither party shall be represented by an attorney at law if the other party is not so represented.

7.4.3. THE HEARING OFFICER

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

7.4.4. RECORD OF THE HEARING

A shorthand reporter shall be present to make a record of the hearing proceedings, and the pre-hearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the shorthand reporter shall be borne by the hospital, but

the cost of the transcript, if any, shall be borne by the party requesting it. The judicial review committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

7.4.5. RIGHTS OF THE PARTIES

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

7.4.6. MISCELLANEOUS RULES

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

7.4.7. BURDENS OF PRESENTING EVIDENCE AND PROOF

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

7.4.8. ADJOURNMENT AND CONCLUSION

After consultation with the chair of the judicial review committee, the hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Both the 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, the hearing shall be closed.

7.4.9. BASIS FOR DECISION

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

7.4.10. DECISION OF THE JUDICIAL REVIEW COMMITTEE

Within 30 days after final adjournment of the hearing, the judicial review committee shall render a decision which shall be accompanied by a report in writing and shall be delivered to the medical executive committee. If the member is currently under suspension, however, the time for the decision and report shall be 15 days. A copy of said decision also shall be forwarded to the administrator, the governing board, and to the member. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. If the final proposed action adversely affects the clinical privileges of a physician or dentist for a period longer than 30 days and is based on competence or professional conduct, the decision shall state that the action if adopted will be reported to the National Practitioner Data Bank, and shall state the text of the report as agreed upon by the committee. The decision shall also state whether the action, if adopted, shall be reported to the Medical Board of California and shall state the text of the report as agreed by the committee. Both the member and the medical executive committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the judicial review committee shall be subject to such rights of appeal or review as described in these bylaws, but shall otherwise be affirmed by the governing board as the final action if it is supported by substantial evidence, following a fair procedure.

7.5. APPEAL

7.5.1. TIME FOR APPEAL

Within 10 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 governing board as the final action if it is supported by substantial evidence, following a fair procedure.

7.5.2. GROUNDS FOR APPEAL

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be: (a) substantial non-compliance with the procedures required by these bylaws or applicable law which has created demonstrable prejudice; (b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 7.5.5 the text of the report(s) to be filed with the Medical Board of California and/or the National Practitioner Data Bank is not accurate.

7.5.3. TIME, PLACE AND NOTICE

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

7.5.4. APPEAL BOARD

The governing board may sit as the appeal board, or it may appoint an appeal board which shall be composed of not less than 3 members of the governing board. 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 governing board shall be neither the attorney firm that represented either party at the hearing before the judicial review committee nor the attorney who assisted the hearing panel or served as hearing officer.

7.5.5. APPEAL PROCEDURE

The proceeding by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the judicial review committee, provided that the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the judicial review committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the judicial review hearing; or the appeal board may remand the matter to the judicial review committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of that party's position on appeal, and to personally appear and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The appeal board shall present to the governing board its written recommendations as to whether the governing board should affirm, modify, or reverse the judicial review committee decision consistent with the standard set forth in Section 7.5.6, or remand the matter to the judicial review committee for further review and decision.

7.5.6. DECISION

- 7.5.6.1. Except as provided in Section 7.5.6.2, within 30 days after the conclusion of the appellate review proceedings, the governing board shall render a final decision and shall affirm the decision of the judicial review committee if the judicial review committee's decision is supported by substantial evidence, following a fair procedure.
- 7.5.6.2. Should the governing board determine that the judicial review committee decision is not supported by substantial evidence, the board may modify or reverse the decision of the judicial review committee and may instead, or shall, where a fair procedure has not been afforded, remand the matter to the judicial review committee for reconsideration, stating the purpose for the referral. If the matter is remanded to the judicial review committee for further review and recommendation, the committee shall promptly conduct its review and make its recommendations to the governing board. 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 chair of the governing board and the judicial review committee.
- 7.5.6.3. The decision shall be in writing, shall specify the reasons for the action taken, shall include the text of the report which shall be made to the National Practitioner Data Bank and the Medical Board of California, if any, and shall be forwarded to the chief of staff, the medical executive and credential committees, the subject of the hearing, and the

administrator, at least (10) days prior to submission to the Medical Board of California.

7.5.7. RIGHT TO ONE HEARING

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

7.6. EXCEPTIONS TO HEARING RIGHTS

7.6.1. APROPRIATENESS OF EXCLUSIVE CONTRACTS

Privileges can be reduced or terminated as a result of a decision to close or continue closure of a department/service pursuant to an exclusive contract, or to transfer an existing exclusive contract, only following review by the medical staff of the related quality of care issues pursuant to Section 14.8 and a determination of appropriateness of the closure, continued closure or transfer as set forth below. The governing board's decision shall uphold the medical staff's determination unless the governing board makes specific written findings that the medical staff's determination is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.

7.6.1.1. The medical staff shall determine the need to close or continue closure of a department/service pursuant to an exclusive contract to be appropriate where:

7.6.1.1.1. a failure to provide full coverage of a needed service cannot be remedied by less extreme measures, such as mandated call schedules; or

7.6.1.1.2. irreconcilable differences within an existing department/service adversely affecting quality of care have not been resolved by less extreme measures; or

7.6.1.1.3. demonstrable efficiencies would result, producing significant improvement in the ability of the medical staff to dispense quality care, which have not been accomplished through less extreme measures.

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

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

- 7.6.1.2. The medical staff shall determine the transfer of an existing exclusive contract to be appropriate only when:
 - 7.6.1.2.1. continued closure of the department/service pursuant to an existing contract is found appropriate pursuant to (a) above, and
 - 7.6.1.2.2. quality of care is maintained or improved by the transfer.
- 7.6.1.3. The medical staff member(s) whose privileges may be adversely affected by the medical staff's determination of appropriateness of the closure or continued closure of a department/service pursuant to an exclusive contract, or transfer of an exclusive contract, may request a hearing before the judicial review committee. Such a hearing will be governed by the provisions of Article VII, except that
 - 7.6.1.3.1. the hearing shall be limited to the following issues:
 - 7.6.1.3.1.1. whether the medical staff's determination of appropriateness is supported by a preponderance of the evidence;
 - 7.6.1.3.1.2. whether the medical staff followed its requirement for notice and comment on the issue of appropriateness;
 - 7.6.1.3.1.3. in cases of transfer, whether the medical staff's determination of effect on quality of care was appropriate.
 - 7.6.1.3.2. All requests for such a hearing will be consolidated. Should an affected medical staff member request a hearing under this section, the medical staff's recommendation regarding the exclusive contract will be deferred, pending the outcome of the judicial review committee hearing.
- 7.6.1.4. A medical staff member providing professional services under a contract with the hospital shall not have medical staff privileges terminated for reasons pertaining to the quality of care provided by the medical staff member without the same rights of hearing and appeal as are available to all members of the medical staff.
- 7.6.1.5. Except as specified in this Section, the termination of privileges following the decision determined to be appropriate by the medical staff to close a department/service pursuant to an exclusive contract or to transfer an exclusive contract shall not be subject to the procedural rights set forth in Article VII.

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

7.6.1.7. Terms of this Section 7.6.1 will take precedence over any inconsistent terms in a contract between a member of the medical staff and the hospital, including, but not necessarily limited to, any contractual provisions purporting to waive all rights of hearing and appeal provided in these bylaws.

7.6.2. AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

No hearing is required when a member's license or legal credential to practice has been revoked or suspended as set forth in Section 6.3.1.1. In other cases described in Sections 6.3.1 and 6.3.2, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority or certifying authority was unwarranted, but only whether the member may continue practice in the hospital with those limitations imposed.

7.6.3. DEPARTMENT/SERVICE FORMATION OR ELIMINATION

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

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

7.6.3.2. The medical staff member(s) whose privileges may be adversely affected by a medical staff's determination of appropriateness of department/service formation or elimination may request a hearing before the judicial review committee. Such a hearing will be governed by the provisions of Article VII, except that

7.6.3.2.1. the hearing shall be limited to the following issues:

7.6.3.2.1.1. whether the medical staff's determination of appropriateness is supported by the preponderance of the evidence;

7.6.3.2.1.2. whether the medical staff followed its requirements for notice and comment on the issue of appropriateness.

7.6.3.2.2. all requests for such a hearing will be consolidated.

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

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

7.7. EXPUNCTION OF DISCIPLINARY ACTION

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

7.8. NATIONAL PRACTITIONER DATA BANK REPORTING

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

7.9. DISPUTING REPORT LANGUAGE

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

If a hearing was held, the dispute process shall be deemed to have been completed.

8. ARTICLE VIII - ALLIED HEALTH STAFF

8.1. DEFINITIONS

“Allied Health Practitioner (AHP)” means a health care professional, other than a physician, who holds a license or other legal credential, as required by California law, to provide certain professional services.

“Allied Health Staff” means those Allied Health Practitioners who may or may not be employees of the hospital nor, pursuant to the terms of these bylaws, eligible for medical staff membership, but have been granted a service authorization to provide certain clinical services.

“Service authorization” means the permission granted to an Allied Health Staff member to provide specified patient care services within his or her qualifications and scope of practice.

8.2. QUALIFICATIONS

An Allied Health Practitioner is eligible for a service authorization in this hospital if he or she:

- 8.2.1 Holds a license, certificate, or other legal credential in a category of AHPs which the governing board has identified as eligible to apply for service authorizations (see Section 8.3, below); and
- 8.2.2 Documents his or her experience, background, training, current competence, judgment, and ability with sufficient adequacy to demonstrate that any patient treated by the practitioner will receive care of the generally recognized professional level of quality established by the medical staff; and
- 8.2.3 Is determined, on the basis of documented references: to adhere strictly to the lawful ethics of his or her 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; and
- 8.2.4 Agrees to comply with all Medical Staff and Department and Division Bylaws, rules and regulations, policies and procedures and protocols, and applicable regulatory bodies, to the extent applicable to the AHP; and
- 8.2.5 Maintains professional liability insurance with a suitable insurer, with minimum limits as determined by the medical executive committee.

8.3 CATEGORIES OF AHPS ELIGIBLE TO APPLY FOR SERVICE AUTHORIZATIONS

The categories of AHPs, based on occupation or profession, which shall be eligible to apply for Allied Health Staff membership and for service authorization in the hospital and the corresponding service authorization prerogatives, terms, and conditions for each such AHP category shall be designated by the governing board, upon the recommendation of the Interdisciplinary Practice Committee (IDPC) and Medical Executive Committee, and when approved by the governing board, shall be set forth in the medical staff rules and regulations and/or policies. Such actions by the IDPC and Medical Executive Committee and the governing board shall be based upon the recommendations of the relevant departments for the designation of categories of AHPs eligible to apply for service authorization and the delineation of corresponding service authorization prerogatives, terms, and conditions for each such AHP category. The governing board shall review the designation of categories of AHPs eligible to apply for service authorizations at least annually and at other times, within its discretion or upon the recommendation of the medical executive committee.

8.4 PROCEDURE FOR GRANTING SERVICE AUTHORIZATION

8.4.1 AHP SCOPE OF PRACTICE

8.4.1.1 An AHP whose scope of practice allows independent practice must apply and qualify for a service authorization and must designate a physician member of the active medical staff who is responsible for the general medical condition of patients for whom the AHP proposes to render services in the hospital.

8.4.1.2 An AHP whose scope of practice does not allow independent practice must apply and qualify for a service authorization and must provide services under the supervision of an active medical staff member who has applied for, qualified for, and been granted similar privileges in accordance with the Medical Staff Bylaws, rules and regulations, as that of the AHP applicant. An AHP under this section may apply to work under the supervision of one active medical staff member or, within the medical executive committee's discretion, a group of medical staff members so long as each of the medical staff members has been granted privileges to which the applicant belongs. Whenever an AHP will be supervised by more than one active staff member, such supervision must be in strict accordance with rules and regulations developed by the appropriate department/section and approved by the medical executive committee.

8.4.1.3 AHP applications for initial granting and renewal of service authorizations respecting nurses in expanded roles and physician's assistants who are eligible for Allied Health 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 IDP Committee shall perform the function which would otherwise be

performed by the Credentials Committee, unless otherwise specified in the medical staff rules and regulations.

- 8.4.2 Except as is provided under Section 8.7.2.1, an AHP who (a) has received a final adverse decision regarding his or her application for a service authorization or (b) withdrew his or her application for a service authorization following an adverse recommendation by the medical executive committee, or (c) after having been granted a service authorization has received a final adverse decision resulting in termination of the authorization or (d) has relinquished his or her service authorization following the issuance of a Medical Staff or governing board recommendation adverse to his or her service authorization, shall not be eligible to reapply for the service authorization 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 AHP relinquished his or her service authorization.
- 8.4.3 An AHP who does not have licensure or certification in an AHP category identified as eligible for service authorizations pursuant to Section 8.3 may not apply for a service authorization but may submit a written request to the Administrator, asking the governing board to consider designating the appropriate category of AHPs as eligible to apply for service authorizations. Upon receipt of such a request, the governing board 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 governing board shall consider such request and the medical executive committee's recommendation, as well as the recommendation of any affected department or division, either before or at the time of its annual review of the categories of AHPs, in accordance with Section 8.3.
- 8.4.4 Each AHP who is granted a service authorization shall be assigned to the clinical department, division appropriate to his or her occupational or professional training and, unless otherwise specified in the medical staff rules and regulations, shall be subject to terms and conditions that parallel those specified in Article II-membership, as they may logically apply to AHPs and may be appropriately tailored to the particular category of AHPs. Each AHP who practices independently must maintain communication with the relevant physician under Section 8.4.1 in order to enable the physician to assume responsibility, to the extent it is indicated, for the general medical condition of the patient. Each AHP who does not practice independently shall be subject to the supervision of one or more members of the active medical staff.

8.5 PREROGATIVES

The prerogatives which may be extended to a member of a particular category of AHP shall be defined in the medical staff rules and regulations and/or policies. Such prerogatives may include:

- 8.5.1 Provision of specified patient care services subject to a medical staff member's responsibility, to the extent indicated, for the patient's general medical condition

and under the general oversight of the medical staff, and, where the AHP does not practice independently, also under the supervision and direction of a member of the active medical staff. AHP services must be consistent with the service authorization granted to the AHP and within the scope of the AHP's licensure or certification.

8.5.2 AHPs are not entitled to medical staff membership or prerogatives.

8.6 RESPONSIBILITIES

Each AHP shall:

- 8.6.1 Meet those responsibilities required by the medical staff rules and regulations and/or policies and if not so specified, meet those responsibilities specified in Section 2.5 of Article II as are generally applicable to the more limited practice of the AHP.
- 8.6.2 Retain appropriate responsibility within his or her area of professional competence for the care of each patient in the hospital for whom he or she is providing services.
- 8.6.3 Participate, when requested, in patient care audit and other quality review, evaluation, and monitoring activities required of AHPs, in evaluating AHP applicants, in supervising initial AHP appointees of his or her same occupation or profession or of an occupation or profession which is governed by a more limited scope of practice statute, and in discharging such other functions as may be required by the medical staff from time to time.

8.7 TERMINATION, SUSPENSION OR RESTRICTION OF SERVICE AUTHORIZATIONS

8.7.1 GENERAL PROCEDURES

- 8.7.1.1 At any time, the Chief of Staff or Chief of the Department or Division to which the AHP has been assigned may recommend to the medical executive committee that an AHP's service authorization be terminated, suspended or restricted. After investigation (including, if appropriate, consultation with the Interdisciplinary Practice Committee), if the medical executive committee agrees that corrective action is appropriate, the MEC shall recommend specific corrective action to the hospital's Governing Board. A Notification Letter regarding the recommendation shall be sent by certified mail to the subject AHP. The Notification Letter shall inform the AHP of the recommendation and the circumstances giving rise to the recommendation.
- 8.7.1.2 Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an Allied Health Staff member to the hearing rights set forth in Articles VI and VII. However, an AHP shall have the right to challenge any recommendation which would constitute grounds for a hearing

under Section 7.2 of the Bylaws (to the extent that such grounds are applicable by analogy to the Allied Health Staff) by filing a written grievance (i.e., a letter objecting to the recommended action and requesting an interview) with the medical executive committee within fifteen (15) days of receipt of the Notification Letter. Upon receipt of a grievance, the medical executive committee or its designee, shall afford the AHP an opportunity for an interview concerning the grievance. Although such interview shall not constitute a “hearing” as established by Article VII of the Bylaws, and need not be conducted according to the procedural rules applicable to such hearings, the purpose of the interview is to allow both the AHP and the party recommending the action the opportunity to discuss the situation and to produce evidence in support of their respective positions. Minutes of the interview shall be retained.

- 8.7.1.3 Within 7 days following the interview, the medical executive committee, based on the interview and all other aspects of the investigation, shall make a final recommendation to the governing board, which shall be communicated in writing, sent by certified mail, to the subject AHP. The final recommendation shall discuss the circumstances giving rise to the recommendation any pertinent information from the interview. Prior to acting on the matter, the governing board may, in its discretion, offer the affected practitioner the right to appeal to the Board or a subcommittee thereof. The governing board shall adopt the medical executive committee’s recommendation, so long as it is reasonable, appropriate under the circumstances and supported by substantial evidence. The final decision by the governing board shall become effective upon the date of its adoption. The AHP shall be provided promptly with notice of the final action, sent by certified mail.

8.7.2 SUMMARY SUSPENSION

- 8.7.2.1 Notwithstanding Section 8.7.1, an Allied Health Practitioner’s service authorization 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 medical executive committee, or the head of the department or designee to which the Allied Health Practitioner has been assigned (or his/her designee). Unless otherwise stated, the summary 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 governing board, the medical executive committee, and the administrator. The notice shall also inform the practitioner of his or her right to file a grievance. The practitioner’s right to file a grievance and subsequent interview procedures shall be in accordance with Section 8.7.1, except that all reasonable efforts shall be made to ensure that the practitioner is given

an interview and that final action is taken within 7 days or as promptly thereafter as practicable.

8.7.2.2 Within one (1) working day of the summary action, the affected practitioner shall be provided with written notice of the action. The notice shall include the reasons for the action and that such action was necessary because of a reasonable probability that failure to take the action could result in imminent danger to the health of an individual.

8.7.2.3 Within five (5) working days following the action, the Interdisciplinary Practice Committee shall meet to consider the matter and make a recommendation to the medical executive committee as to whether the summary suspension should be vacated or continued pending the outcome of any interview with the affected practitioner. Within eight (8) days following the imposition of the action, the medical executive committee shall meet and consider the matter in light of any recommendation forwarded from the Interdisciplinary Practice Committee or the Committee on Allied Health Practitioners. Within two (2) working days following the medical executive committee's meeting, the medical executive committee shall provide written notice to the affected practitioner regarding its determination on whether the summary action should be vacated or continued pending the outcome of any interview proceeding.

8.7.3 AUTOMATIC SUSPENSION, TERMINATION OR RESTRICTION

8.7.3.1 Notwithstanding subsection 8.7.1, above, an AHP's service authorization shall automatically terminate in the event that:

8.7.3.1.1 The AHP's certification, license, or other legal credential expires or is revoked.

8.7.3.1.2 With respect to an AHP who must practice under physician supervision:

8.7.3.1.2.1 The medical staff membership of the supervising physician is terminated, whether such termination is voluntary or involuntary; or

8.7.3.1.2.2 The supervising physician no longer agrees to act in such capacity for any reason, or the relationship between the AHP and the supervising physician is otherwise terminated, regardless of the reason therefore;

8.7.3.1.2.3 The supervisory rights of the supervising physician are or have been suspended.

- 8.7.3.2 Where the AHP's service authorization is automatically terminated for reasons specified in 8.7.3.1.2.1 or 8.7.3.1.2.2 above, the AHP may apply for reinstatement as soon as the AHP has found another physician active medical staff member who agrees to supervise the AHP. In this case, the medical executive committee may, in its discretion, expedite the reapplication process.
- 8.7.3.3 Notwithstanding Section 8.7.1, above, in the event that the AHP's certification or license is restricted, suspended, or made the subject of an order of probation, the AHP's service authorization shall automatically be subject to the same restrictions, suspension, or conditions of probation.
- 8.7.3.4 Where the AHP's privileges are automatically terminated, suspended, or restricted pursuant to this subsection, the notice and interview procedures under Section 8.7.1 shall not apply and the AHP shall have no right to an interview except, within the discretion of the medical executive committee, regarding any factual dispute over whether or not the circumstances giving rise to the automatic termination, suspension, or restriction actually exist.

8.7.4 APPLICABILITY OF SECTION

The rights afforded by this section shall not apply to any decision regarding whether a category of AHP shall be eligible for a service authorization and the terms or conditions of such decision pursuant to Section 8.3 of this Article.

8.8 REAPPLICATION

Every 2 years, each AHP on the Allied Health Staff must reapply for a renewed service authorization in accordance with Section 8.4. Annual review of each AHP on the Allied Health Staff will be performed by the IDPC.

9. ARTICLE IX – OFFICERS

9.1 OFFICERS OF THE MEDICAL STAFF

9.1.1 IDENTIFICATION

The officers of the medical staff shall be the chief of staff, chief of staff-elect, and immediate past chief of staff.

9.1.2 QUALIFICATIONS

Officers must be members of the active medical staff at the time of their nominations and election, and must remain members in good standing during their

term of office. Failure to maintain such status shall create a vacancy in the office involved. All officers must be licensed as physicians and surgeons, given the nature of their duties in office.

9.1.3 NOMINATIONS

9.1.3.1 The medical staff election year shall be each even numbered medical staff year. A nominating committee shall be appointed by the medical executive committee not later than 120 days prior to the annual staff meeting to be held during the election year or at least 45 days prior to any special election. The nominating committee shall consist of the one member chosen by each of the department chairs from among the active medical staff who are not then members of the medical executive committee. The nominating committee shall nominate one or more nominees for each office. The nominations of the committee shall be reported to the medical executive committee at least 60 days prior to the annual meeting and shall be delivered or mailed to the voting members of the medical staff at least 30 days prior to the election.

9.1.3.2 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 chair of the nominating committee, is endorsed by the signature of at least 10% of other members who are eligible to vote, and bears the candidate's written consent. These nominations shall be delivered to the chair of the nominating committee as soon as reasonably practicable, but at least 20 days prior to the date of election. If any nominations are made in this manner, the voting members of the medical staff shall be advised by notice delivered or mailed at least 10 days prior to the meeting. Nominations from the floor will be recognized if the nominee is present and consents.

9.1.4 ELECTIONS

The chief of staff-elect shall be endorsed at the annual meeting of the medical staff which falls during the election year. Voting shall be by written ballot, and authenticated sealed mail ballots will be counted. Written ballots shall include handwritten signatures on the envelope for comparison with signatures on file, when necessary. A nominee 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 run-off 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 majority vote of the medical executive committee shall decide the election by secret written ballot at its next meeting or a special meeting called for that purpose.

9.1.5 TERM OF ELECTED OFFICE

Each officer shall serve a 2 year term, commencing on the first day of the medical staff year following the election. Each officer shall serve in each office until the

end of that officer's term, or until a successor is elected, unless that officer shall sooner resign or be removed from office. At the end of that officer's term, the chief of staff shall automatically assume the office of immediate past chief of staff and the chief of staff-elect shall automatically assume the office of chief of staff.

9.1.6 RECALL OF OFFICERS

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

9.1.7 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the medical staff. Vacancies, other than that of 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 chief of staff, then the chief of staff-elect shall serve out that remaining term and shall immediately appoint an ad hoc nominating committee to decide promptly upon nominees for the office of chief of staff-elect. Such nominees shall be reported to the medical executive committee and to the medical staff. A special election to fill the position shall occur at the next regular staff meeting. If there is a vacancy in the office of chief of staff-elect, that office need not be filled by election, but the medical executive committee shall appoint an interim officer to fill this office until the next regular election, at which time the election shall also include the office of chief of staff.

9.2 DUTIES OF OFFICERS

9.2.1 CHIEF OF STAFF

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

- 9.2.1.1 enforcing the medical staff bylaws and rules and regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;
- 9.2.1.2 calling, presiding at, and being responsible for the agenda of all meetings of the medical staff;

- 9.2.1.3 serving as chair of the medical executive committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;
- 9.2.1.4 serving as an ex officio member of all other staff committees without vote, unless chief of staff membership in a particular committee is required by these bylaws;
- 9.2.1.5 interacting with the administrator and governing board in all matters of mutual concern within the hospital;
- 9.2.1.6 appointing committee members for all standing committees other than the medical executive committee and all special medical staff, liaison, or multi-disciplinary committees, except where otherwise provided by these bylaws and, except where otherwise indicated, designating the chairs of these committees;
- 9.2.1.7 representing the views and policies of the medical staff to the governing board and to the administrator;
- 9.2.1.8 being a spokesperson for the medical staff in external professional and public relations;
- 9.2.1.9 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;
- 9.2.1.10 serving on liaison committees with the governing board and administration, as well as outside licensing or accreditation agencies.

9.2.2 CHIEF OF STAFF-ELECT

The chief of staff-elect shall assume all duties and authority of the chief of staff in the absence of the chief of staff. The chief of staff-elect shall be a member of the medical executive committee 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. The chief of staff-elect shall chair the Professional ad hoc committee. This is an ad hoc committee of the medical executive committee which meets as needed to address difficulties in interactions between physicians.

9.2.3 IMMEDIATE PAST CHIEF OF STAFF

The immediate past chief of staff shall be a member of the medical executive committee and shall perform such other duties as may be assigned by the chief of staff or delegated by these bylaws, or by the medical executive committee.

9.2.4 TREASURER

The duties of the treasurer shall be performed by the chief of staff-elect. The duties shall include, but not be limited to:

- 9.2.4.1 receiving and safeguarding all funds of the medical staff;
- 9.2.4.2 performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the chief of staff or medical executive committee.

10. ARTICLE X - CLINICAL DEPARTMENTS AND SECTIONS

10.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND SECTIONS

The medical staff shall be organized into clinical departments. Each department shall be organized as a separate component of the medical staff and shall have a chair selected and entrusted with the authority, duties, and responsibilities specified in Section 10.5. A department may be further divided, as appropriate, into sections which shall be directly responsible to the department within which it functions, and which shall have a section chief selected and entrusted with the authority, duties and responsibilities specified in Section 10.6. When appropriate, the medical executive committee may recommend to the medical staff the creation, elimination, modification, or combination of departments or sections.

10.2 CURRENT DEPARTMENTS AND SECTIONS

10.2.1 The current departments and sections are:

- 10.2.1.1 Emergency Medicine
- 10.2.1.2 Medicine
 - 10.2.1.2.1 Cardiology
 - 10.2.1.2.2 Family Practice
- 10.2.1.3 Obstetrics and Gynecology
- 10.2.1.4 Pediatrics
- 10.2.1.5 Radiology
- 10.2.1.6 Surgery
 - 10.2.1.6.1 Anesthesiology
 - 10.2.1.6.2 Cardiovascular Surgery
 - 10.2.1.6.3 General Surgery/ENT/et al.
 - 10.2.1.6.4 Neurosurgery

- 10.2.1.6.5 Ophthalmology
- 10.2.1.6.6 Oral/Maxillofacial/Dentistry
- 10.2.1.6.7 Orthopedics/et al.
- 10.2.1.6.8 Pathology
- 10.2.1.6.9 Urology

10.3. ASSIGNMENT TO DEPARTMENTS AND SECTIONS

Each member shall be assigned membership in at least one department, and to a section, if any, within such department, but may also be granted membership and/or clinical privileges in other departments or sections consistent with practice privileges granted.

10.4. FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

- 10.4.1. Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. This can be done either at the departmental level or through the multidisciplinary peer review committee.
- 10.4.2. Recommending to the medical executive committee guidelines for the granting of clinical privileges and the performance of specified services within the department.
- 10.4.3. Evaluating and making appropriate recommendations regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that department.
- 10.4.4. Conducting, participating and making recommendations regarding continuing education programs pertinent to departmental clinical practice.
- 10.4.5. Reviewing and evaluating departmental adherence to: (1) medical staff policies and procedures and (2) sound principles of clinical practice.
- 10.4.6. Coordinating patient care provided by the department's members with nursing and ancillary patient care services.
- 10.4.7. Submitting written reports to the medical executive committee concerning: (1) the department's review and evaluation activities, actions taken thereon, and the results of such action; and (2) recommendations for maintaining and improving the quality of care provided in the department and the hospital.
- 10.4.8. Meeting at least four times per year for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other department and staff functions.

- 10.4.9. Establishing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols.
- 10.4.10. Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified.
- 10.4.11. Accounting to the medical executive committee for all professional and medical staff administrative activities within the department.
- 10.4.12. Appointing such committees as may be necessary or appropriate to conduct department functions.
- 10.4.13. Formulating recommendations for departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval by the medical executive committee and the medical staff.

10.5. DEPARTMENT CHAIRS

10.5.1. QUALIFICATIONS

Each department shall have a chair and vice-chair who shall be members of the active staff and shall be qualified by licensure, training, experience and demonstrated ability in at least one of the clinical areas covered by the department. Department chairs must be certified by an appropriate specialty board or must demonstrate comparable competence. (Exception may be made with contract groups and noted in their Rules & Regulations)

10.5.2. SELECTION

Department chairs and vice-chairs shall be elected every 2 years by those members of the department who are eligible to vote. For the purpose of this election, each department chair may appoint a nominating committee of 3 members at least 60 days prior to the meeting at which election is to take place. The recommendations of the department and/or nominating committee of one or more nominees for chair and vice-chair positions shall be circulated to the voting members of each department at least 20 days prior to the election. Nominations also may be made from the floor when the election meeting is held, as long as the nominee is present and consents to the nomination; or nominations may also be made by eligible members in written form with signature confirmation by the nominee. A ballot will be sent to all voting members. Vacancies due to any reason shall be filled for the unexpired term through special election by the respective department with such mechanisms as that department may adopt.

10.5.3. TERM OF OFFICE

Each department chair and vice-chair shall serve a 2 year term which coincides with the medical staff year or until their successors are chosen, unless they shall sooner resign, be removed from office, or lose their medical staff membership or

clinical privileges in that department. Department officers shall be eligible to succeed themselves.

10.5.4. REMOVAL

After election and ratification, removal of department chairs and vice-chairs from office may occur for cause by a two-thirds vote of the medical executive committee and a two-thirds vote of the department members eligible to vote on departmental matters who cast votes.

10.5.5. DUTIES

Each chair shall have the following authority, duties and responsibilities, and the vice-chair, in the absence of the chair, shall assume all of them and shall otherwise perform such duties as may be assigned:

- 10.5.5.1. act as presiding officer at departmental meetings;
- 10.5.5.2. report to the medical executive committee and to the chief of staff regarding all professional and administrative activities within the department;
- 10.5.5.3. generally monitor the quality of patient care and professional performance rendered by members with clinical privileges in the department through a planned and systematic process; oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the department by the medical executive committee in coordination and integration with organization-wide quality assessment and improvement activities;
- 10.5.5.4. review and advise departmental programs for retrospective patient care review, ongoing monitoring of practice, credentials review and privilege delineation, medical education, utilization review, and quality assessment and improvement;
- 10.5.5.5. be a member of the medical executive committee, and give guidance on the overall medical policies of the medical staff and hospital and make specific recommendations and suggestions regarding the department;
- 10.5.5.6. transmit to the medical executive committee the department's recommendations concerning practitioner appointment and classification, reappointment, criteria for clinical privileges, monitoring of specified services, and corrective action with respect to persons with clinical privileges in the department;
- 10.5.5.7. endeavor to enforce the medical staff bylaws, rules, policies and regulations within the department;

- 10.5.5.8. implement within the department appropriate actions taken by the medical executive committee;
- 10.5.5.9. participate in every phase of administration of the department, including cooperation with the nursing service and the hospital administration in matters such as personnel (including assisting in determining the qualifications and competence of department/service personnel who are not licensed independent practitioners and who provide patient care services), supplies, special regulations, standing orders and techniques;
- 10.5.5.10. assist in the preparation of such annual reports, including budgetary planning, pertaining to the department as may be required by the medical executive committee;
- 10.5.5.11. recommend delineated clinical privileges for each member of the department; and
- 10.5.5.12. 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.
- 10.5.5.13. the chair of the department shall serve on the credentials committee.

10.6. FUNCTIONS OF SECTIONS

Subject to approval of the medical executive committee, each section shall perform the functions assigned to it by the department chair. Such functions may include, without limitation, retrospective patient care reviews, evaluation of patient care practices, credentials review and privileges delineation, and continuing education programs. The section shall transmit regular reports to the department chair on the conduct of its assigned functions.

10.7. SECTION CHIEFS

10.7.1. QUALIFICATIONS

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

10.7.2. SELECTION

Each section chief shall be selected or elected by such mechanism as the medical staff may adopt. This mechanism may be determined by the Department or Section with approval by the MEC. In the event there is no criteria, the Section Chief will be appointed by the Department Chair with approval of MEC. This mechanism may be determined by the Department or Section with approval by the MEC.

10.7.3. TERM OF OFFICE

Each section chief shall serve a two-year term which coincides with the medical staff year or until a successor is chosen, unless the section chief shall sooner resign or be removed from office or lose medical staff membership or clinical privileges in that section. Section chiefs shall be eligible to succeed themselves.

10.7.4. REMOVAL

After appointment and ratification, a section chief may be removed by the department chair and the medical executive committee.

10.7.5. DUTIES

Each section chief shall:

10.7.5.1. act as presiding officer at section meetings;

10.7.5.2. evaluate the clinical work performed in the section;

10.7.5.3. conduct investigations and submit reports and recommendations to the department chair regarding the clinical privileges to be exercised within the section by members of or applicants to the medical staff; and

10.7.5.4. perform such other duties commensurate with the office as may from time to time be reasonably requested by the department chair, the chief of staff, or the medical executive committee.

11. ARTICLE XI – COMMITTEES

11.1. DESIGNATION

Medical staff committees shall include but not be limited to, the medical staff meeting as a committee of the whole, meetings of departments and divisions, meetings of committees established under this Article, and meetings of special or ad hoc committees created by the medical executive committee (pursuant to this Article) or by departments (pursuant to Sections 10.4.10 and 10.4.12). The committees described in this Article shall be the standing committees of the medical staff. Special or ad hoc committees may be created by the medical executive committee to perform specified tasks. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the chief of staff, subject to consultation with and approval by the medical executive committee. Medical staff committees shall be responsible to the medical executive committee.

11.2. GENERAL PROVISIONS

11.2.1. TERMS OF COMMITTEE MEMBERS

Unless otherwise specified, committee members shall be appointed for a term of 2 years, and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee.

11.2.2. REMOVAL

If a member of a committee ceases to be a member in good standing of the medical staff, or loses employment or a contract relationship with the hospital, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the medical executive committee.

11.2.3. VACANCIES

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

11.3. MEDICAL EXECUTIVE COMMITTEE

11.3.1. COMPOSITION

The medical executive committee shall consist of the following persons:

- 11.3.1.1. the officers of the medical staff;
- 11.3.1.2. the department chairs;
- 11.3.1.3. the Interdisciplinary Peer Review chairperson;
- 11.3.1.4. the Medical Care Policy chairperson
- 11.3.1.5. the Quality Council chairperson

11.3.2. DUTIES

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

- 11.3.2.1. representing and acting on behalf of the medical staff in the intervals between medical staff meetings, subject to such limitations as may be imposed by these bylaws;
- 11.3.2.2. coordinating and implementing the professional and organizational activities and policies of the medical staff;

- 11.3.2.3. receiving and acting upon reports and recommendations from medical staff departments, divisions, committees, and assigned activity groups;
- 11.3.2.4. recommending actions to the governing board on matters of a medical-administrative nature;
- 11.3.2.5. adopting policies regarding the structure of the medical staff, the mechanisms to review credentials and delineate individual clinical privileges, the granting of individual staff memberships and privileges, the organization of quality assessment and improvement activities and mechanisms of the medical staff, termination of medical staff membership and fair hearing procedures, needed changes to medical staff bylaws, and other matters relevant to the operation of an organized medical staff;
- 11.3.2.6. evaluating the medical care rendered to patients in the hospital;
- 11.3.2.7. participating in the development of all medical staff and hospital policy, practice, and planning;
- 11.3.2.8. reviewing the qualifications, credentials, performance and professional competence, and character of applicants and staff members, and making recommendations to the governing board at least quarterly regarding staff appointments and reappointments, assignments to departments, clinical privileges, and corrective action;
- 11.3.2.9. 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;
- 11.3.2.10. taking reasonable steps to develop continuing education activities and programs for the medical staff;
- 11.3.2.11. 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;
- 11.3.2.12. reporting to the medical staff at each regular staff meeting;
- 11.3.2.13. assisting in the obtaining and maintenance of accreditation;
- 11.3.2.14. developing and maintenance of methods for the protection and care of patients and others in the event of internal or external disaster;
- 11.3.2.15. appointing such special or ad hoc committees as may seem necessary or appropriate to assist the medical executive committee in carrying out its functions and those of the medical staff;

- 11.3.2.16. reviewing the quality and appropriateness of services provided by contract physicians;
- 11.3.2.17. reviewing and approving the designation of the hospital's authorized representative for National Practitioner Data Bank purposes; and
- 11.3.2.18. establishing a mechanism for dispute resolution between medical staff members (including limited license practitioners) involving the care of a patient.

11.3.3. MEETINGS

The medical executive committee shall meet as often as necessary, but at least once a month, except in August, and shall maintain a record of its proceedings and actions. The administrator or designee shall be invited to attend all meetings in a non-voting capacity.

11.4. CREDENTIALS COMMITTEE

11.4.1. COMPOSITION

The credentials committee shall consist of representation of major clinical specialties and each of the staff departments. The credentials committee shall be chaired by the chief of staff-elect. The chair of each clinical department should be a member of the credentials committee.

11.4.2. DUTIES

The credentials committee shall:

- 11.4.2.1. review and evaluate the qualifications of each practitioner applying for initial appointment, reappointment, or modification of clinical privileges, and, in connection therewith, obtain and consider the recommendations of the appropriate departments;
- 11.4.2.2. submit required reports and information on the qualifications of each practitioner applying for membership or particular clinical privileges including recommendations with respect to appointment, membership category, department affiliation, clinical privileges, and special conditions;
- 11.4.2.3. investigate, review and report on matters referred by the chief of staff or the medical executive committee regarding the qualifications, conduct, professional character or competence of any applicant or medical staff member; and
- 11.4.2.4. submit periodic reports to the medical executive committee on its activities and the status of pending applications.

- 11.4.2.5. Periodically review Departmental privilege forms and requirements for credentialing.

11.4.3. MEETINGS

The credentials committee shall meet as often as necessary at the call of its chair. The committee shall maintain a record of its proceedings and actions and shall report to the medical executive committee.

11.5. PHARMACY AND THERAPEUTICS COMMITTEE

11.5.1. COMPOSITION

The pharmacy and therapeutics committee shall consist of at least 3 representatives from the medical staff, a representative from the pharmaceutical service, as well as from the nursing service and hospital administration.

11.5.2. DUTIES

- 11.5.2.1. The duties of the pharmacy and therapeutics committee shall include:
- 11.5.2.2. assisting in the formulation of professional practices and policies regarding the continuing evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the hospital, including antibiotic usage;
- 11.5.2.3. advising the medical staff and the pharmaceutical service on matters pertaining to the choice of available drugs;
- 11.5.2.4. making recommendations concerning drugs to be stocked on the nursing unit floors and by other services;
- 11.5.2.5. periodically developing and reviewing a formulary or drug list for use in the hospital;
- 11.5.2.6. evaluating clinical data concerning new drugs or preparations requested for use in the hospital;
- 11.5.2.7. establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;
- 11.5.2.8. maintaining a record of all activities relating to pharmacy and therapeutics functions and submitting periodic reports and recommendations to the medical executive committee concerning those activities;
- 11.5.2.9. developing proposed policies and procedures for, and continuously evaluating the appropriateness of blood and blood products usage, including the screening, distribution, handling and administration, and monitoring of blood and blood components' effects on patients; and

11.5.2.10. reviewing untoward drug reactions.

11.5.3. MEETINGS

The committee shall meet as often as necessary at the call of its chair but at least four times per year. It shall maintain a record of its proceedings and shall report its activities and recommendations to the medical executive committee as needed.

11.6. BYLAWS COMMITTEE

11.6.1. COMPOSITION

The bylaws committee shall consist of at least 3 members of the medical staff. The immediate past chief of staff will chair this committee.

11.6.2. DUTIES

The duties of the bylaws committee shall include:

- 11.6.2.1. conducting an annual review of the medical staff bylaws, as well as the rules and regulations and forms promulgated by the medical staff, its departments and divisions;
- 11.6.2.2. submitting recommendations to the medical executive committee for changes in these documents as necessary to reflect current medical staff practices; and
- 11.6.2.3. receiving and evaluating for recommendation to the medical executive committee suggestions for modification of the items specified as above.

11.6.3. MEETINGS

The bylaws committee shall meet as often as necessary at the call of its chair but at least annually. It shall maintain a record of its proceedings and shall report its activities and recommendations to the medical executive committee.

11.7. QUALITY COUNCIL

11.7.1. COMPOSITION

The quality council shall consist of such members as may be designated by the medical executive committee including, insofar as possible, at least one representative from each clinical department, from the nursing service and from administration. If there is a Chief Medical Officer, then that person shall sit as the chair of quality council. The Chief Medical Officer is a member of the Hospital administration and because of this conflict is not a voting member of the Quality Council. He may, however, vote in the event of a tie.

11.7.2. DUTIES

The quality council shall perform the following duties:

- 11.7.2.1. recommend for approval of the medical executive committee plans for maintaining quality patient care within the hospital. These may include mechanisms to:
 - 11.7.2.1.1. establish systems to identify potential problems in patient care;
 - 11.7.2.1.2. set priorities for action on problem correction;
 - 11.7.2.1.3. refer priority problems for assessment and corrective action to appropriate departments or committees;
 - 11.7.2.1.4. monitor the results of quality assessment and improvement activities throughout the hospital; and
 - 11.7.2.1.5. coordinate quality council activities.
 - 11.7.2.1.6. submit regular confidential reports to the medical executive committee on the quality of medical care provided and on quality assessment and improvement activities conducted.

11.7.3. MEETINGS

The committee shall meet as often as necessary at the call of its chair, but at least ten times per year. It shall maintain a record of its proceedings and report its activities and recommendations to the medical executive committee and governing board on a regular basis.

11.8. HEALTH AND WELL-BEING COMMITTEE

11.8.1. COMPOSITION

The health and well-being committee shall be comprised of no less than 2 active members of the medical staff, a majority of which, including the chair, shall be physicians. Except for initial appointments, each member shall serve a term of 2 years, and may serve consecutive terms. Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assessment and improvement committees while serving on this committee.

11.8.2. DUTIES

The health and well-being committee may receive reports related to the health, well-being, or impairment of medical staff members and, as it deems appropriate, may investigate such reports. With respect to matters involving individual medical staff members, the committee may, on a voluntary basis, provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be

confidential; however, in the event information received by the committee clearly demonstrates that the health or known impairment of a medical staff member poses an unreasonable risk of harm to hospitalized patients, that information may be referred for corrective action. The committee shall also consider general matters related to the health and well-being of the medical staff and, with the approval of the executive committee, develop educational programs or related activities.

11.8.3. MEETINGS

The committee shall meet as often as necessary. It shall maintain only such record of its proceedings as it deems advisable, but shall report on its activities to the medical executive committee four times per year.

11.9. INTERDISCIPLINARY PRACTICE COMMITTEE

11.9.1. COMPOSITION

The interdisciplinary practice committee (IDPC) shall consist of the chief nursing officer, and an equal number of physicians appointed by the chief of staff and registered nurses appointed by the chief nursing officer as feasible. Licensed or certified health professionals other than registered nurses who perform functions requiring standardized procedures shall be included in the committee. The chair of the committee shall be a physician member of the active medical staff appointed by the chief of staff.

11.9.2. DUTIES

The IDPC shall perform functions consistent with the requirements of law and regulation. The IDPC shall routinely report to the governing board through the medical executive committee and, in addition, shall submit a report directly to the governing board and the medical executive committee.

11.9.2.1. evaluating and making recommendations regarding the need for and appropriateness of the performance of in-hospital services by allied health practitioners (AHPs).

11.9.2.2. evaluating and making recommendations regarding:

11.9.2.2.1. the mechanism for evaluating the qualifications and credentials of AHPs who are eligible to apply for and provide in-hospital services;

11.9.2.2.2. the minimum standards of training, education, character, competence, and overall fitness of AHPs eligible to apply for the opportunity to perform in-hospital services;

- 11.9.2.2.3. identification of in-hospital services which may be performed by an AHP, or category of AHPs, as well as any applicable terms and conditions thereon; and
- 11.9.2.2.4. the professional responsibilities of AHPs who have been determined eligible to perform in-hospital services.
- 11.9.2.3. making recommendations regarding appropriate monitoring, supervision, and evaluation of AHPs who may be eligible to perform in-hospital services.
- 11.9.2.4. evaluating and reporting whether in-hospital services proposed to be performed or actually performed by AHPs are inconsistent with the rendering of quality medical care and with the responsibilities of members of the medical staff.
- 11.9.2.5. evaluating and reporting on the effectiveness of supervision requirements imposed upon AHPs who are rendering in-hospital services.
- 11.9.2.6. periodically evaluating and reporting on the efficiency and effectiveness of in-hospital services performed by AHPs.
- 11.9.2.7. coordinating insofar as necessary with the committee on interdisciplinary practice.

11.9.3. MEETINGS

The IDPC shall meet at the call of the chair at such intervals as the chair or the medical executive committee may deem appropriate, but at least four times per year.

11.10. CONTINUING MEDICAL EDUCATION COMMITTEE

11.10.1. COMPOSITION

The continuing medical education committee shall be composed of physician members and other health professionals of the medical staff whose number should be appropriate to the size of the hospital and amount of program activities produced annually. The composition shall be a chairperson, who shall serve for at least two years.

11.10.2. DUTIES

The continuing medical education committee shall perform the following duties:

- 11.10.2.1. plan, implement, coordinate and promote ongoing clinical programs for the medical staff. This includes:

- 11.10.2.1.1. identifying the educational needs of the medical staff;
- 11.10.2.1.2. formulating clear statements of objectives for each program;
- 11.10.2.1.3. assessing the effectiveness of each program;
- 11.10.2.1.4. choosing appropriate teaching methods and knowledgeable faculty for each program; and
- 11.10.2.1.5. documenting staff attendance at each program.
- 11.10.2.1.6. assist in developing processes to assure optimal patient care and contribute to the continuing education of each practitioner.
- 11.10.2.2. establish liaison with the quality assessment and improvement program of the hospital in order to be apprised of problem areas in patient care, which may be addressed by a specific continuing medical education activity.
- 11.10.2.3. maintain close liaison with other hospital medical staff and department committees concerned with patient care.
- 11.10.2.4. make recommendations to the medical executive committee regarding library needs of the medical staff.
- 11.10.2.5. advise administration of the financial needs of the continuing medical education program.

11.10.3. MEETINGS

The continuing medical education committee shall meet as often as necessary, but at least four times per year. It shall maintain minutes of the program planning discussions and report to the medical executive committee.

11.11. PEER REVIEW COMMITTEE

11.11.1. COMPOSITION

The Interdisciplinary Peer Review Committee shall consist of medical staff members from the various medical staff clinical departments. The Chair shall be selected by the Chief of Staff with MEC approval and shall be appointed for a period of two years. Representatives from Quality Management, Administration and other areas shall be selected as needed. Only physician members of the Committee may vote.

11.11.2. DUTIES

The Interdisciplinary Peer Review Committee is responsible to conduct ongoing review and evaluation of activities that contribute to the preservation and improvement of the quality, performance, effectiveness and efficiency of the patient care provided at Desert Regional Medical Center. Peer review will include review-trended data indicative of the type and quality of patient care provided, cases identified through quality indicators, and significant, potential, or actual adverse patient occurrences. A peer or peers of the physician responsible for the patient's care will participate in the review. Depending upon the severity and circumstances, these reviews may be accomplished per applicable Medical Staff Peer Review Policies.

11.11.3. MEETINGS

The Interdisciplinary Peer Review Committee shall meet ten times per year or as needed; they shall maintain permanent records of findings, proceedings and actions and report to the Medical Executive Committee.

11.12. ADMINISTRATIVE AFFAIRS COMMITTEE

11.12.1. COMPOSITION

The Chair shall be the Immediate Past Chief of Staff and shall be appointed for a period of two years. Additional members to the Committee shall be appointed jointly by the Chair and by the Chief of Staff. Only physician members of the Committee shall vote.

11.12.2. DUTIES

11.12.2.1. To resolve conflict that cannot be resolved through normal channels.

11.12.2.2. Serve as an investigative arm to the Medical Executive Committee.

11.12.2.3. To review situations that may arise involving physicians on staff or situations between physicians and administration.

11.12.2.4. Recommend to the Medical Executive Committee actions to be taken and to monitor the effectiveness of the actions.

11.12.2.5. The committee shall not undertake investigations pursuant to Article 9.1 unless specifically assigned such responsibility pursuant to Article 9.1.3.1, and the Committee's activities shall not otherwise be subject to Article 9.1.

11.12.3. MEETINGS

The Administrative Affairs Committee shall meet as often as necessary to conduct the business of the Committee.

11.13. MEDICAL CARE POLICY COMMITTEE

11.13.1. COMPOSITION

The Chair shall be selected by the Chief of Staff with MEC approval and shall be appointed for a period of two years. The additional members shall be appointed jointly by the Chair and the Chief of Staff. Representatives from Quality Management, Nursing, Administration and other areas may be selected as needed. All members of the Committee may vote.

11.13.2. DUTIES

11.13.2.1. The multidisciplinary committee will review and make recommendations to the Medical Executive Committee on all policies and procedures related to physician patient care matters.

11.13.2.2. The Committee will serve as resource/research body for the Medical Executive Committee on policy related matters.

11.13.2.3. The Committee may also suggest or recommend that a specific policy or rule be developed in the interest of quality patient care.

11.13.3. MEETINGS

The Medical Care Policy Committee shall meet as needed.

11.14 UTILIZATION REVIEW COMMITTEE

11.14.1 COMPOSITION

The chair and the co-chair shall be selected by the Chief of Staff with MEC approval and shall be appointed for a period of two (2) years. They shall be either a member of the active or administrative medical staff. The membership shall consist of at least two (2) physicians. Non-physician members may include care and resource managers, quality improvement representatives, as well as members from administration, finance, admitting, medical records, nursing, skilled nursing, in-patient acute rehab, hospital compliance officer and ancillary service providers.

11.14.2 DUTIES

- 11.14.2.1 The Utilization Review Committee will develop and/or approve criteria for the provision of the timely review of the medical necessity for admission, continued stay, and services rendered.
- 11.14.2.2 The Utilization Review Committee will monitor the summary of review activities performed by committee designees.
- 11.14.2.3 The Utilization Review Committee will report trends identified that will result in improved quality of care and efficient utilization of hospital services.
- 11.14.2.4 The Utilization Review Committee will not include any individual who is directly responsible for the care of the patient whose care is being reviewed, or who has a financial interest in the hospital.

11.14.3 MEETINGS

The Utilization Review Committee will meet bimonthly and more frequently if deemed necessary. Committee minutes shall be recorded and sent to the Medical Executive Committee and the Governing Board.

12. ARTICLE XII – MEETINGS

12.1 GENERAL MEDICAL STAFF MEETINGS

12.1.1 REGULAR MEETINGS

Regular meetings of the members shall be held twice a year, on the second Tuesday of the month, unless at a different time designated with proper notice. Notice of this meeting shall be given to the members at least 14 days prior to the meeting.

12.1.2 AGENDA

The order of business at a meeting of the medical staff shall be determined by the chief of staff and medical executive committee. The agenda shall include, insofar as feasible:

- 12.1.2.1 reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;
- 12.1.2.2 administrative reports from the chief of staff, departments, and committees, and the administrator;

12.1.2.3 election of officers when required by these bylaws;

12.1.2.4 reports by responsible officers, committees and departments on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the staff and on the fulfillment of other required staff functions;

12.1.2.5 old business; and

12.1.2.6 new business.

12.1.3 SPECIAL MEETINGS

medical executive committee, or shall be called upon the written request of 10% of the members of the active medical staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the medical executive committee within 30 days after receipt of such request. No later than 10 days prior to the meeting, notice shall be sent to the members of the staff which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

12.2 COMMITTEE AND DEPARTMENT MEETINGS

12.2.1 REGULAR MEETINGS

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

12.2.2 SPECIAL MEETINGS

A special meeting of any medical staff committee, department or section may be called by the chair thereof, the medical executive committee, or the chief of staff.

12.3 QUORUM

12.3.1 GENERAL STAFF MEETINGS

The presence of one-third of the total members of the active medical staff at any regular or special meeting in person shall constitute a quorum for the purpose of amending these bylaws or the rules and regulations of the medical staff or for the election or removal of medical staff officers. If a quorum is not present, written ballots shall be sent.

12.3.2 DEPARTMENT AND COMMITTEE MEETINGS

A quorum of chair plus fifty percent of the voting members shall be required for medical executive committee meetings. For other committees, department and section meetings, a quorum shall consist of chair plus one of the voting members.

12.4 VOTING AND MANNER OF ACTION

12.4.1 VOTING

Unless otherwise specified in these bylaws, only members of the active medical staff may vote in medical staff departmental or staff elections, and at department and medical staff meetings and all duly appointed members of medical staff committees are entitled to vote on committee matters, except as may otherwise be specified in these bylaws.

12.4.2 MANNER OF ACTION

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

12.5 MINUTES

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

12.6 ATTENDANCE REQUIREMENTS

12.6.1 SPECIAL ATTENDANCE

At the discretion of the chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular department, division, or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least 7 days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at any meeting to which notice was given, unless excused by the medical executive committee upon a showing of good cause, shall be a basis for corrective action.

12.7 CONDUCT OF MEETINGS

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

12.8 EXECUTIVE SESSION

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

13. ARTICLE XIII - CONFIDENTIALITY, IMMUNITY AND RELEASES

13.1 AUTHORIZATION AND CONDITIONS

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

- 13.1.1 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's professional ability and qualifications;
- 13.1.2 authorizes persons and organizations to provide information concerning such practitioner to the medical staff;
- 13.1.3 agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the medical staff or the hospital who would be immune from liability under Section 13.3 of this Article; and
- 13.1.4 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.

13.2 CONFIDENTIALITY OF INFORMATION

13.2.1 GENERAL

Records and proceedings of all medical staff committees having the responsibility of evaluation and improvement of quality of care rendered in this hospital, including, but not limited to, meetings of the medical staff meeting as a committee of the whole, meetings of departments and divisions, meetings of committees established under Article XI, and meetings of special or ad hoc

committees created by the medical executive committee or by departments and including information regarding any member or applicant to this medical staff shall, to the fullest extent permitted by law, be confidential.

13.2.2 BREACH OF CONFIDENTIALITY

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

13.3 IMMUNITY FROM LIABILITY

13.3.1 FOR ACTION TAKEN

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

13.3.2 FOR PROVIDING INFORMATION

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

13.4 ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity provided by this Article shall apply to all acts, communications, minutes, 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:

13.4.1 application for appointment, reappointment, or clinical privileges;

13.4.2 corrective action;

13.4.3 hearings and appellate reviews;

13.4.4 utilization reviews;

13.4.5 other department, or section, committee, or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

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

13.5 RELEASES

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

13.6 INDEMNIFICATION

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

14. ARTICLE XIV - GENERAL PROVISIONS

14.1 ADOPTION AND AMENDMENT OF REVISIONS TO THE RULES AND REGULATIONS

Consideration shall be given to the adoption, amendment, or repeal of the Medical Staff Rules and Regulations, upon the request of:

- (1) The medical executive committee, at the suggestion of the chief of staff or the bylaws committee and after approval by the medical executive committee. Petitions for changes to the Rules and Regulations may be submitted to the Medical Executive Committee from any member or groups of members of the medical staff. They may be submitted for presentation to the Medical Executive

Committee through the Bylaws Chair or the respective Department Chair. An Allied Health Practitioner or the Chair of the InterDisciplinary Committee may also submit a request in a similar manner.

or

- (2) Upon timely written petition signed by at least 10% of the members of the medical staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these rules and regulations.

Decisions about such changes shall be made at a regular or special meeting of the medical staff, or by special ballot delivered via mail, email or fax to all voting members of the medical staff. A document indicating the changes must be available for all members at these meetings. Notice must be sent to all members that a change is to be voted upon at special meetings in advance by at least fourteen (14) days. Rules and Regulations changes are part of the standard agenda at all semiannual meetings of the Medical Staff. All ballots will be submitted by mail initially at the last known address in their Medical Staff files but may be sent in an alternative manner at the request of the individual voting member. All ballots must be accompanied by a document indicating the changes. These documents shall include the exact working of the existing Rules and Regulations language, if any, and the proposed changes(s).

If a quorum fifty percent (50%) of the voting members of the Medical Staff is present at a semiannual or special meeting for the purpose of enacting a rules and regulation change, then the change shall require an affirmative vote of greater than fifty percent (50%) of the members voting in person. At the request of the quorum or if there is an insufficient number of voting members of the Medical Staff for a quorum present at the meeting then the vote may be by written ballot. Ballots require a simple majority of respondents as long as the ballots are sent to all voting members.

If a quorum fifty percent (50%) of the voting members of the Medical Staff is present at a semiannual or special meeting for the purpose of enacting a rules and regulation change, then the change shall require an affirmative vote of greater than fifty percent (50%) of the members voting in person. At the request of the quorum or if there is an insufficient number of voting members of the Medical Staff for a quorum present at the meeting then the vote may be by written ballot. Ballots require a simple majority of respondents as long as the ballots are sent out to all voting members.

Rules and regulations changes adopted by the medical staff shall become effective following approval by the governing board, which approval shall not be withheld unreasonably or automatically within 60 days if no action is taken by the governing board. If approval is withheld, the reasons for doing so shall be specified by the governing board in writing, and shall be forwarded to the chief of staff, the medical executive and bylaws committee. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the medical staff rules and regulations. If there is a conflict between the bylaws

and the rules and regulations, the bylaws shall prevail. After the changes have been approved the Medical Staff Rules and Regulations will be amended to reflect these changes and after the document has been reviewed by the Bylaws Chair for errors it will be published on the Medical Staff web site - <http://drmcmedstaff.org>. The date of the document and the effective date of the changes will be the date of approval by the Governing Board.

14.2 DUES OR ASSESSMENTS

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

14.3 AUTHORITY TO ACT

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

14.4 DIVISION OF FEES

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

14.5 NOTICES

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

Chief of Staff
c/o Medical Staff Services
Desert Regional Medical Center
1150 N. Indian Canyon Drive
Palm Springs, California 92262

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

14.6 DISCLOSURE OF INTEREST

All nominees for election or appointment to medical staff offices, department chairships, or the medical executive committee shall, at least 20 days prior to the date of election or appointment, disclose in writing to the medical executive committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware

which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff.

14.7 MEDICAL STAFF CREDENTIALS FILES

14.7.1 INSERTION OF ADVERSE INFORMATION

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

- 14.7.1.1 Any person may provide information to the medical staff about the conduct, performance or competence of its members.
- 14.7.1.2 When a request is made for insertion of adverse information into the medical staff member's credentials file, the respective department chair and chief of staff shall review such a request.
- 14.7.1.3 After such a review a decision will be made by the respective department chair and chief of staff to:
 - 14.7.1.3.1 not insert the information;
 - 14.7.1.3.2 notify the member of the adverse information by a written summary and offer the opportunity to rebut this assertion before it is entered into the member's file; or
 - 14.7.1.3.3 insert the information along with a notation that a request has been made to the medical executive committee for an investigation as outlined in Section 6.1.2 of these bylaws.
- 14.7.1.4 This decision shall be reported to the medical executive committee. The medical executive committee, when so informed, may either ratify or initiate contrary actions to this decision by a majority vote.

14.7.2 REVIEW OF ADVERSE INFORMATION AT THE TIME OF REAPPRAISAL AND REAPPOINTMENT

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

- 14.7.2.1 Prior to recommendation on reappointment, the credentials committee, as part of its reappraisal function, shall review any adverse information in the credentials file pertaining to a member.
- 14.7.2.2 Following this review, the credentials committee shall determine whether documentation in the file warrants further action.
- 14.7.2.3 With respect to such adverse information, if it does not appear that an investigation and/or adverse action on reappointment is warranted, the

credentials committee shall so inform the medical executive committee.

14.7.2.4 However, if an investigation and/or adverse action on reappointment is warranted, the credentials committee shall so inform the medical executive committee.

14.7.2.5 No later than 60 days following final action on reappointment, the medical executive committee shall, except as otherwise provided:

14.7.2.5.1 initiate a request for corrective action, based on such adverse information and on the credentials committee's recommendation relating thereto, or

14.7.2.5.2 cause the substance of such adverse information to be summarized and disclosed to the member.

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

14.7.2.7 In the event that adverse information is not utilized as the basis for a request for corrective action, or disclosed to the member as provided herein, it shall be removed from the file and discarded, unless the medical executive committee, by a majority vote, determines that such information is required for continuing evaluation of the member's:

14.7.2.7.1 character;

14.7.2.7.2 competence; or

14.7.2.7.3 professional performance.

14.7.3 CONFIDENTIALITY

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

14.7.3.1 The records of the medical staff and its departments and committees responsible for the evaluation and improvement of the quality of patient care rendered in the hospital shall be maintained as confidential.

14.7.3.2 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 requirement that confidentiality be maintained.

- 14.7.3.3 Information which is disclosed to the governing body of the hospital or its appointed representatives—in order that the governing body may discharge its lawful obligations and responsibilities—shall be maintained by that body as confidential.
- 14.7.3.4 Information contained in the credentials file of any member may be disclosed with the member’s consent, or to any medical staff or professional licensing board, or as required by law. However, any disclosure outside of the medical staff shall require the authorization of the chief of staff and the concerned department chair and notice to the member.
- 14.7.3.5 A medical staff member shall be granted access to the individual’s credentials file, subject to the following provisions:
 - 14.7.3.5.1 timely notice of such shall be made by the member to the chief of staff or the chief of staff’s designee;
 - 14.7.3.5.2 the member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information—including peer review committee findings, letters of reference, proctoring reports, complaints, etc.—shall be provided to the member, in writing, by the designated officer of the medical staff, (at the time the member reviews the credentials file)/(within a reasonable period of time, as determined by the medical staff). Such summary shall disclose the substance, but not the source, of the information summarized;
 - 14.7.3.5.3 the review by the member shall take place in the medical staff office, during normal work hours, with an officer or designee of the medical staff present.
- 14.7.3.6 In the event a notice of action or proposed action is filed against a member, access to that member’s credentials file shall be governed by Section 7.4.1.

14.7.4 MEMBER’S OPPORTUNITY TO REQUEST CORRECTION/DELETION OF AND TO MAKE ADDITION TO INFORMATION IN FILE

- 14.7.4.1 After review of the file as provided under Section 14.7.3.5 the member may address to the Chief of Staff a written request for correction or deletion of information in the credentials file. Such request shall include a statement of the basis for the action requested.
- 14.7.4.2 The Chief of Staff shall review such a request within a reasonable time and shall recommend to the medical executive committee, after such review, whether or not to make the correction or deletion requested.

The medical executive committee, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote.

14.7.4.3 The member shall be notified promptly, in writing, of the decision of the medical executive committee.

14.7.4.4 In any case, a member shall have the right to add to the individual's credentials file, upon written request to the medical executive committee, a statement responding to any information contained in the file.

14.8 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

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

14.8.1 the decision to execute an exclusive contract in a previously open department or service;

14.8.2 the decision to renew or modify an exclusive contract in a particular department or service;

14.8.3 the decision to terminate an exclusive contract in a particular department or service.

14.9 RETALIATION PROHIBITED

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

15. ARTICLE XV - ADOPTION AND AMENDMENT OF BYLAWS

15.1 PROCEDURE

Upon the request of:

- (1) The medical executive committee, at the suggestion of the chief of staff or the bylaws committee and after approval by the medical executive committee. Petitions for changes to the Bylaws may be submitted to the Medical Executive Committee from any member or groups of members of the medical staff. They

may be submitted for presentation to the Medical Executive Committee through the Bylaws Chair or the respective Department Chair. An Allied Health Practitioner or the Chair of the Inter Disciplinary Committee may also submit a request in a similar manner.

or

- (2) Upon timely written petition signed by at least ten percent (10%) of the members of the medical staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these bylaws.

Decisions about such changes shall be made at a regular or special meeting of the medical staff, or by special ballot delivered via mail, email or fax to all voting members of the medical staff. A document indicating the changes must be available for all members at these meetings. Notice must be sent to all members that a change is to be voted upon at special meetings in advance by at least 14 days. Bylaws changes are part of the standard agenda at all semiannual meetings of the Medical Staff. All ballots will be submitted by mail initially at the last known address in their Medical Staff files but may be sent in an alternative manner at the request of the individual voting member. All ballots must be accompanied by a document indicating the changes. These documents shall include the exact wording of the existing bylaw language, if any, and the proposed change(s).

15.2 ACTION ON BYLAW CHANGE

If a quorum (50%) of the voting members of the Medical Staff is present at a semiannual or special meeting for the purpose of enacting a bylaw change, then the change shall require an affirmative vote of greater than 50% of the members voting in person. At the request of the quorum or if there is an insufficient number of voting members of the Medical Staff for a quorum present at the meeting then the vote may be by written ballot. Ballots require a simple majority of respondents as long as the ballots are sent out to all voting members.

15.3 GOVERNING BOARD APPROVAL

Bylaw changes adopted by the medical staff shall become effective following approval by the governing board, which approval shall not be withheld unreasonably, or automatically within 60 days if no action is taken by the governing board. Medical staff members are provided with copies of the revisions in the bylaws, rules and regulations and medical staff policies. If approval is withheld, the reasons for doing so shall be specified by the governing board in writing, and shall be forwarded to the chief of staff, the medical executive and bylaws committee. After the changes have been approved, the Medical Staff Bylaws will be amended to reflect these changes and after the document has been reviewed by the Bylaws Chair for errors it will be published on the Medical Staff web site - <http://drmcmedstaff.org>. The date of the document and the effective date of the changes will be the date of approval by the Governing Board.

15.4 EXCLUSIVITY

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

15.5 EFFECT OF THE BYLAWS

Upon adoption and approval as provided in Article XV, 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.

15.6 SUCCESSOR IN INTEREST/AFFILIATIONS

15.6.1. SUCCESSOR IN INTEREST

These bylaws, and privileges of individual members of the medical staff accorded under these bylaws, will be binding upon the medical staff, and the governing board 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 governing board or its successor in interest. Until such time as the new bylaws are approved, the existing bylaws of each institution will remain in effect.

15.6.2. AFFILIATIONS

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

15.7 CONSTRUCTION OF TERMS AND HEADINGS

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

ADOPTED by the Medical Staff of Desert Regional Medical Center

Date: September 5, 2011

/s/ Narasimha Rao, MD

Narasimha Rao, MD

Chief of Staff

APPROVED by the Governing Board on

Date: September 15, 2011

/s/Frank R. Ercoli, M.D.

Frank R. Ercoli, M.D.

Chair, Governing Board