# STANFORD HEALTH CARE TRI-VALLEY MEDICAL STAFF BYLAWS

**Stanford Health Care Tri-Valley**

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**STANFORD HEALTH CARE TRI-VALLEY MEDICAL STAFF BYLAWS**

## PREAMBLE

These Bylaws are adopted in order to provide for the organization of the Medical Staff of Stanford Health Care Tri-Valley to: 1) 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, 2) to govern the orderly resolution of issues, and 3) to govern the conduct of Medical Staff functions supportive of those purposes. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Directors, and relations with applicants to and members of the Medical Staff.

## DEFINITIONS

1. ADVANCED PRACTICE PROFESSIONAL or APP, and ALLIED HEALTH PROFESSIONAL or AHP means an individual, other than a licensed physician, dentist, podiatrist, or clinical psychologist who exercises independent judgment within the areas of his or her professional competence and the limits established by the Board of Directors, the Medical Staff, and the applicable State Practice Act, who is qualified to render direct or indirect care under the supervision or direction of a Medical Staff member possessing privileges to provide such care in the Hospital, and who may be eligible to exercise privileges and prerogatives in conformity with the rules adopted by the Board of Directors, these Bylaws, and the Medical Staff Rules and Regulations. APPs and AHPs are not eligible for Medical Staff membership.

2. ATTENDING PHYSICIAN means the physician who is a Medical Staff member who maintains overall responsibility for each patient admitted.

3. BOARD OF DIRECTORS or BOARD means the governing body of the Hospital.

4. CHIEF EXECUTIVE OFFICER means the individual appointed by the Board of Directors to act on its behalf in the overall management of the Hospital.

5. CHIEF OF STAFF means the chief officer of the Medical Staff elected by members of the Medical Staff.

6. CLINICAL PRIVILEGES means the specific scope and content of patient care services granted to a Medical Staff member or APP/AHP within the Stanford Health Care Tri-Valley.

7. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE), also referred to as proctorship, refers to the evaluation of a member's proficiency in the exercise of clinical privileges initially granted and overall eligibility for continued staff membership and advancement to the requested staff category. FPPE will also apply to existing Medical Staff members requesting additional privileges, or

physicians who are recommended for a focused review due to concerns related to performance or patient outcomes.

8. GOOD STANDING means a Medical Staff Member, Advanced Practice Professional, or Allied Health Professional is in good standing when, at the time of the assessment of standing, their membership and/or clinical privileges are not voluntarily or involuntarily limited, restricted, suspended, or otherwise encumbered for medical disciplinary cause or reason (excluding medical leaves of absence).

9. HOSPITAL means Stanford Health Care Tri-Valley.

10. INVESTIGATION means a formal process specifically initiated by the Medical Executive Committee, in accordance with these Bylaws, to determine the validity, if any, of a concern or complaint raised about a member of the Medical Staff.

11. MEDICAL DISCIPLINARY CAUSE OR REASON means an aspect of a practitioner's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

12. MEDICAL EXECUTIVE COMMITTEE means the executive committee of the Medical Staff, which shall constitute the governing body of the Medical Staff as described in these Bylaws.

13. MEDICAL STAFF or STAFF means those physicians (M.D. or D.O.), oral surgeons, dentists, clinical psychologists, and podiatrists who have been granted recognition as members of the Medical Staff pursuant to the terms of these Bylaws.

14. MEDICAL STAFF'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.

15. MEDICAL STAFF YEAR means the period from January 1 to December 31.

16. MEMBER means, unless otherwise expressly limited, any physician (M.D. or D.O.), oral surgeon, dentist, clinical psychologist, or podiatrist holding a current license to practice within the scope of his or her license who is a member of the Medical Staff.

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

18. PRIVILEGES on the Medical Staff, for the purposes of describing categories of membership, means the duties and prerogatives of each category, and not clinical privileges to provide patient care, treatment, and services.

# ARTICLE I

# NAME

The name of this organization is the Medical Staff of Stanford Health Care Tri-Valley.

# ARTICLE II

# MEMBERSHIP

## 2.1 NATURE OF MEMBERSHIP

Only licensed physicians, oral surgeons, dentists, clinical psychologists, and podiatrists who are members of the Medical Staff or have been granted temporary membership and clinical privileges, including those in a medical administrative position by virtue of a contract with the Hospital, may admit or provide medical or health-related services to patients in the Hospital. Appointment to the Medical Staff shall confer only such privileges and prerogatives as have been granted in accordance with these Bylaws and shall be subject to the authority described in the Medical Staff Bylaws, Rules and Regulations, and Medical Staff policies.

## 2.2 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for the Honorary Staff, the basic ongoing responsibilities of each member of the Medical Staff include:

(a) Meeting the professional standards of the Medical Staff of this Hospital, including managing and coordinating the treatments and services of patients and providing patients with quality care;

(b) Abiding by the Medical Staff Bylaws, Rules and Regulations, and policies, and Hospital policies consistent with these Bylaws that apply to the activities of a Medical Staff member;

(c) Abiding by the lawful and ethical principles of the American Medical Association;

(d) Preparing, dictating (when indicated), and completing medical and other required records in a timely fashion for all patients for whom the member provides care in the Hospital;

(e) Training on the electronic health record to ensure proper completion of medical records needed to provide appropriate patient care. The Hospital is responsible for providing adequate initial training and ongoing support and resources to ensure that each practitioner with clinical privileges can successfully use the electronic health record;

(f) Cooperating with members, nurses, hospital administration, and others so as to maintain and improve patient care, and abide by the Medical Staff

Code of Professional Behavior;

(g) Making arrangements for continuous patient coverage as determined by the Medical Staff. Attending Physicians must provide adequate 24-hour coverage for their hospitalized patients;

(h) Participating in such emergency room coverage, as may be determined by the Medical Staff. Emergency room backup call for unassigned patients is not required for Medical Staff membership, however, Medical Staff members are encouraged to participate in voluntary emergency room backup call;

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

(j) Maintaining a professional liability insurance policy with limits at least equal to the minimum amount established by the Board for Medical Staff members who hold clinical privileges;

(k) Completing and or attesting to the completion of continuing education in accordance with State licensure requirements;

(l) Notifying the Chief of Staff within fourteen (14) business days of the involuntary termination of medical staff membership or involuntary limitation, reduction, or loss of clinical privileges at another hospital, health plan, medical group, or health facility;

(m) Notifying the Chief of Staff within fourteen (14) business days of a final judgment or settlement in a malpractice action; any restriction or sanction of licensure or Drug Enforcement Administration registration; any report filed with the National Practitioner Data Bank; and any exclusions from or restrictions on participation in any federal health care programs;

(n) 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 and participating in the proctorship program;

(o) Paying annual dues and reappointment fees in the amounts set by the Medical Staff;

(p) Participating in peer review in accordance with the timelines set forth in the Medical Staff Peer Review Policy;

(q) Abiding by the terms of the MEDICAL STAFF INFORMATION CONFIDENTIALITY AGREEMENT; and

(r) Refraining from unlawful fee splitting or unlawful inducements relating to patient referrals.

The failure by any Medical Staff member to abide by any of the duties specified above shall be grounds for disciplinary action, as deemed appropriate by the

Medical Executive Committee.

## 2.3 BASIC QUALIFICATIONS OF MEDICAL STAFF MEMBERSHIP

### 2.3.1 LICENSE

All applicants and Staff members shall hold a valid, unsuspended and unrestricted license to practice medicine, osteopathic medicine, dentistry, or podiatry in the State of California. The Medical Staff shall not provide an initial application to any practitioner whose professional licensure authorizing him or her to practice his or her profession in the State of California is limited or subject to an accusation, probation, stipulation, or otherwise limited by the applicable licensing authority, until the licensing authority concludes its inquiries and any related actions or conditions are formally terminated. No applicant or Staff member shall be automatically entitled to Staff membership or to the exercise of particular privileges merely because he or she is licensed to practice in California or in any other state, or is a member of any particular professional organization, or has staff membership or clinical privileges in another health care facility, or is certified by any clinical board. Staff membership or particular privileges shall be granted or denied on the basis of professional and ethical criteria, adequate physical and mental health status, and shall not be denied on the basis of sex, race, age, ethnicity creed, culture, color, national origin, religion, sexual orientation, gender identity or expression, political affiliation, or physical or mental impairment that does not pose a threat to the quality of patient care, or any other basis prohibited by law.

### 2.3.2 BOARD CERTIFICATION

To qualify for initial appointment to the Medical Staff, applicants must be board certified by the American Board of Medical Specialties to hold privileges in a specialty or sub-specialty recognized. (This does not include clinical psychologists, dentists, or podiatrists.) Board certification by a member Board of the American Osteopathic Association (AOA) meets this requirement. Initial applicants who are board-eligible (as defined by the relevant Board) may hold membership and privileges for up to 5 years while obtaining board certification. Initial applicants in divisions where there is a corresponding ABMS sub-specialty Board will need a subspecialty certificate in that area for privileging. Any exceptions to these requirements must be approved by the Credentials Committee. These minimum requirements do not preclude stricter requirements for specified privileges as set forth in privilege delineation forms. Board certification is a complex process with multiple different boards and requirements. It is recognized that unanticipated situations may arise where specified requirements and deadlines are not fully appropriate. Any such cases will be adjudicated by the Credentials Committee, with final approval from Medical Executive Committee for any suggested exceptions to these requirements.

### 2.3.3 CURRENT PRACTICE

To establish current professional training, experience, and eligibility to perform the privileges requested, at a minimum an applicant must produce evidence that he or she has actively practiced in his or her intended field for at least two of the preceding four years at an acute care facility accredited by The Joint Commission, or any successor organization, or has completed a clinical residency or a formal fellowship training within the preceding 18 months.

### 2.3.4 CHARACTER

All applicants and Staff members must be found acceptable to the Medical Staff with respect to character, experience, judgment, training, ability, ethics, qualifications, good reputation, and ability to work with others.

### 2.3.5 PROFESSIONAL LIABILITY INSURANCE

All applicants and Staff members, with the exception of physicians on the Honorary Staff or leave of absence, must maintain current professional liability insurance in amounts required by the Board of Directors. A current certificate of insurance must be provided to the Medical Staff Services Department. Any change in coverage amounts, type, or carrier must be reported to the Medical Staff Services Department within 14 days of such action. Cancellation or termination of professional liability insurance must be reported to the Medical Staff Services Department immediately upon such action being taken.

# ARTICLE III

# CATEGORIES OF MEMBERSHIP

## 3.1 CATEGORIES

The categories of the Medical Staff shall include the following: Active, Courtesy, Consulting, Telemedicine Consulting, Provisional, office based, and Honorary. At each time of reappointment, the member's staff category shall be determined.

## 3.2 ACTIVE STAFF

### 3.2.1 QUALIFICATIONS

(a) The Active Staff consists of members who regularly admit and/or engage in patient care encounters at the Hospital at an activity level as defined by the Medical Staff upon recommendation of the member's department.

(b) Active Staff must meet the qualifications set out in Paragraph 2.3 and Article IV of these Bylaws and satisfy the meeting requirements outlined by Article XII of these Bylaws.

(c) Active Staff must have satisfactorily completed proctoring requirements and have been a member in good standing of the Provisional Staff for at least one year.

(d) Members of the Active Staff must be in close enough proximity to the Hospital to respond to calls from the Hospital or emergency room that require immediate physician attention. A member must respond to calls within fifteen (15) minutes and, in emergency situations that require immediate physical attendance, be physically present in the Hospital within forty-five (45) minutes of being requested to do so.

### 3.2.2 PREROGATIVES

(a) Active Staff are entitled to admit patients and exercise such clinical privileges as have been granted pursuant to Article V of these Bylaws.

(b) Active Staff may vote on matters presented at general and special meetings of the Medical Staff, and of the department. They may hold Medical Staff or department office and serve as voting members of Medical Staff committees to which they are appointed.

## 3.3 COURTESY STAFF

### 3.3.1 QUALIFICATIONS

(a) The Courtesy Staff consists of members who admit and/or engage

in patient care encounters at the Hospital at an activity level defined by the Medical Staff upon recommendation of the member's department.

(b) Courtesy Staff must meet the qualifications set out in Paragraph 2.3 and Article IV of these Bylaws. In addition, members of the Courtesy Staff must hold Active Staff membership at a Joint Commission-accredited hospital.

(c) Courtesy Staff must have satisfactorily completed proctoring requirements and have been a member in good standing of the Provisional Staff for at least one year.

3.3.2 PREROGATIVES

(a) Courtesy Staff are entitled to admit patients and exercise such clinical privileges as have been granted pursuant to Article V of these Bylaws.

(b) Courtesy Staff may attend Medical Staff department, committee, and general Medical Staff meetings. They shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

3.3.3 ADVANCEMENT

In order to advance to the Active Staff, a Courtesy Staff member in good standing must demonstrate eligibility by meeting the activity requirements defined by the member's department and the meeting requirements as outlined by Article XII of these Bylaws. A request must be submitted in writing to the Credentials Committee.

3.4 CONSULTING STAFF

3.4.1 QUALIFICATIONS

(a) The Consulting Staff consists of members who possess adequate clinical and professional expertise within the consultant's specialty and have been asked to provide patient care in a service that is not available from the Active or Courtesy Staff.

(b) Consulting Staff must hold Active Staff membership at a Joint Commission-accredited hospital.

(c) Consulting Staff must have satisfactorily completed proctoring requirements and have been a member in good standing of the Provisional Staff for at least one year.

3.4.2 PREROGATIVES

(a) Consulting Staff are entitled to exercise such clinical privileges as have been granted pursuant to Article V of these Bylaws.

(b) Members of the Consulting Staff may attend Medical Staff department, committee, and general Medical Staff meetings. They shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

3.4.3 ADVANCEMENT

In order to advance to the Active or Courtesy staff, a Consulting Staff member in good standing must demonstrate eligibility by meeting the relevant activity requirements defined by the member's department. A request must be submitted in writing to the Credentials Committee.

3.4.4 LIMITATIONS

Consulting Staff members cannot admit patients to the Hospital.

## 3.5 TELEMEDICINE TELEHEALTH CONSULTING STAFF

3.5.1 QUALIFICATIONS

(a) The Telemedicine Telehealth Consulting Staff consists of members who possess adequate clinical and professional expertise within their specialty, who provide patient care services to Hospital patients from a distant location through interactive telecommunications, and who have been asked to provide patient care in a service that is not available from the Active or Courtesy Staff, unless part of a group that provides services through a contract with the hospital.

(b) Telemedicine Telehealth Consulting Staff must have satisfactorily completed proctoring requirements and have been a member in good standing of the Provisional Staff for at least one year.

3.5.2 LIMITATIONS

Telemedicine Consulting Staff members are not eligible to admit patients to the Hospital, to provide patient care services on the Hospital premises, to vote or hold office, or to serve on committees. These limitations apply to those members who have telemedicine privileges only.

3.5.3 PREROGATIVES

(a) Telemedicine Consulting Staff are entitled to exercise such clinical privileges as have been granted pursuant to Article V of these Bylaws.

(b) Telemedicine Consulting Staff may attend Medical Staff department,

committee, and general Medical Staff meetings. They shall have no right to vote at such meetings.

## 3.6 PROVISIONAL STAFF

### 3.6.1 PROVISIONAL STAFF STATUS

All new members of the Medical Staff shall be appointed to the Provisional Staff for a period of one (1) year. Provisional Staff membership and privileges shall expire after one (1) year unless that status is extended by the Medical Executive Committee, upon a finding of good cause, for an additional period of up to twelve (12) months, in six (6) month increments. A Medical Executive Committee recommendation to extend, or not extend, Provisional Staff membership shall not be subject to review pursuant to Article VIII of these Bylaws.

### 3.6.2 PREROGATIVES

(a) Provisional Staff are entitled to admit patients and exercise such clinical privileges as have been granted pursuant to Article V of these Bylaws, subject to the proctoring requirements described in Paragraphs 3.6.3 and 5.3.

(b) Members of the Provisional Staff may attend Medical Staff department, committee, and general Medical Staff meetings. They shall have no right to vote at such meetings.

### 3.6.3 FOCUSED PROFESSIONAL PRACTICE EVALUATION AND OBSERVATION OF PROVISIONAL STAFF MEMBERS

Each Provisional Staff member shall undergo a period of observation by designated proctors, as described in Paragraph 5.3, to evaluate the member's proficiency in exercising the clinical privileges initially granted and overall eligibility for continued Staff membership and advancement to the requested Staff category. Observation of Provisional Staff members shall follow the format each department deems appropriate for adequate evaluation of the Provisional Staff member, which may include concurrent and/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 chief to the Credentials Committee.

### 3.6.4 ADVANCEMENT

(a) A Provisional Staff member in good standing shall be eligible for advancement to the Active, Courtesy, Consulting, or Telemedicine Telehealth Consulting Staff if the member has satisfactorily completed the proctoring requirements set by the member's department, demonstrated the clinical competence to exercise the privileges initially granted, met the activity requirements set by the

member's department during the Provisional Staff membership period, and have been a member in good standing of the Provisional Staff for at least one year. A request for advancement must be submitted in writing to the Credentials Committee. The Provisional Staff member's performance and clinical competence shall be evaluated by the relevant department chief to determine if the member is eligible for advancement. The department chief shall make a recommendation to the Credentials Committee for advancement to the appropriate Staff category or for modification or termination of Medical Staff membership and/or clinical privileges.

(b) If, at the expiration of the Provisional Staff membership period, the member has failed to complete the proctoring requirements and/or failed to meet the activity requirements set by the member's department, the member shall be deemed to have voluntarily resigned from the Medical Staff and to have relinquished Staff membership and clinical privileges. The member shall be given regular notice of the expiration of membership. A member whose appointment expires under this Paragraph shall not have any rights of hearing and appeal set out in Article VIII of these Bylaws.

## 3.7 OFFICE-BASED STAFF

### 3.7.1 QUALIFICATIONS

The Office-Based Staff consists of members who have been on the Medical Staff and who desire to continue their relationship with the Medical Staff and are no longer involved in direct patient care in the Hospital. The Medical Staff member must be in good standing in any category except Provisional to be considered for this Staff category.

### 3.7.2 LIMITATIONS

Office-Based Staff members are not eligible to admit or provide direct patient care services, to vote or hold office, or to serve on committees. They hold membership without clinical privileges.

### 3.7.3 PREROGATIVES

Office-Based Staff members may attend meetings of their assigned department, general Medical Staff meetings, and medical education programs.

## 3.8 HONORARY STAFF

### 3.8.1 QUALIFICATIONS

The Honorary Staff shall consist of retired physicians, dentists, and podiatrists who have previously practiced at the Hospital and are deemed deserving of honorary membership by virtue of their contributions to the

Medical Staff.

3.8.2 PREROGATIVES

Honorary Staff members shall not be obligated to pay annual membership dues. They may attend medical education programs

LIMITATIONS

3.8.3 Honorary Staff members are not eligible to admit patients to the Hospital or exercise clinical privileges, to vote or hold office, to serve on committees, or to attend department, committee, or general Medical Staff meetings.

## 3.9 GENERAL LIMITATIONS AND EXPIRATION OF MEMBERSHIP AND PRIVILEGES

Members of the Active, Courtesy, or Consulting staff who do not admit patients and/or have not exercised their clinical privileges for a period of two (2) years shall be deemed to have voluntarily resigned from the Medical Staff and relinquished their Medical Staff membership and clinical privileges. A member who is deemed to have resigned and relinquished membership and privileges under this Paragraph shall not have any rights of hearing and appeal set out in Article VIII of these Bylaws.

## 3.10 MODIFICATION OF MEMBERSHIP CATEGORY

On its own, or upon recommendation of the Credentials Committee, the Medical Executive Committee may recommend changes in the Staff category of a member consistent with the requirements of the Bylaws or policies.

A member may, either in connection with reappointment or at any time, request a change in Staff category by submitting a written request to the Credentials Committee. Applications for change in status may not be submitted within six (6) months of the time a similar request has been denied.

# ARTICLE IV INITIAL APPOINTMENT, REAPPOINTMENT, CREDENTIALING AND RECREDENTIALING

## 4.1 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment and reappointment, the applicant shall have the burden of: 1) producing complete and accurate information for a proper evaluation of the applicant's qualifications and suitability for the clinical privileges and Staff category requested, 2) resolving any reasonable doubts about these matters, and 3) satisfying requests for information. The applicant's failure to sustain this burden and/or the provision of information containing significant misrepresentations or omissions shall be grounds for denial of the application or subsequent termination, suspension, or limitation of membership or privileges. This burden may include submission to a medical, psychiatric, or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Executive Committee. The Medical Executive Committee will select the examining physician. The applicant's failure to sustain this burden will be grounds for denial of the application.

## 4.2 DURATION OF APPOINTMENT

Except as otherwise provided in these Bylaws, appointments shall be for a maximum period of twenty-four (24) months.

## 4.3 APPLICATION FOR INITIAL APPOINTMENT, REAPPOINTMENT, CREDENTIALING AND RECREDENTIALING

All applications for initial appointment or reappointment to the Medical Staff shall be submitted on a form approved by the Medical Executive Committee and signed by the applicant. The form shall require detailed information that shall include, but not be limited to, information concerning:

(a) The applicant's qualifications, including, but not limited to, current professional training, experience, and ability to perform the clinical privileges requested, current licensure and any restrictions, suspensions, or conditions imposed thereon, current Drug Enforcement Administration registration, if applicable, documentation of successful completion of ACLS or neonatal resuscitation (as required by specific departments), and continuing medical education information related to the clinical privileges requested; Maintenance of DEA certification. Practitioners under a 2113 Exemption are required to obtain and maintain a DEA certification. Psychologists, Dentists and members in the Administrative, and Affiliate categories are exempt; pathologists and non-interventional radiologists may also be exempted from this requirement if they provide an attestation confirming that they do not and will not prescribe any controlled substances. Practitioners may also be exempted if they provide attestation acceptable to the Credentials and Privileges Committee confirming that the

do not and will not prescribe any controlled substances.

(b) Peer references from practitioners in the same professional discipline as the applicant with personal knowledge of the applicant's professional competence, quality of care, and ethical character within the previous 24 months. Three (3) peer references are required in connection with applications for initial appointment and two (2) peer references are required in connection with an application for reappointment.

(c) Requests for membership categories, departments, and clinical privileges;

(d) Past or pending professional disciplinary actions involving restrictions, suspensions, or loss of medical staff membership or privileges at any acute care facility or ambulatory surgery center, or of any license, certification, or registration, or any convictions for misdemeanors or felonies;

(e) Current physical and mental health status relevant to the clinical privileges being requested; and

(f) Professional liability coverage.

## 4.4 APPOINTMENT AUTHORITY

Appointments, denials and revocations of appointment to the Medical Staff shall be made as set forth in these Bylaws, but only after there has been a recommendation from the Medical Executive Committee.

## 4.5 EFFECT OF APPLICATION

In addition to the matters set forth in Paragraph 4.1, by applying for appointment or reappointment to the Medical Staff, each applicant or member:

(g) Agrees to be interviewed by the chief of the department in which clinical privileges are requested, by the Credentials Committee, and/or by the Medical Executive Committee;

(h) Authorizes consultation with others who have been associated with the applicant and who may have information bearing on his or her qualifications for Staff membership and/or clinical privileges, and authorizes such individuals and organizations to candidly provide all such information;

(i) 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 possession of such records and documents to permit such inspection and copying;

(j) Releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the

applicant;

(k) Releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;

(l) Consents to disclosure of credentialing and peer review information in accordance with the Practitioner Information Sharing Agreement among Stanford-affiliated entities and to the disclosure to other hospitals, medical associations, licensing boards, and other similar organizations of any information regarding his or her professional or ethical standing that the Hospital or Medical Staff may have, and releases the Medical Staff and Hospital from liability for so doing to the fullest extent permitted by law;

(m) Acknowledges responsibility for timely payment of Medical Staff dues and assessments;

(n) Pledges to provide quality care for his or her patients;

(o) Pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, seeking consultation whenever necessary, refraining from providing "ghost" surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners;

(p) Acknowledges that he or she has read and agrees to be bound by the Medical Staff Bylaws, Rules and Regulations, and policies as they exist and as they may be modified from time to time;

(q) Pledges to notify the Medical Staff Services Department in writing promptly, and no later than 14 calendar days, following any action taken regarding his or her license, Drug Enforcement Administration registration, participation in federal health care programs, any report filed with the National Practitioner Data Bank, any final judgment or settlement in a malpractice action, or any other action or change in circumstances that could affect his or her qualifications for Medical Staff membership and/or clinical privileges at the Hospital;

(r) Pledges to work cooperatively with members, nurses, Hospital administrative staff and others so as not to adversely affect patient care or Hospital operations;

(s) Assures timely completion of medical records, as described in these Bylaws and the Medical Staff Policy & Procedure for Medical Records; and

(t) Agrees to sign an authorization that permits the Medical Staff to conduct a full criminal background check, the nature and scope of which will be disclosed to the applicant.

## 4.6 ACTION ON THE APPLICATION

### 4.6.1 VERIFICATION OF INFORMATION

The applicant shall deliver a completely filled-in, signed, and dated application and supporting documents and an advance payment of a Medical Staff processing fee to the staff of the Medical Staff Services Department, as an agent of the Credentials Committee. The staff of the Medical Staff Services Department shall, in a timely fashion, seek to collect or verify the references, licensure, continuing education, status with federal health care programs, and other similar information needed to complete the file, including any California Business and Professions Code Section 805 reports from the licensing body. Licensure will be verified with the primary source at the time of appointment and initial granting of clinical privileges, at reappointment or renewal or revision of clinical privileges, and at the time of expiration. The Medical Staff's authorized representative shall query the National Practitioner Data Bank regarding the applicant or member and submit any resulting information to the Credentials Committee for inclusion in the applicant's or member's credentials file.

If problems are encountered in the verification process, the staff of the Medical Staff Services Department shall notify the applicant of the nature of these problems, and it shall be the applicant's obligation to obtain the required information.

An application that is not complete shall not qualify for a credentialing recommendation. A complete application for Medical Staff membership must include all the information requested on the application form and any additional information requested that relates to the evaluation of the applicant's professional qualifications as may be deemed relevant by the department chief, Credentials Committee, Medical Executive Committee, and/or Board of Directors. Failure to complete the application or to submit any additional requested information within thirty (30) days of a request will be deemed a voluntary withdrawal of the application. Termination of the credentialing process shall not entitle the applicant to review or appeal pursuant to Article VIII of the Medical Staff Bylaws. Notwithstanding the foregoing, an application that is incomplete only with respect to a single clinical privilege or group of clinical privileges may be recommended with respect to the clinical privileges (but only those privileges) for which it is complete. There shall be no prejudice to reapplication following withdrawal of an application prior to receipt of any of an adverse decision.

New applicants must meet the basic qualifications for membership set forth in Section 2.3. If a new applicant fails to satisfy these threshold criteria, the application will not be processed unless a waiver has been granted pursuant to this Section.

If the applicant does not meet one or more basic qualifications for membership or for the clinical privilege(s) requested, the applicant may submit

comments and request an exception or waiver of the applicable requirements. The comments and request shall be reviewed by the Medical Executive Committee and the Board of Directors. For good cause, the Medical Executive Committee may recommend, and the Board of Directors may grant, an exception or waiver of any requirement. An applicant who is denied an exception or waiver shall not be entitled to any hearing or appeal rights described in Article VIII of these Bylaws.

When necessary, collection and verification is completed, the staff of the Medical Staff Services Department shall transmit the application and all supporting materials to the department chief for evaluation.

4.6.2 DEPARTMENT ACTION

After an application has been deemed complete, it shall be forwarded to the chief of the department in which the practitioner has requested clinical privileges. The chief shall review the privileges application (and may arrange for a personal interview of the applicant) and take action within 30 days. The chief shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of clinical privileges requested or previously granted and the applicant's participation in relevant continuing education, and shall make a recommendation to the Credentials Committee. If the chief recommends appointment, the chief shall also recommend Staff category, clinical privileges, and any special conditions to be attached to the appointment.

4.6.3 CREDENTIALS COMMITTEE ACTION

Within 60 days following receipt, the Credentials Committee shall review the department chief's report and recommendation and other relevant information. The Credentials Committee may elect to interview the applicant and request additional information. Within 60 days following review of the departmental recommendation, the Credentials Committee shall transmit to the Medical Executive Committee a written report and its recommendation as to appointment and, if appointment is recommended, as to department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment

4.6.4 MEDICAL EXECUTIVE COMMITTEE ACTION

Within 60 days of 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. Following consideration of the Credentials Committee report and recommendation, the Medical Executive Committee shall prepare a written report and recommendation to grant, defer, or deny the application. If the application

is recommended for approval, the report shall be forwarded to the Board along with recommendation specifying the Staff category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment.

When a final recommendation of the Medical Executive Committee is adverse to the applicant, such recommendation shall not be forwarded to the Board of Directors until the applicant has either waived or exhausted his or her procedural rights as provided in Article VIII. If the applicant does not request a Judicial Review Committee hearing in accordance with Article VIII, the Medical Executive Committee's recommendation shall be presented to the Board of Directors as the final action of the Medical Staff.

4.6.5 BOARD OF DIRECTORS ACTION

Within 60 days following receipt of the Medical Executive Committee recommendation, the Board of Directors may accept, defer, or reject the recommendation of the Medical Executive Committee or refer the matter back to the Medical Executive Committee for further consideration, stating the purpose for such referral.

Whenever the proposed decision of the Board is contrary to the recommendation of the Medical Executive Committee, the Board shall submit its decision and supporting documentation to the Medical Executive Committee for further review. Thereafter, the Medical Executive Committee shall consider the matter and send its report and recommendation to the Board. The Board shall then render its final decision.

The Board of Directors may appoint two or more members of the Board to a Subcommittee. The Board Subcommittee shall act on the Board's behalf to review and act upon applications to the Medical Staff.

4.6.6 NOTICE OF FINAL DECISION

Notice of the final decision shall be given to the Chief of Staff, the Medical Executive Committee, the Credentials Committee, the chief of each department concerned, and the applicant.

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 he or she is assigned; 3) the clinical privileges granted; and 4) any special conditions attached to the appointment.

4.6.7 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant who has received a final adverse decision regarding initial appointment or reappointment shall not be eligible to reapply to the Medical Staff for a period of 24 months. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier

adverse action no longer exists.

4.6.8 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. Special or unusual circumstances may constitute good cause and warrant exceptions.

## 4.7 REAPPOINTMENTS

### 4.7.1 APPLICATION

At least 120 days prior to the expiration date of the current Staff appointment (except for temporary appointments), a reapplication form shall be sent to the member. 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 Paragraph 4.5. Upon receipt of the application, the information shall be processed as set forth commencing at Paragraph 4.8. Failure to submit an application by the specified due date will result in action as designated under Paragraph 4.9.5.

### 4.7.2 EFFECT OF APPLICATION PROCESS

The effect of an application for reappointment or modification of Staff status or clinical privileges is the same as that set forth in Paragraph 4.7.

### 4.7.3 STANDARDS AND PROCEDURE FOR REVIEW

When a member submits an application for reappointment, the member shall be subject to an in-depth review generally following the procedures set forth in Paragraph 4.8.

### 4.7.4 INTERIM REAPPOINTMENT

If it appears that an application for reappointment will not be fully processed by the expiration date of the member's appointment, for reasons other than the reapplicant's failure to return documents or otherwise timely cooperate in the reappointment process, the Medical Executive Committee may recommend to the Board of Directors that a time-specific and member-specific interim reappointment of the member's status and clinical privileges be granted. An interim appointment pursuant to this Paragraph does not create a vested right in the member for continued appointment through the entire next term but only until such time as processing of the application is concluded. The member shall continue to be subject to the reapplication review process outlined in Paragraph 4.8.

### 4.7.5 FAILURE TO TIMELY FILE REAPPOINTMENT APPLICATION

A completed application for reappointment, including all the items described

in Paragraph 4.5, must be submitted to the Medical Staff Office by the specified due date.

If a completed application for reappointment is not received by the specified due date, written notice by email and mail shall be promptly sent to the applicant advising that the application has not been received. Should the member's tardiness result in the Medical Staff's inability to process the application through all the evaluation and approval levels up to and including final action by the Board of Directors prior to the end of the member's current term of appointment, the member's Medical Staff membership and clinical privileges will expire at the end of the current term of appointment. Thereafter, reinstatement to the Medical Staff shall require a new application and compliance with the appointment procedures applicable to new applicants.

## 4.8 LEAVE OF ABSENCE

In accordance with Medical Staff policy, a member may apply for a leave of absence from the Medical Staff. A leave may be granted by the Chief of Staff for a period not to exceed two (2) years. During the leave of absence, the member shall not exercise any clinical privileges, but may continue to access the electronic medical record as appropriate to complete medical records and/or respond to peer review inquiries. Except for leaves of absence to fulfill military service obligations, a leave of absence exceeding two years will be deemed a voluntary resignation from the Medical Staff and will result in automatic termination of membership and privileges without any procedural rights provided in Article VIII, unless required by law. If a member's current appointment is due to expire during the leave, the member must apply for reappointment, otherwise appointment and clinical privileges will lapse at the end of the current appointment period.

Except for maternity leaves, members must report to the Medical Staff Services Department any time if (a) they are away from Medical Staff and/or patient care responsibilities for longer than 90 days; and (b) the reason for such absence is related to their physical or mental health or their ability to care for patients safely and competently. Upon receipt of credible information that these criteria are met (a and b above), the Chief of Staff may invoke a medical leave of absence without a request from the Medical Staff member.

## 4.9 REINSTATEMENT FROM LEAVE OF ABSENCE

Individuals seeking reinstatement from a leave of absence must submit a written request at least 30 days before the end of the leave, accompanied by a summary of their professional activities during the leave. Requests for reinstatement will be reviewed by the relevant department chief and the Chief of Staff and these individuals may request additional information and/or documentation relevant to the request for reinstatement. If these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. If either individual reviewing the request has any questions or concerns, those questions will be noted and the

reinstatement request will be forwarded to the Credentials Committee and the Medical Executive Committee for review and recommendation, and the recommendation forwarded to the Board for action. If a request for reinstatement is not granted for reasons related to clinical competence or professional conduct, the individual will be entitled to procedural rights under Article VIII.

If the leave of absence was for health reasons (except for maternity leave), the request for reinstatement must be accompanied by a report from the treating physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested. The department chief (or designee) in consultation with the Chief of Staff (or designee) shall determine the sufficiency of the report and may request additional information. If additional information is needed, the individual must sign authorizations to enable the release of sufficient information to determine whether the member is able to safely provide care to patients.

Failure to timely request reinstatement from a leave of absence will be deemed a voluntary resignation from the Medical Staff and will result in automatic termination of membership and privileges at the end of the approved leave. A member whose membership is automatically terminated will not be entitled to the procedural rights provided in Article VIII, unless required by law.

## ARTICLE V

## CLINICAL PRIVILEGES

### 5.1 REQUESTS FOR INITIAL, RENEWAL, OR MODIFICATION OF PRIVILEGES

Each application for Active, Courtesy, Consulting, Telemedicine-Telehealth Staff 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.

A member providing clinical services at the 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 licensure, certificate, or other legal credential authorizing practice in this State, and consistent with any restrictions thereon. The exercise of clinical privileges shall be subject to the policies and procedures of the department and the authority and the recommendation of the chief of the department for which the applicant is a member.

### 5.2 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, peer recommendations, and the documented results of patient care and other quality review and monitoring that 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 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

#### 5.3.1 GENERAL PROVISIONS

All initial appointees to the Provisional Staff and all Practitioners granted new clinical privileges shall be subject to a period of focused professional practice evaluation in accordance with the policies established by the member's department.

#### 5.3.2 FAILURE TO COMPLETE FOCUSED PROFESSIONAL PRACTICE EVALUATION

If an initial appointee or a member exercising new privileges fails to complete the focused professional practice evaluation requirements within the time of Provisional Staff membership or if a member exercising new additional clinical privileges fails to complete the focused professional practice evaluation requirements within one year, the member shall be deemed to have voluntarily relinquished those specific clinical privileges, unless extended upon recommendation of the department chief and

Medical Executive Committee and by approval of the Board of Directors. At the discretion of the Medical Executive Committee, an exception may be made for members of the Consulting Staff.

If a member fails to successfully complete the requirements of focused professional practice evaluation due to a medical disciplinary cause or reason, the department chief shall refer the matter to the Medical Executive Committee with a request for an investigation under Article VII.

## 5.4 MODIFICATION OF CLINICAL PRIVILEGES

### 5.4.1 APPLICATION

A Medical Staff member who seeks a modification in clinical privileges may submit such a request at any time, except that such application may not be filed within six (6) months of the time a similar request has been denied.

Upon recommendation of the Credentials Committee, pursuant to a request by a member, or on its own motion, the Medical Executive Committee may recommend a change in the clinical privileges of a member.

## 5.5 TEMPORARY PRIVILEGES

In accordance with Medical Staff policy, a physician may apply for temporary privileges. All the requirements stated in the policy must be met prior to temporary privileges being granted, including verification of licensure, insurance, NPDB query, current clinical competence, hospital/training program affiliation, and primary source verification. Temporary privileges may be granted for a period not to exceed 120 days.

## 5.6 DISASTER PRIVILEGES

Disaster privileges may be granted when the Hospital's Emergency Management Plan has been activated, and the Hospital is unable to meet immediate patient care needs. Requests for disaster privileges will be processed in accordance with the Disaster Privileges for Volunteer Licensed Independent Practitioners and Advance Practice Providers Policy. The Chief of Staff or the Chief Executive Officer, or their respective designees, may grant disaster privileges.

## 5.7 EMERGENCY PRIVILEGES

In the case of an emergency, any member of the Medical Staff, to the degree permitted by his or her license and regardless of department, Staff status, or clinical privileges, may do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The member must make every reasonable effort to communicate promptly with the department chief 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, must defer to the department chief with respect to further care of the patient at the Hospital.

In the event of an emergency, any person may 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 care to qualified members of the Medical Staff when they become available.

5.8 TELEMEDICINE PRIVILEGES

A qualified practitioner may be granted telemedicine privileges regardless of whether the individual is appointed to the Medical Staff. Telemedicine privileges include diagnostic or treatment services provided by practitioners from a distant site to hospital patients via telemedicine devices (audio, video, or data communications). Telemedicine does not include telephone or electronic mail communications.

Requests for initial or renewed telemedicine privileges shall be processed through one of the following options, as approved by Medical Executive Committee:

(a) A request for telemedicine privileges may be processed through the same process for Medical Staff applications and requests for clinical privileges, as set forth in the Bylaws. In such case, the individual must satisfy all qualifications and requirements set forth in the Bylaws, except those relating to geographic location, coverage arrangements, and emergency room coverage responsibilities.

(b) If the individual requesting telemedicine privileges is practicing at a distant hospital that is Joint Commission–accredited or a Medicare-participating organization ("Distant Site"), a request for telemedicine privileges may be processed using an abbreviated process that relies on the credentialing and privileging decisions made by the Distant Site. In such cases, the Hospital must ensure through a written agreement that the Distant Site will comply with all applicable Medicare regulations and accreditation standards. The Distant Site must provide:

(i) confirmation that the practitioner is licensed in California;

(ii) a current list of privileges granted to the practitioner; and

(iii) any other attestations or information required by the agreement or requested by the Hospital.

This information shall be provided to the Credentials Committee and Medical Executive Committee for review and recommendation to the Board for final action. Notwithstanding the process set forth in this paragraph, an applicant for telemedicine privileges may be ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in the Bylaws.

Telemedicine privileges, if granted, shall be for a period of not more than two years. Individuals granted telemedicine privileges shall be subject to the Medical Staff's peer review activities. The results of the peer review activities, including any

adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners, or staff, will be shared with the hospital or entity providing telemedicine services.

Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

# ARTICLE VI ALLIED HEALTH PROFESSIONALS / ADVANCED PRACTICE PROFESSIONALS

## 6.1 MEDICAL STAFF ROLE

(a) The Medical Staff is responsible for reviewing and making recommendations to the Board of Directors regarding the credentials and clinical privileges of each APP or AHP seeking or exercising privileges, including those employed by or seeking employment with the Hospital. This will occur at the time of initial application and each time the APP or AHP seeks renewal of privileges. The Medical Staff shall have general responsibility for monitoring the quality of care provided in the Hospital by health care professionals who are neither employed by the Hospital nor eligible for Medical Staff membership, but who are permitted to treat patients at the Hospital by virtue of APP/AHP status. The Medical Staff may cede the monitoring responsibility, in accordance with applicable laws and accreditation standards, to Hospital administration in the case of individual APPs/AHPs who are employed by the Hospital, where oversight by the Medical Staff would not be efficient or practicable. However, all APPs/AHPs, including employees of the Hospital, shall be bound by the applicable Medical Staff Bylaws and Rules and Regulations governing the practice of AHPs/APPs.

(b) The Medical Staff shall fulfill its responsibilities under this Article by performing the following functions with respect to AHP/APP categories under its jurisdiction:

(1) Making recommendations to the Board of Directors regarding the categories of APPs/AHPs who are permitted to render patient care services in the Hospital.

(2) Establishing standards of practice for each category;

(3) Credentialing and privileging APPs/AHPs from each category who apply for clinical privileges or renewal of clinical privileges as an AHP/APP;

(4) Undertaking peer review of APPs/AHPs in each category; and

(5) Establishing appropriate standards and procedures for carrying out these functions.

# ARTICLE VII

# CORRECTIVE ACTION

## 7.1 CORRECTIVE ACTION INVESTIGATIONS

### 7.1.1 CRITERIA FOR INITIATION

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members and APPs/AHPs. When reliable information indicates a practitioner 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/or Rules and Regulations; (4) below applicable professional standards, a request for an investigation or action against such practitioner may be initiated by the Chief of Staff, a department chief, the Medical Executive Committee, or the Chief Executive Officer.

### 7.1.2 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 record of the reasons.

### 7.1.3 INVESTIGATION

If the Medical Executive Committee determines 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. If the investigation is delegated to an officer or 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 practitioner shall be notified that an investigation is being conducted and shall be given an opportunity to meet with the investigating body and/or 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 other persons. However, such investigation and interviews shall not constitute a "hearing" as that term is used in Article VIII, 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.

### 7.1.4 MEDICAL 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:

(a) Determining no corrective action need be taken and, if the Medical Executive Committee determines that there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's file;

(b) Deferring action for a reasonable time where circumstances warrant;

(c) Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude the department chief from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response, which shall be placed in the member's file;

(d) Recommending the imposition of terms of probation or special limitations upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admission, mandatory consultation, or proctoring;

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

(f) Recommending modification of Staff status or limitation of any prerogatives directly related to the member's delivery of patient care;

(g) Recommending suspension, revocation, or probation of Medical Staff membership; or

(h) Taking other actions deemed appropriate under the circumstances.

### 7.1.5 SUBSEQUENT ACTION

If the Medical Executive Committee recommends corrective action as set forth in Paragraph 8.2, it shall promptly notify the concerned member of his or her right to a hearing under Article VIII. The recommendation of the Medical Executive Committee shall be held in abeyance pending an exhaustion or waiver of rights under Article VIII, unless a summary restriction or suspension of clinical privileges is imposed under Paragraph 7.2.

### 7.1.6 FAILURE OF MEDICAL EXECUTIVE COMMITTEE TO TAKE ACTION

If the Board of Directors reasonably determines, based on reliable

information, that corrective action as to a member is warranted but the Medical Executive Committee has failed to take action, the Board of Directors or its designee shall consult with the Chief of Staff and may thereafter direct the Medical Executive Committee to conduct an investigation or otherwise initiate corrective action proceedings. In the event the Medical Executive Committee fails to take action in response to such a direction, the Board of Directors, after written notice to the Medical Executive Committee, may conduct an investigation or otherwise initiate corrective action proceedings on its own initiative.

Any such proceedings shall afford the member substantially the same procedural rights that are described in Article VIII.

## 7.2 SUMMARY RESTRICTION OR SUSPENSION

### 7.2.1 CRITERIA FOR INITIATION

The Medical Executive Committee may summarily suspend or restrict a member's clinical privileges where the failure to take such action may result in an imminent danger to the health of any individual. In addition, the following persons may take summary action: the Chief of Staff, the Vice Chief of Staff, or the Secretary/Treasurer of the Medical Staff.

Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the member, the Board of Directors, the Medical Executive Committee, the department chief, and the Chief Executive Officer. 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 chief or by the Chief of Staff, considering where feasible the wishes of the patient in the choice of a substitute member.

When no person or committee listed above is available to impose a summary suspension or restriction, the Board of Directors or its designee may take such action if a failure to do so would be likely to result in an imminent danger to the health of any individual. Prior to exercising this authority, the Board of Directors or its designee must make reasonable attempts to contact two of the persons or committees otherwise authorized to take summary action. Summary action by the Board of Directors or its designee that has not been ratified by the Medical Executive Committee within two working days, excluding weekends and holidays, after the summary action shall terminate automatically.

### 7.2.2 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as practicable, and in no later than 10 days after such summary restriction or suspension has been imposed, a meeting of the Medical

Executive Committee shall be convened to review and consider the action. Upon request, the member 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 VIII, nor shall any procedural rules apply. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension and shall promptly notify the member of its decision.

7.2.3 PROCEDURAL RIGHTS

In the event that the Medical Executive Committee continues a summary restriction or suspension such that it remains in effect for more than 14 days or is otherwise reportable to the Medical Board of California, the member shall be entitled to the procedural rights set forth in Article VIII.

7.3 AUTOMATIC PROBATION, SUPENSION, RESTRICTION, RELINQUISHMENT, OR TERMINATION

In the following instances, a member's Medical Staff membership and/or clinical privileges will be automatically suspended, restricted, relinquished, or terminated without a right to hearing under Article VIII. A meeting with the Medical Executive Committee may be requested, but such meeting shall be limited to the question of whether the grounds for action as set forth below have occurred or, with respect to circumstances set forth in Paragraphs 7.3.1(b) and (c) and 7.3.2, whether the member can continue to practice with the restrictions in place.

7.3.1 CHANGE IN LICENSURE STATUS

(a) Revocation or Expiration

Whenever a member's license or other legal credential authorizing practice in this State is revoked or has expired, Medical Staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective. In the case of an expired license, Medical Staff membership and clinical privileges will automatically be reinstated upon receipt by the Medical Staff Services Department of evidence of license renewal, so long as the renewal occurs within thirty (30) days of the expiration.

(b) Restriction or Suspension

Whenever a member's license or other legal credential authorizing practice in this State is restricted or suspended by the applicable licensing or certifying authority, any clinical privileges that the member has been granted at the Hospital that are within the scope of said restriction or suspension shall be automatically restricted or suspended in a similar manner, as of the date such action becomes

effective and throughout its term.

(c) Probation

Whenever a member is placed on probation by the applicable licensing or certifying authority, his or her Medical Staff membership 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.

7.3.2 DRUG ENFORCEMENT ADMINISTRATION ACTIONS

(d) Revocation, Limitation, Suspension, or Expiration

Whenever a member's Drug Enforcement Administration certificate is revoked, limited, or suspended or expires, the member's clinical privileges will be automatically suspended as of the date such action becomes effective and throughout its term. In the case of an expired certificate, the automatic suspension will be lifted upon receipt by the Medical Staff Services Department of evidence of renewal.

(e) Probation

Whenever a member's Drug Enforcement Administration certificate is subject to probation, the member's ability 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.

7.3.3 FEDERAL HEALTH CARE PROGRAM EXCLUSIONS AND SANCTIONS

Whenever a member’s participation in a federal health care program has been revoked, limited, or suspended, the member’s clinical privileges to practice at the Hospital shall be revoked, limited or suspended, as of the date such action becomes effective and throughout its term.

7.3.4 LAPSE IN PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance that meets the limits set by the Board shall be grounds for automatic suspension of a member's clinical privileges. If the member fails to provide evidence of required professional liability insurance to the Medical Staff Services Department within thirty (30) days of the automatic suspension, the member's Medical Staff membership and clinical privileges shall automatically terminate.

7.3.5 NONPAYMENT OF MEDICAL STAFF DUES AND ASSESSMENTS

Failure to pay dues or assessments within sixty (60) days of initial notification of delinquency will result in automatic suspension of a member's clinical privileges. Thereafter, failure to pay dues within thirty (30) days of

automatic suspension will result in automatic termination of Medical Staff membership and clinical privileges.

7.3.6 HEALTH IMMUNIZATION, VACCINATION, OR TB TEST REQUIREMENTS

Whenever a Medical Staff member or APP/AHP fails to comply with immunization, vaccination, and/or TB test requirements as set forth in the Communicable Disease Screening for Medical Staff Policy, the practitioner shall be notified in writing. Thereafter, failure to complete the requirement(s) by the specified deadline will result in automatic suspension of clinical privileges. If a practitioner's clinical privileges remain suspended for more than sixty (60) days, they will be deemed to have voluntarily resigned from the Medical Staff and/or relinquished their clinical privileges.

7.3.7 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

Failure without good cause to appear and satisfy the requirements of Section 12.6 (special appearances) will result in the automatic suspension of clinical privileges until such time as the practitioner attends the special meeting. If the practitioner does not attend the special meeting within thirty (30) days of automatic suspension, the practitioner will be deemed to have voluntarily resigned from the Medical Staff and/or relinquished clinical privileges.

7.3.8 MEDICAL EXECUTIVE COMMITTEE DELIBERATIONS

As soon as practicable after the effective date of an automatic suspension or restriction under Paragraphs 7.3.1 (licensure action), 7.3.2 (DEA action), 7.3.3 (federal health care program action), or 7.3.6 (immunization requirements), the Medical Executive Committee shall convene to review and consider the facts and may recommend such further corrective action as it deems appropriate. The Medical Executive Committee review shall not address the propriety of the licensure, DEA action, or federal health care program action, but instead shall address what action should be taken by the Medical Staff. There is no need for the Medical Executive Committee to act on automatic suspensions for failure to maintain professional liability insurance (Paragraph 7.3.4) or failure to pay dues (Paragraph 7.3.5). Members whose clinical privileges are automatically revoked, terminated, or suspended and/or who have been deemed to have resigned their Medical Staff membership under this Paragraph shall be entitled to a hearing under Article VIII only if the revocation or suspension must be reported to the licensing body and/or the National Practitioner Data Bank.

7.3.9 NOTICE OF AUTOMATIC SUSPENSION OR ACTION

Notice of an automatic suspension or action shall be given to the affected member, the Medical Executive Committee, the Chief Executive Officer,

and the Board of Directors, but such notice shall not be required for the suspension to become effective. Patients affected by an automatic suspension or action shall be assigned to another member by the department chief or Chief of Staff. The wishes of the patient and affected member shall be considered, where feasible, in choosing a substitute member.

7.3.10 AUTOMATIC TERMINATION

Unless otherwise specified, if a member is automatically suspended for more than six (6) months, his or her Medical Staff membership or the affected clinical privileges (if the suspension is a partial suspension), shall be automatically terminated without the right to a hearing under Article VIII. Thereafter, reinstatement to the Medical Staff shall require a new application and compliance with the appointment procedures applicable to new applicants.

# ARTICLE VIII HEARINGS AND APPELLATE REVIEWS

## 8.1 GENERAL PROVISIONS

### 8.1.1 EXHAUSTION OF REMEDIES

If corrective action described in Paragraph 8.2 below is taken or recommended, the member must exhaust the administrative remedies afforded by these Bylaws before resorting to legal action.

### 8.1.2 DEFINITIONS

For purposes of this Article, the term "member" may include "applicant," as applicable under the circumstances, and references to “the Medical Executive Committee” may include “the Board of Directors,” if the Board of Directors was the body that rendered the decision that resulted in a hearing being requested.

### 8.1.3 FINAL ACTION

Recommended corrective actions described in Paragraph 8.2 shall become final only after the hearing and appellate rights set forth in these Bylaws have either been exhausted or waived.

### 8.1.4 SUBSTANTIAL COMPLIANCE

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

### 8.1.5 INTRA-ORGANIZATIONAL REMEDIES

The hearing and appeal rights established in these Bylaws are strictly “judicial” rather than “legislative” in structure and function. Judicial Review Committees have no authority to adopt or modify rules and standards or to decide questions about the merits or substantive validity of Bylaws, Rules and Regulations, or policies. However, the Medical Executive Committee, in conjunction with the Board of Directors may, in its discretion, entertain challenges to the merits or substantive validity of Bylaws, Rules and Regulations, or policies and decide those questions. If the only issue in a case is whether a Bylaw, Rule, Regulation, or policy is lawful or meritorious, the member is not entitled to a hearing or appellate review. In such cases, the member must submit his or her challenge first to the Medical Executive Committee and only thereafter may he or she seek judicial intervention in a court of law or equity.

## 8.2 GROUNDS FOR HEARING

Except as otherwise specified in these Bylaws, when the Medical Executive

Committee has recommended or taken any one or more of the following actions as to a member, the member may request a hearing if such action or recommendation is taken for medical disciplinary cause or reason and must be reported to the member's licensing board under California Business and Professions Code Section 805 or any successor statute or to the National Practitioner Data Bank:

(a) Denial of application for initial appointment or reappointment to the Medical Staff.

(b) Summary suspension of Medical Staff membership and/or clinical privileges for a period in excess of 14 days.

(c) Revocation of Medical Staff membership and/or clinical privileges.

(d) Denial of requested clinical privileges.

(e) Involuntary reduction or restriction of clinical privileges for a cumulative total of thirty (30) days or more in any twelve (12) month period.

(f) Involuntary imposition of special limitations on Medical Staff membership or the exercise of clinical privileges, including but not limited to mandatory consultation, proctoring requirements (except for proctoring incidental to Provisional Staff status and new clinical privileges), or a co-admission requirement, to the extent such limitation affects the member's exercise of clinical privileges for a cumulative total of 30 or more days in a 12-month period.

(g) Any other disciplinary action or recommended action that must be reported to the Medical Board of California or the National Practitioner Data Bank.

## 8.3 REQUEST FOR HEARING

### 8.3.1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which the Medical Executive Committee has taken or recommended an action as set forth in Paragraph 8.2, the Medical Executive Committee shall give the member prompt notice of the recommendation or action and of the right to request a hearing pursuant to Paragraph 8.3.2. The notice shall:

(a) Describe the action that has been taken or recommended.

(b) State the reasons for the action. (When appropriate, a supplemental notice of charges may be provided subsequently, in the event a hearing is requested.)

(c) Advise the member of the right to request a hearing within thirty (30) days following receipt of the notice.

(d) Summarize the member's rights in the hearing under the Bylaws.

(e) In the event the action or recommendation is of a type that must be reported to the Medical Board of California pursuant to Section 805 of the Business and Professions Code if implemented, explain that the action or recommended action, if implemented, will be so reported.

(f) If the action or recommendation 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, state that the action, if implemented, will be reported to the National Practitioner Data Bank.

8.3.2 REQUEST FOR HEARING

The member shall have 30 days following receipt of notice of such action to request a hearing. The request for hearing shall be in writing addressed to the Chief of Staff and must be postmarked no later than 30 days from the date of receipt of the notice. The request will be considered to be received in a timely manner if postmarked or personally delivered to the Medical Staff Services Department within the time limit. The member shall state, in writing, his or her intentions with respect to attorney representation at the hearing in the request for hearing. 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 to have accepted the recommendation or action involved.

8.3.3 NOTICE OF HEARING

Upon receipt of a hearing request, the Medical Executive Committee shall schedule a hearing and, at least 30 days prior to the hearing, give notice to the member of the time, place, and date of the hearing. The date of the commencement of the hearing shall be not less than 30 days from the date of the notice of hearing, or more than 60 days from the date the Chief of Staff receives the hearing request; provided, however, that when the request is received from a member who is under summary suspension, the hearing shall commence within 45 days from the date of receipt of the hearing request. A hearing is deemed to commence upon voir dire of the Judicial Review Committee members. The parties and the Judicial Review Committee shall cooperate with each other in scheduling additional hearing sessions, as necessary, to complete the process as soon as practicable. Notwithstanding the above timeframes, the parties may agree to extensions, or the Hearing Officer may grant extensions on a showing of good cause. Good cause shall include, but not necessarily be limited to, failure by the other party to comply with the discovery provisions of these Bylaws. The notice of hearing shall contain the names of the witnesses, so far as then reasonably known or anticipated, who are expected to testify on behalf of the Medical Executive Committee. This list shall be updated, as necessary and appropriate, at least 10 days prior to the commencement of the hearing.

8.3.4 NOTICE OF CHARGES

The Medical Executive Committee shall provide the member with a written notice of reasons or charges specifying the acts or omissions with which the member is charged. This notice shall include a list of any cases that are anticipated to be presented and discussed in support of the charges at the hearing, if this information has not been provided earlier.

8.3.5 JUDICIAL REVIEW COMMITTEE

When a hearing is requested, the Medical Executive Committee shall appoint a Judicial Review Committee composed of no fewer than three (3) members of the Active Staff. The members of the Judicial Review Committee shall be unbiased and shall not have acted as accusers, investigators, fact-finders, or initial decision-makers in the same matter; shall gain no direct financial benefit from the outcome; and shall not be in direct economic competition with the member who requested the hearing. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving on the Judicial Review Committee. When feasible, the Judicial Review Committee shall consist of at least one-member practicing in the same specialty as the affected member. If it is not feasible to appoint a Judicial Review Committee from the Active Staff, the Medical Executive Committee may appoint members from other Staff categories or practitioners who are not members of the Medical Staff. In the event practitioners who are not members of the Medical Staff are appointed to the Judicial Review Committee, they shall be appointed 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. The Medical Executive Committee shall designate the chair. The Medical Executive Committee also has the discretion to enter into an agreement with the member to hold the hearing before a mutually acceptable arbitrator or arbitrators. Failure or refusal to exercise this discretion shall not constitute a breach of the Medical Executive Committee's responsibility to provide a hearing. The Medical Executive Committee may delegate to the Chief of Staff or another member of the Medical Executive Committee the decision-making authority for issues addressed in this Paragraph.

8.3.6 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 a waiver of the right to a hearing and appeal regarding the Medical Executive Committee’s recommendation or action and shall be deemed to constitute voluntary acceptance of the recommendation or action involved.

8.3.7 CONDUCT OF THE HEARING

At the discretion of the Medical Executive Committee, all hearing sessions may be conducted by virtual videoconference platform instead of in person.

In that circumstance, all hearing participants, including the parties and their legal counsel, if any, the Hearing Officer, the Judicial Review Committee members or arbitrator(s), the witnesses, and the court reporter, may attend the hearing sessions remotely, so long as all participants can see each other, can hear and be heard during the proceedings, and have access to all evidence admitted at the hearing, either by electronic means or hard copies. The Hearing Officer has authority and discretion to rule on questions regarding the implementation of the virtual proceedings.

8.3.8 POSTPONEMENTS AND EXTENSIONS

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

8.4 HEARING PROCEDURE

8.4.1 PREHEARING PROCEDURE

(g) If either side to the hearing requests in writing a list of witnesses, within 15 days of such request, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. Failure to produce this information or to update it as necessary and appropriate at least 10 days before the commencement of the hearing shall constitute good cause to grant a continuance. In such situations, the Hearing Officer shall issue a written statement to that effect.

(h) The member shall have the right as soon as practicable after the receipt of the request for hearing to inspect and copy at his or her expense any documentary information that is relevant to the charges that the Medical Executive Committee has in its possession or under its control. As soon as practicable after receipt of the Medical Executive Committee's request, the Medical Executive Committee shall have the right to inspect and copy at its expense any documentary information that is relevant to the charges that the member has in his or her possession or control. 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 practitioners other than the member.

The Hearing Officer shall consider and rule upon any dispute or controversy concerning a request for access to information and may impose any safeguards required to protect the peer review process and to further the interests of justice. When ruling upon requests for

access to information and determining the relevancy thereof, the Hearing Officer shall consider, among other factors, the following:

(i) Whether the information sought may be introduced to support or defend the charges;

(ii) The exculpatory or inculpatory nature of the information sought, if any; i.e., whether there is a reasonable probability that the result of the hearing would be influenced significantly by the information if received into evidence;

(iii) The burden imposed on the party in possession of the information sought, if access is granted;

(iv) Any previous requests for access to information submitted or resisted by the parties to the same proceeding; and

(v) Whether information sought is advisory or deliberative, rather than factual, and whether its disclosure would intrude on privacy rights or otherwise threaten the frank and open exchange of ideas in the process by which peer review decisions or policies are formulated.

In addition to the discovery of documents as provided above, each party shall be entitled to receive a copy of all documents anticipated to be introduced at the hearing. Failure of a party to produce these materials or to update them as necessary and appropriate at least 10 days before the commencement of the hearing shall constitute good cause to grant a continuance or to limit introduction of any documents not provided to the other party.

(i) It shall be the duty of the member and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing.

8.4.2 REPRESENTATION

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, and/or character. If the member elects not to be represented by an attorney at the hearing, the Medical Executive Committee shall not be so represented. Any party may consult with legal counsel for the purpose of preparing for any aspect of the hearing outside the hearing sessions. In the absence of legal counsel, the member and the Medical Executive Committee may be represented at the hearing only by a practitioner licensed to practice in the State of California who is not also an attorney.

### 8.4.3 HEARING OFFICER

The Medical Executive Committee shall appoint a Hearing Officer to preside over the hearing. The Hearing Officer shall be an attorney-at-law qualified to preside over a quasi-judicial hearing, but an attorney regularly utilized by the Hospital for legal advice regarding its affairs and activities shall not be eligible to serve as Hearing Officer. The Hearing Officer must not act as a prosecuting officer or as an advocate and shall gain no direct financial benefit from the outcome of the hearing. 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 pertaining to matters of law, procedure, or the admissibility of evidence. If the Hearing Officer determines that either side is not proceeding in an efficient and expeditious manner, he or she may take such discretionary action as seems warranted by the circumstances. The Hearing Officer may participate in the deliberations of the Judicial Review Committee and be a legal advisor to it but shall not be entitled to vote.

### 8.4.4 EXAMINATION FOR BIAS

Prior to the commencement of the evidentiary portion of the hearing, the parties shall have a reasonable opportunity to question the Judicial Review Committee members and the Hearing Officer and have the right to challenge the appointment of any Judicial Review Committee member or the Hearing Officer based on the criteria for service set forth in the Bylaws. The Hearing Officer shall establish the procedure by which this right may be exercised, which may include requirements that questions be proposed in writing in advance of the hearing and be presented by the Hearing Officer. The Hearing Officer shall rule on any challenges in accordance with applicable legal principles defining standards of impartiality for hearing panels and hearing officers in proceedings of this type.

### 8.4.5 RECORD OF THE HEARING

A record of the hearing, and the pre-hearing proceedings if deemed appropriate by the Hearing Officer, by means of a shorthand reporter shall be made. The cost of attendance of the shorthand reporter shall be borne by the Hospital, but the cost of preparation 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 be taken only under oath administered by any person lawfully authorized to administer such oath.

### 8.4.6 RIGHTS OF THE PARTIES

Both sides to the hearing shall have the right to be provided with all

information made available to the Judicial Review Committee and to submit a written statement at the close of the presentation of evidence. Within reasonable limitations, both sides may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who testify 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. At its discretion, the Judicial Review Committee may request or permit both sides to file written arguments.

8.4.7 ADMISSIBILITY OF EVIDENCE

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 shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. The Judicial Review Committee may present questions to the witnesses or request additional witnesses if it deems such action appropriate.

8.4.8 BURDENS OF PRESENTING EVIDENCE AND PROOF

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. The burden of proof during the hearing shall be as follows:

A member or applicant requesting the hearing to challenge a recommendation to deny an application for appointment to the Medical Staff or application for any initial or additional clinical privileges shall have the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that he or she is sufficiently qualified to be granted such membership or privileges at the Hospital. This burden requires the production of information that allows for adequate evaluation and resolution of reasonable doubts concerning the member’s current qualifications. The member or applicant shall not be permitted to introduce information not produced upon the request of any committee or person on behalf of the Medical Staff during the application process unless the member or applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

Except as provided above, the Medical Executive Committee shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that its recommendation is reasonable and warranted and that any corrective action was reasonable and warranted at the time it was imposed and/or continued. The term "reasonable and warranted" means within the range of alternatives reasonably open to the Medical Executive Committee under the circumstances, and not necessarily that the action or

recommendation is the only measure or the best measure that could have been taken or formulated in the opinion of the Judicial Review Committee. If the Judicial Review Committee finds, based on the evidence presented at the hearing, that the action being challenged is not within the range of reasonable and warranted alternatives open to the Medical Executive Committee, the Judicial Review Committee may recommend a different result, which may be either more adverse or less adverse to the member than the action that prompted the hearing.

#### 8.4.9 ADJOURNMENT AND CONCLUSION

The Hearing Officer may adjourn and reconvene the hearing without special notice, with due consideration for reaching an expeditious conclusion to the hearing. Upon conclusion of the presentation of oral and written evidence, the receipt of closing written arguments and/or the presentation of oral closing arguments, the hearing shall be closed. Thereafter, outside the presence of any person other than the Hearing Officer, the Judicial Review Committee shall conduct its deliberations. Once the Judicial Review Committee has concluded its deliberations, the hearing shall be finally adjourned.

#### 8.4.10 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 on any written statement, memorandum, and argument submitted in accordance with these Bylaws.

#### 8.4.11 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 and the affected member. A copy of the decision shall also be forwarded to the Chief Executive Officer and the Board of Directors. 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 decision reached. The decision and report shall include a written explanation of the procedure for appealing the decision. The decision of the Judicial Review Committee shall be considered final, following adoption by the Board of Directors, subject only to such rights of appeal or review as described in these Bylaws.

### 8.5 APPEAL

#### 8.5.1 TIME FOR APPEAL

Within 30 days after receipt of the decision of the Judicial Review Committee, the member or the Medical Executive Committee may request appellate review. A written request for such review shall be delivered to the

Chief of Staff, the Chief Executive Officer, and the other side in the hearing. If a request for appellate review is not requested within such period, the Judicial Review Committee decision shall be presented to the Board of Directors as the final decision of the Medical Staff.

8.5.2 GROUNDS FOR APPEAL

A written request for an appeal shall identify the grounds for appeal and include a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be limited to:

(j) Substantial non-compliance with the procedures required by these Bylaws or applicable law so as to deny the party a fair hearing; or

(k) The decision is not supported by substantial evidence in light of the record as a whole.

8.5.3 APPELLATE HEARING

If appellate review is requested, the Appeal Board shall, within 15 days after receipt of the notice of appeal, schedule a hearing date and cause each side to be given notice of the time, place and date of the hearing. The date for the appellate hearing shall not be less than 30 or more than 60 days from the date of such notice. The time for the appellate hearing may be extended by the Appeal Board for good cause.

8.5.4 APPEAL BOARD

The Board of Directors may sit as the Appeal Board, or it may appoint an Appeal Board, which shall be composed of not less than three (3) members of the Board of Directors. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person did not take part in a prior hearing on the same matter and no conflict of interest otherwise exists. 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.

8.5.5 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. However, the Appeal Board may accept additional oral and written evidence, subject to a showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the Judicial Review Committee hearing. The Appeal Board shall also have the discretion to remand the matter to the Judicial Review Committee for the taking of further evidence or for clarification or reconsideration of the Judicial Review Committee's decision. In such instances, the Judicial Review Committee shall report back to the

Appeal Board within such reasonable time limits as the Appeal Board sets. Each party shall have the right to be represented by legal counsel in connection with the appeal, whether or not the other side is so represented, to present a written statement in support of his or her position on appeal, and to personally appear and make oral argument. The Appeal Board may conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The Appeal Board shall present to the Board of Directors its written recommendations as to whether the Board of Directors should affirm, modify, or reverse the Judicial Review Committee decision or remand the matter to the Judicial Review Committee for further review and decision.

8.5.6 DECISION

(l) Within 30 days after the conclusion of the appellate review proceeding, the Board of Directors shall render a decision in writing specifying the reasons for the action taken and shall forward copies thereof to each side involved in the hearing.

(m) The Board of Directors may affirm, modify, or reverse the decision of the Judicial Review Committee or remand the matter to the Judicial Review Committee for reconsideration. If the matter is remanded to the Judicial Review Committee for further review and recommendation, the Judicial Review Committee shall promptly conduct its review and make its recommendations to the Board of Directors.

8.5.7 RIGHT TO ONE HEARING

No member shall be entitled to more than one evidentiary hearing and one appellate review on any adverse action or recommendation upon which a hearing may be requested under these Bylaws. This applies without regard to whether such recommendation or action was taken by the Medical Executive Committee or the Board of Directors, or a combination of acts of such bodies.

8.6 EXCLUSIVE CONTRACT HEARING RIGHTS

In order to qualify or exercise clinical privileges in any Department that is subject to an exclusive contract, a practitioner must be a member of the Medical Staff (with the exception of AHPs/APPs and physicians working in a locums capacity for the contracted entity), hold the applicable clinical privileges, and be an employee, partner, contractor, or associate (hereinafter “affiliate”) of the group, individual, or entity that holds the exclusive contract (hereinafter “contracted entity”). Upon (1) the departure of the affiliate from the contracted entity, or (2) the termination of the exclusive contract with the Hospital, whichever occurs first, when all of the affiliate’s clinical privileges are encompassed by the exclusive contract, the affiliate shall be deemed to have voluntarily resigned from the Medical Staff and to have voluntarily relinquished his or her clinical privileges. Such a resignation and

relinquishment shall not entitle the practitioner to the procedural rights described in Article VIII. To the extent the practitioner holds clinical privileges beyond those encompassed by the exclusive contract, his or her departure from the contracted entity or the termination of the exclusive contract will not result in the practitioner's voluntary resignation from the Medical Staff and the practitioner's remaining clinical privileges will remain intact.

## 8.7 REPORTING REQUIREMENTS

The Authorized Representative shall report adverse actions to the licensing body and National Practitioner Data Bank as required by law.

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# ARTICLE IX OFFICERS AND

# MEMBER-AT-LARGE

## 9.1 OFFICERS OF THE MEDICAL STAFF

The officers shall be the Chief of Staff, the Vice Chief of Staff, and the Secretary/Treasurer.

## 9.2 QUALIFICATIONS OF OFFICERS AND MEMBER-AT-LARGE OF CREDENTIALS COMMITTEE

Officers must be members of the Active Staff at the time of nomination and election and must remain members of the Active Staff in good standing during their term of office. Officers may not simultaneously hold leadership positions as an officer or department chief on another hospital medical staff.

In addition, each candidate must fulfill the following criteria:

### 9.2.1 CHIEF OF STAFF

(i) Previous member of the Medical Executive Committee.

(ii) Current member in good standing of the Active Staff for at least 3 consecutive years preceding the election.

### 9.2.2 VICE CHIEF OF STAFF

Served as a member in good standing of the Active Staff for at least 3 consecutive years preceding the election.

### 9.2.3 SECRETARY/TREASURER

Served as a member in good standing of the Active Staff for at least 2 consecutive years preceding the election.

### 9.2.4 MEMBER-AT-LARGE OF CREDENTIALS COMMITTEE

Served as a member in good standing of the Active Staff for at least 2 consecutive years preceding the election.

## 9.3 DISCLOSURE OF INTERESTS

All appointees or nominees for election to the position of Medical Staff officer or the Member-at-Large of the Credentials Committee shall, at least 45 days before the date of the election, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their

activities or responsibilities on behalf of the Medical Staff. That information shall be available to the general Medical Staff through the Medical Staff Services Department. Affiliations or relationships to be disclosed shall include, but not be limited to, service as medical directors of a hospital unit, membership in a Hospital-contracted group, medical directorships, membership on the board of directors of primary insurance groups, service as a medical staff officer at another hospital, receipt of payments from other hospitals, and other similar affiliations or relationships. Disclosure shall include a statement as to whether the physician receives an annual amount in connection with the disclosed affiliation or relationship between $7,500 to $30,000, between $30,001 to $75,000, or over $75,000.

## 9.4 NOMINATIONS AND ELECTIONS

### 9.4.1 NOMINATIONS

The Medical Staff election shall be held biannually. By September 15, the Credentials Committee, serving as the Nominating Committee, shall notify all members of the Active Staff that it is accepting nominations for Medical Staff officers and the Member-at-Large of the Credentials Committee. The announcement shall be published electronically using confidential email.

Active Staff members wishing to become candidates must present a written notice of such to the Credentials Committee that must contain the endorsement of three (3) members of the Active Staff. Nominations must be submitted to the Credentials Committee by October 1.

The Credentials Committee shall select a slate of candidates for each of the following positions as necessary:

Chief of Staff

Vice Chief of Staff

Secretary/Treasurer

Member-at-Large of the Credentials Committee

By November 1, the Nominating Committee's slate, as well as the names of any other qualified candidate(s), shall be published electronically using confidential email.

### 9.4.2 ELECTION

By November 15, secret ballots shall be due by confidential secured electronic voting program. In the event no candidate receives a majority of the votes cast, a run-off election shall be held between the two (2) candidates receiving the greatest number of votes. This run-off election will be conducted using the same electronic method as the initial election. The Chief of Staff shall present the results of the election at the December

quarterly Medical Staff meeting and shall send a notice of the election results to the Active Staff.

## 9.5 TERM OF OFFICE

All terms shall run from January 1 through December 31. The Chief of Staff, Vice Chief of Staff, Secretary/Treasurer, and Credentials Committee Member-at-Large shall serve a term of two (2) years and may run for a second term if nominated by the Nominating Committee. The Credentials Committee Member-at-Large may serve for additional terms beyond a second term if nominated by the Nominating Committee.

## 9.6 VACANCIES IN OFFICE

Vacancies in office occur upon death or disability, resignation, removal of the officer, or the loss of membership on the Active Staff. A vacancy in the position of Chief of Staff shall be filled by the Vice Chief of Staff for the remainder of the elected term. If there is a vacancy in the position of Vice Chief of Staff, the position shall be filled by the Secretary/Treasurer for the remainder of the elected term. Vacancies in positions other than the Chief of Staff and Vice Chief of Staff shall be filled for the remainder of the elected term by appointments made by the Medical Executive Committee.

## 9.7 RECALL OF OFFICERS

Any Medical Staff officer or the Member-at-Large of the Credentials Committee 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 a two-thirds (2/3) vote of the Medical Executive Committee or may be initiated by a petition signed by at least one-third (1/3) of the Active Staff. Prior to balloting, a special meeting shall be called to discuss the recall. Recall shall require a two-thirds (2/3) vote of the Active Staff members. Voting shall be done by secret ballot published by email.

## 9.8 DUTIES OF OFFICERS

### 9.8.1 CHIEF OF STAFF

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

(a) Serving as chair of the Medical Executive Committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;

(b) Serving as a member of the Credentials Committee;

(c) Serving as an ex-officio member of all other staff committees with a vote;

(d) Interacting with the Chief Executive Officer and Board of Directors in all matters of mutual concern within the Hospital;

(e) Appointing, in consultation with the Medical Executive Committee, members for all standing and special Medical Staff, liaison, or multi-disciplinary committees, except where otherwise provided by these Bylaws and, except where otherwise indicated, appointing the chairs of these committees;

(f) Being responsible for the functioning of the Medical Staff organization of the Hospital and keeping, or causing to be kept, a careful supervision over clinical work in all departments;

(g) Representing the view and policies of the Medical Staff to the Board of Directors and to the Chief Executive Officer;

(h) Being a spokesperson for the Medical Staff for internal and external professional and public relations and serving as communications officer or delegating such spokesperson and communications duties;

(i) Performing such other functions as may be assigned to him or her by these Bylaws, the Medical Staff, or by the Medical Executive Committee;

(j) In the interim between Medical Executive Committee meetings, perform those responsibilities of the Committee that, in his or her reasonable opinion, must be accomplished prior to the next regular or special meeting of the Medical Executive Committee; and

(k) Serving on liaison committees with the Board of Directors and administration as well as outside licensing or accreditation agencies;

(l) Appointing a physician to serve as the Medical Staff representative to the California Medical Association's Organized Medical Staff Section; and

(m) In conjunction with the Medical Executive Committee, reviewing and approving outside contracted services.

9.8.2 <u>VICE CHIEF OF STAFF</u>

In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all the duties and have the authority of the Chief of Staff. He or she shall be a member of the Medical Executive Committee, Credentials Committee, ex-officio non-voting member of the Medical Staff Quality Committee, and a member of the Hospital Quality Council. He or she shall automatically succeed the Chief of Staff when the latter fails to serve for any reason. He or she shall also perform such duties of supervision as may be assigned by the Chief of Staff.

### 9.8.3 SECRETARY/TREASURER

The Secretary/Treasurer shall be a member of the Medical Executive Committee. In the absence of the Chief of Staff and the Vice Chief of Staff, he or she shall temporarily assume all the duties and have the authority of Chief of Staff. The Secretary/Treasurer shall also be responsible for receiving and safeguarding all funds of the Medical Staff, presenting the quarterly general Medical Staff meeting minutes for approval, submitting an annual financial report at the December quarterly general Medical Staff meeting, and attending to all appropriate correspondence and notices on behalf of the Medical Staff.

## 9.9 DUTIES OF CREDENTIALS COMMITTEE MEMBER-AT-LARGE

The Credentials Committee Member-at-Large shall serve as a voting member of the Credentials Committee.

# ARTICLE X

# CLINICAL DEPARTMENTS

## 10.1 ORGANIZATION OF CLINICAL DEPARTMENTS

The Medical Staff shall be organized into 11 clinical departments.

1. Department of Anesthesiology
2. Department of Cardiology
3. Department of Emergency Medicine
4. Department of Family Medicine
5. Department of Medicine
6. Department of Obstetrics and Gynecology
7. Department of Orthopedics & Physical Rehabilitation
8. Department of Pediatrics
9. Department of Pathology
10. Department of Radiology
11. Department of Surgery

Each department shall have a chief, who shall have the overall authority, duties, and responsibilities specified in Paragraph 10.2.5. When appropriate, the Medical Executive Committee may recommend to the Medical Staff the creation, elimination, modification, or combination of departments.

Optional sections may be formed within a clinical department.

## 10.2 CLINICAL DEPARTMENTS

### 10.2.1 ASSIGNMENT TO A CLINICAL DEPARTMENT

Each member shall be assigned membership in at least one clinical department. Written application may be made for membership to more than one clinical department, if so desired by the applicant. A member shall have voting rights in the primary clinical department in which he or she is a member.

### 10.2.2 FUNCTIONS OF CLINICAL DEPARTMENTS

The general functions of each clinical department shall include:

(a) 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 and for the purpose of improving care. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work is subject to such review is a member of that department;

(b) Recommending to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the department, and activity levels necessary to qualify for the Active and Courtesy Staff;

(c) Evaluating and making appropriate recommendations regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within the department;

(d) Conducting, participating in, and making recommendations regarding continuing education programs pertinent to department-specific practice;

(e) Reviewing and evaluating departmental adherence to: (1) Medical Staff policies and procedures and (2) sound principles of clinical practice;

(f) Coordinating patient care provided by the clinical department's members with nursing and ancillary patient care services;

(g) Submitting written reports to the Medical Executive Committee concerning: (1) the department's review and evaluation activities, action 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;

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

(i) Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified;

(j) Accounting to the Medical Executive Committee for all professional and Medical Staff administrative activities within the department;

(k) Appointing such committees as may be necessary or appropriate to conduct clinical department functions; and

(l) Formulating recommendations for clinical department rules and regulations reasonably necessary for the proper discharge of its responsibilities, subject to the approval by the Medical Executive

Committee.

10.2.3 QUALIFICATIONS OF CLINICAL DEPARTMENT CHIEF AND VICE CHIEF

Each clinical department shall have a chief and vice chief who shall be members of the Active Staff and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the department. Department chiefs must be certified by an appropriate specialty board or must demonstrate comparable competence as determined by the Medical Executive Committee. A physician in the specialties of anesthesiology, emergency medicine, pathology, and radiology must be a current member of the contracted group to be elected and/or serve as chief or vice chief. The chief and vice chief may not simultaneously hold leadership positions as an officer or department chief on another hospital medical staff.

10.2.4 ELECTION OF CLINICAL DEPARTMENT CHIEF AND VICE CHIEF

Elections shall be held in alternating years.

The departments of anesthesiology, obstetrics and gynecology, orthopedics and physical rehabilitation, pathology, and surgery shall conduct elections in even-numbered years.

The departments of cardiology, emergency medicine, family medicine, medicine, pediatrics, and radiology shall conduct elections in odd-numbered years.

At least forty-five (45) days prior to the final department meeting of the year, a notice will be published to the Active Staff members that nominations are being accepted. Nominations will be solicited and open for a period of fifteen (15) days. A qualified Active Staff member may nominate himself or herself. A nomination made by another Staff member will be verified to validate the candidate accepts the nomination. The names of all qualified candidates will be published thirty (30) days prior to the final department meeting. Fifteen (15) days prior to the final department meeting, voting will be conducted via confidential secured electronic voting program. The results of the election will be announced at the final meeting of the year.

Each candidate shall be elected by majority vote. In the event no candidate receives a majority of the votes cast, a run-off election shall be held between the two candidates receiving the greatest number of votes. If required, the run-off election shall be conducted in the same electronic method as the initial election.

Should any of these elections not be held within the specified period, the Chief of Staff shall make interim appointments to these posts. The outgoing department chief shall continue serving until an appointment has been made, or until the election is held. The department shall have 45 days from the last day of the Medical Staff year to call a meeting and conduct an election to elect a new chief or vice chief. If a new chief or vice chief is not

elected at the subsequent meeting, or a meeting is not held within the time specified, the interim appointment(s) made by the Chief of Staff shall stand.

10.2.5 DUTIES OF CLINICAL DEPARTMENT CHIEF

Each department chief shall be responsible for the following:

(m) Acting as presiding officer at clinical department meetings;

(n) Representing the department and reporting to the Medical Executive Committee and to the Chief of Staff regarding all professional and administrative activities within the department;

(o) Generally monitoring 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 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;

(p) Developing and implementing clinical department programs for proctoring, retrospective patient care review, ongoing monitoring of practice, credentials review and privilege delineation, medical education, utilization review, and quality assessment and improvement;

(q) Serving as a member of the Medical Executive Committee, providing guidance on the overall medical policies of the Medical Staff and the Hospital, and making specific recommendations and suggestions regarding the department;

(r) Transmitting to the Medical Executive Committee the department's recommendations concerning practitioner appointment and classification, reappointment, and clinical privileges, criteria for clinical privileges, monitoring of specified services, corrective action with respect to persons with clinical privileges in the department, and recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services within the department, and for space and other resources needed by the department;

(s) Endeavoring to enforce the Medical Staff Bylaws and policies and procedures within the department;

(t) Implementing, within the department, appropriate actions taken by the Medical Executive Committee;

(u) Participating in every phase of administration of the department, including cooperation with the nursing service and the Hospital administration in matters such as personnel, supplies, special regulations, standing orders and techniques, integration of the

department into the primary functions of the Hospital, and coordination and integration of interdepartmental and intradepartmental services;

(v) Assisting in the preparation of reports, including budgetary planning, pertaining to the department, as may be required by the Medical Executive Committee;

(w) Providing orientation and continuing education to all persons in the department or service;

(x) Assessing and recommending to administration those off-site resources needed for patient care, treatment, and services not provided by the department or the Hospital;

(y) Developing and implementing policies and procedures to guide and support the provision of care, treatment, and services within the department;

(z) Determining the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services; and

(aa) Performing 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.

10.2.6 TERM OF OFFICE

The term of office shall be for a two-year period, commencing January 1 through December 31 of the following year, or until a successor is chosen, unless the chief shall sooner resign, be removed from office, or lose Medical Staff membership or clinical privileges in that clinical department, or lose membership on the Active Staff. Clinical department chiefs shall be eligible to serve multiple terms.

10.2.7 VACANCIES

In the event of a vacancy in the position of clinical department chief, or in the event of his or her prolonged disability, the vice chief will assume the duties of the position and the vice chief shall become the chief of the department. In that event, a new vice chief will be elected by the department. In the event of a vacancy or prolonged disability of both the chief and the vice chief, a new chief and vice chief shall be elected by the department consistent with the provisions of Paragraph 10.2.4.

10.2.8 REMOVAL

Any clinical department chief or vice chief may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, serious acts of moral turpitude, or failure to continuously meet the

requirements of office. Recall of a chief or vice chief may be initiated by a two-thirds (2/3) vote of the Medical Executive Committee or by a petition signed by at least one-third (1/3) of the Active Staff members of the department. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds (2/3) vote of the Active Staff members of the applicable department. Voting shall be at a special meeting or by email ballot.

# ARTICLE XI

# COMMITTEES

## 11.1 DESIGNATION OF COMMITTEES

Committees of the Medical Staff shall be known as "standing" and "special" committees. Except as otherwise provided herein, committees act in an advisory capacity and make regular reports to the Medical Executive Committee.

Unless otherwise provided in these Bylaws or in a committee protocol, at the beginning of the staff year the Chief of Staff shall appoint the chairs of all standing committees. Active Staff members will be given the option to volunteer for committee membership. Appointments will be made by the Chief of Staff as necessary, in consultation with the department chief and committee chair, to complete the necessary committee composition. The Chief of Staff shall appoint the chair of any ad hoc or special committee at the time such committee is created.

The Chief of Staff may request the chairs of standing committees to attend Medical Executive Committee meetings. In such cases, the committee chair shall attend the Medical Executive Committee meetings in an ex-officio, non-voting capacity.

The Chief of Staff may appoint non-Medical Staff members to any committee to which he or she may make appointments. Such personnel shall only vote and be counted for purposes of determining a quorum if permitted by the chair or by the rules of the committee.

Unless otherwise specified in the Bylaws, the Chief of Staff and the Chief Executive Officer (or his or her designee) shall be ex-officio members of all Medical Staff committees; the Chief of Staff shall serve with a vote and the Chief Executive Officer (or designee) shall serve without a vote.

## 11.2 COMMITTEE PROTOCOLS AND CHARTERS

Written protocols or charters may be developed by a committee to assist it in fulfilling its functions. Such protocols or charters shall include the composition, duties, quorum, and meeting frequency. Committee protocols and charters shall be in compliance with Joint Commission and Title 22 standards, recommended by the committee, and approved by the Medical Executive Committee and the Board of Directors, and shall be reviewed on a triennial basis.

## 11.3 VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee was made.

## 11.4 REMOVAL

The Chief of Staff may remove members of committees, subject to consultation

with and approval of the Medical Executive Committee. This Article does not apply to members serving on committees by virtue of elected positions.

11.5 STANDING COMMITTEES

The standing committees of the Medical Staff shall be as follows:

BIOETHICS COMMITTEE

CANCER COMMITTEE

CREDENTIALS COMMITTEE (includes nominating and bylaws functions)

HEALTH INFORMATION MANAGEMENT (HIMS)

INFECTION CONTROL/PHARMACY & THERAPEUTICS

INTERDISCIPLINARY PRACTICE COMMITTEE

MEDICAL EXECUTIVE COMMITTEE

MEDICAL STAFF QUALITY COMMITTEE

PHYSICIAN WELL BEING COMMITTEE

CRITICAL CARE COMMITTEE

O.R. COMMITTEE

NEONATAL / PEDIATRIC CARE COMMITTEE

BLOOD AND TISSUE REVIEW COMMITTEE

UTILIZATION REVIEW COMMITTEE

11.6 MEDICAL EXECUTIVE COMMITTEE

11.6.1 REPRESENTATION

The Medical Executive Committee shall consist of the Chief of Staff, immediate past Chief of Staff, Vice Chief of Staff, Secretary/Treasurer, and the chiefs of all clinical departments. Other specialty representatives may be invited to attend when appropriate. The Chief of Staff shall serve as chair.

The Chief Executive Officer (or designee), Chief Medical Officer, Chief Nursing Executive, Vice President of Quality/Risk Management, and a representative of the Board of Directors shall be ex-officio non-voting members.

11.6.2 SPECIFIC DUTIES AND RESPONSIBILITIES

The organized Medical Staff, by approval of these Bylaws, grants to the Medical Executive Committee the primary authority and responsibility over activities related to the functions of self-governance, including the organized Medical Staff structure, credentialing, including membership and clinical privileges, review and action on reports of the Medical Staff committees, departments and other assigned activity groups, and performance improvement. The Medical Executive Committee may assess Medical Staff dues and authorize the use of such dues, as appropriate, for the purposes of the Medical Staff, including, without limitation, the designation and retention of independent legal counsel at the expense of the Medical Staff. The Medical Executive Committee shall carry out its duties under the auspices of the Medical Staff Bylaws, Rules and Regulations, and policies.

The Medical Executive Committee is empowered to act for the Medical Staff between meetings of the organized Medical Staff within the scope of its responsibilities.

11.6.3 REMOVAL

(a) Medical Staff Officer

A Medical Staff officer may be removed from the Medical Executive Committee only if the Medical Staff acts to remove that member from the position held as an officer, in the same manner as provided in Paragraph 9.7 for recall of officers.

(b) Department Chief

A department chief may be removed from the Medical Executive Committee only if removed from the department chief position as provided in Paragraph 10.2.8.

# ARTICLE XII

# MEDICAL STAFF MEETINGS

## 12.1 NOTICE

### 12.1.1 GENERAL MEETINGS

Written notice stating the place, day, and hour of any special meeting of the Medical Staff shall be delivered by email to Active Staff members at least forty-eight (48) hours before the date of such meeting.

### 12.1.2 CLINICAL DEPARTMENT MEETINGS

Scheduled clinical department meetings will be published stating the place, day, and hour for any meeting at which a vote will be conducted. Notice shall be delivered by email to the Active Staff members of the department at least two (2) weeks before the date of such meeting.

### 12.1.3 COMMITTEE MEETINGS

Regularly scheduled committee meetings will be published in the Medical Staff meeting calendar. Any changes in meeting dates, times, or locations will be delivered by email.

## 12.2 MEETING FREQUENCY

### 12.2.1 GENERAL MEDICAL STAFF

The Medical Staff shall hold quarterly general meetings to conduct current business. The annual meeting of the Medical Staff shall be the final quarterly meeting of the year. The new Medical Staff officers and the Credentials Committee Member-at-Large shall be announced at this meeting.

### 12.2.2 CLINICAL DEPARTMENT MEETINGS

Clinical department meetings shall occur as necessary to conduct their business. Additional meetings may be called by the chief of the department, the Medical Executive Committee, the Chief of Staff, or by written request of three (3) of the current Active Staff members of the department.

### 12.2.3 COMMITTEE MEETINGS

Committees will meet as necessary to conduct their business. Requirements for meeting frequency dictated by State or Joint Commission requirements shall be included in the individual committee protocol or charter.

## 12.3 MEETING ATTENDANCE

Active Staff shall be required to attend a minimum of 3 committee, department, and/or general Medical Staff meetings and: (a) return at least 3 attestation pages certifying that they have read the Medical Staff Newsletters; or (b) attend 3 additional committee, department, or general Medical Staff meetings during a 12-month period.

## 12.4 STAFF SUPPORT

A staff member in the Medical Staff Services Department may attend and provide staff support to any Medical Staff meeting.

## 12.5 MINUTES

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 summary of the minutes shall be forwarded to the Medical Executive Committee.

## 12.6 SPECIAL ATTENDANCE

When a member's practice or conduct is scheduled for discussion at a regular or special committee meeting or department meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice to attend shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a general indication of the issues involved. Failure without good cause to appear at any meeting with respect to which the practitioner was given such notice shall be grounds for automatic suspension under Section 7.3.7.

## 12.7 QUORUM REQUIREMENTS

No specific quorum requirements shall be required to conduct business at a general Medical Staff meeting. Clinical departments and committees (except as stated below) shall determine their own quorum requirements.

A quorum of fifty (50) percent of the voting members shall be required for Medical Executive Committee and Credentials Committee meetings. All other committee quorums, if any, shall be specified in the individual committee protocol or charter.

## 12.8 EXECUTIVE SESSION

At the call of its chair, any Medical Staff committee or department may meet in executive session, with attendance restricted to Medical Staff members, a recording secretary, and such advisors or other attendees as the chair may specifically request to attend.

# ARTICLE XIII

# PRACTITIONERS' RIGHTS

## 13.1 RIGHT TO AN AUDIENCE

Each physician on the Medical Staff has the right to an appearance before the Medical Executive Committee, with the concurrence of the Chief of Staff.

## 13.2 SPECIAL MEETINGS

Any member may call a general Medical Staff meeting upon presentation to the Medical Executive Committee of a petition signed by twenty-five (25) percent of the members of the Active Staff. The Medical Executive Committee will schedule a general Medical Staff meeting for the specific purposes addressed by the petitioners. A meeting called in this manner shall be held within 45 days of receipt of the request. No business other than that identified in the petition may be transacted.

# ARTICLE XIV REVIEW, REVISION, ADOPTION

# OF BYLAWS

## 14.1 RESPONSIBILITY

The Medical Staff shall have the responsibility to formulate, review on a periodic basis, adopt and recommend to the Board of Directors, Medical Staff Bylaws and amendments thereto.

## 14.2 PROCEDURE

Except as otherwise provided in this Article, proposed amendments to the Medical Staff Bylaws shall be considered by the Credentials Committee, serving in its capacity as the Bylaws Committee, and the Medical Executive Committee, and approved by the Medical Staff membership and by the Board of Directors. The procedures described in this Article shall be the sole method for initiation, adoption, and amendment of the Bylaws.

## 14.3 ACTION ON A BYLAWS CHANGE

The Active Staff will be notified of proposed amendments to the Bylaws by mail, email, or other electronic means at least twenty (20) days prior to a quarterly general Medical Staff meeting at which time proposed amendments will be discussed. If a proposed amendment is revised, the revised amendment shall be distributed to the Active Staff.

Adoption of amendments to the Bylaws requires fifty percent (50%) of those eligible to vote and voting. Voting shall be conducted by secret ballot using confidential secured electronic voting program. Balloting will close seven days (7 days) after the quarterly general Medical Staff meeting at which the proposed amendments were discussed.

If a proposed amendment fails to receive the required majority vote, the Medical Staff, the Medical Executive Committee, and the Board of Directors shall be notified.

## 14.4 DIRECT PROPOSAL BY MEDICAL STAFF

Voting members of the Active Staff may propose amendments to the Medical Staff Bylaws directly to the Board of Directors by petition signed by at least twenty-five percent (25%) of the Active Staff. The proposed amendments cannot contravene or be inconsistent with federal, state, or local law, regulation, or accreditation standards set forth by The Joint Commission.

Proposals to amend the Bylaws must first be communicated to the Medical Executive Committee and to the Active Staff. The proposed amendment must be

distributed at least twenty (20) days prior to a vote and a general Medical Staff meeting must be held to discuss the proposed amendments. The adoption of any proposed amendments requires a vote of two-thirds (2/3) of the Active Staff. Voting shall be conducted by secret ballot using confidential secured electronic voting program. Balloting will close seven days (7 days) general Medical Staff meeting at which the proposed amendments were discussed.

14.5 APPROVAL

These Bylaws and amendments shall be effective when approved by the Board of Directors, which approval shall not be withheld unreasonably, or automatically within sixty (60) days if no action is taken by the Board of Directors. If approval is withheld, the reasons for doing so shall be specified by the Board of Directors in writing and shall be forwarded to the Chief of Staff, the Medical Executive Committee, and the Medical Staff.

# ARTICLE XV POLICIES, RULES, AND REGULATIONS

## 15.1 MEDICAL EXECUTIVE COMMITTEE AUTHORITY

The Medical Executive Committee shall have the authority to establish policy as appropriate to conduct the routine business of the Medical Staff, including but not limited to issues of credentialing and privileging, medical record completion guidelines, and Medical Staff policies, including department and committee policies.

The Medical Executive Committee initiates and adopts Rules and Regulations as it may deem necessary for the proper conduct of its work and shall review its Rules and Regulations on a periodic basis to comply with current Medical Staff practice. Adoption of such Rules and Regulations shall become effective upon approval of the Board of Directors, which approval shall not be withheld unreasonably, or automatically after sixty (60) days if no action is taken by the Board of Directors. In the latter event, the Board of Directors shall be deemed to have approved the Rules and Regulations adopted by the Medical Executive Committee.

### 15.1.1 ROUTINE REVIEW OF RULES, REGULATIONS, AND POLICIES

Medical Staff policies and Rules and Regulations shall be reviewed on a triennial basis. Applicants to and members of the Medical Staff shall be governed by such policies and Rules and Regulations as properly initiated and adopted. If there is a conflict between the Bylaws and the policies or Rules and Regulations, the Bylaws shall prevail. The mechanism described in this Article shall be the sole method for initiation, adoption, and amendment of the policies, Rules, and Regulations.

### 15.1.2 AMENDMENT TO RULES AND REGULATIONS

The Medical Executive Committee shall notify the Medical Staff of any proposed changes to the Rules and Regulations at least thirty (30) days prior to taking action.

The Medical Staff has fourteen (14) days to notify the Medical Executive Committee of any disagreement, which shall require a two-thirds (2/3) vote of the Active Staff who voted. Disagreement between the Medical Staff and the Medical Executive Committee on a proposed amendment shall be subjected to the conflict resolution process set forth in Paragraph 17.4.

If there is no disagreement, the proposed amendment to the Rules and Regulations will be submitted to the Board of Directors. Within fourteen (14) days of the Board's approval of the proposed amendments to the Rules and Regulations, notice of such approval will be sent to the Medical Staff.

In cases of a documented need for an urgent amendment to the Rules and Regulations necessary to comply with the law or regulations, the Medical Executive Committee may provisionally adopt the amendment as necessary. The Board of Directors may provisionally approve the amendment without first communicating with the organized Medical Staff. When such an urgent amendment has been adopted, the Medical Executive Committee will immediately notify the Medical Staff and the Medical Staff may review and comment on the provisional amendment retrospectively. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendment will become final. In the event of a conflict, the conflict resolution process set forth in Paragraph 17.4 will be implemented and a revised amendment may be submitted to the Board of Directors for action.

15.1.3 AMENDMENT TO MEDICAL STAFF POLICIES

The Medical Executive Committee shall be responsible for the general policies governing the Medical Staff, including department and committee protocols and charters and medical record completion guidelines. Proposed new policies or amendments to existing policies shall first be reviewed and approved by the department or committee initiating such policy in accordance with the voting requirements outlined in each department or committee protocol or charter. Proposed amendments will be forwarded to the Board of Directors for final approval. Following approval by the Board of Directors, the Medical Staff will be notified.

Active Staff may dispute amendments to policies through the conflict resolution process set forth in Paragraph 17.4.

## 15.2 MEDICAL STAFF AUTHORITY TO AMEND RULES AND REGULATIONS OR POLICIES

Voting members of the Active Staff may make proposals regarding Rules and Regulations or policies directly to the Board of Directors, by petition signed by at least twenty percent (20%) of the Active Staff. Proposals to adopt a new Rule, Regulation or policy, or an amendment to existing documents, must first be communicated to the Medical Executive Committee and to the Active Staff. The proposed amendment must be distributed at least thirty (30) days prior to a vote. Approval of the proposed amendment requires a two-thirds (2/3) vote of the Active Staff. The amendment cannot contravene or be inconsistent with federal, state, or local law, regulation, or accreditation standards set forth by The Joint Commission.

If the amendment proposed by the Medical Staff is approved by the Active Staff, the Medical Executive Committee shall consider the proposal at its next scheduled meeting. If there is agreement between the Medical Staff and the Medical Executive Committee, it will forward the proposed amendment to the Board of Directors.

If the Medical Executive Committee is not in agreement with the proposed

amendment to the Rules and Regulations and/or policy, the matter shall be subjected to the conflict resolution process set forth in Paragraph 17.4**.**

# ARTICLE XVI

# CONFIDENTIALITY, IMMUNITY, AND RELEASES

## 16.1 CONFIDENTIALITY

### 16.1.1 GENERAL

Medical Staff, department, or committee minutes, files, and records, including information regarding any Member or applicant to the Medical Staff shall, to the fullest extent permitted by law, be confidential. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the Medical Staff committee files and shall not become part of any particular patient's file or of the general Hospital records. Dissemination of such information and records shall only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff or, where no officially adopted policy exists, only with the express approval of the Medical Executive Committee or its designee.

### 16.1.2 PRESERVATION OF CONFIDENTIALITY

Members of the Medical Staff shall respect and preserve the confidentiality of all communications and information generated in connection with credentialing, peer review, and performance improvement activities as is specifically authorized by these Bylaws, the Medical Staff Rules and Regulations, or by the Medical Executive Committee. Members pledge to invoke the protection of all applicable laws, including California Evidence Code Section 1157, in legal proceedings in order to preserve the confidentiality of this information.

### 16.1.3 BREACH OF CONFIDENTIALITY

Inasmuch as effective credentialing, quality improvement, 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 records, information, discussions, or deliberations of Medical Staff departments or committees, except in conjunction with peer review activities of another health facility, 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.

## 16.2 IMMUNITY FROM LIABILITY

### 16.1.4 FOR ACTION TAKEN

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

16.1.5 FOR PROVIDING INFORMATION

Each representative of the Medical Staff and the Hospital and all third parties shall be immune, to the fullest extent permitted by law, from liability to an applicant or Staff member for damages or other relief by reason of providing information in good faith to a representative of the Medical Staff, the Hospital, or any other health-related organization concerning such person who is, or has been, an applicant to or member of the Medical Staff, or who did, or does, exercise clinical privileges or provide services at the Hospital or by reason of otherwise participating in Medical Staff credentialing, quality improvement, or peer review activities.

## 16.3 ACTIVITIES AND INFORMATION COVERED

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

(a) Application for appointment, reappointment and/or requests for clinical privileges;

(b) Corrective action;

(c) Hearings and appellate reviews;

(d) Quality improvement and peer review;

(e) Utilization review;

(f) Reports to or queries of the National Practitioner Data Bank, Medical Board of California, and/or peer review organizations; and

(g) Other Hospital, department, or committee activities related to monitoring and improving the quality of patient care and appropriate professional conduct.

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to an applicant or member’s professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or other matter that might directly or indirectly affect patient care.

## 16.4 RELEASES

Each applicant or member shall, upon request of the Medical Staff or the 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.

16.5 CUMULATIVE EFFECT

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

16.6 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 a 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, quality management, or utilization management activities including, but not limited to: (1) as a member of or witness for a Medical Staff department, committee, or Judicial Review Committee, (2) as a member of or witness for the Board of Directors 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 members 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. The indemnity set forth herein is expressly conditioned on the member's good faith belief that his or her actions and/or communications are reasonable and warranted and in furtherance of the Medical Staff's peer review, quality or performance improvement, or utilization management responsibilities, in accordance with the purposes of the Medical Staff, as set forth in these Bylaws. In no event will the Hospital indemnify a Member for acts or omissions taken in bad faith or outside of the scope of official Medical Staff duties.

## ARTICLE XVII

## GENERAL PROVISIONS

### 17.1 COMPLETING AND DOCUMENTING MEDICAL HISTORY AND PHYSICAL EXAMINATIONS

(a) The Medical Executive Committee is responsible for setting and enforcing record completion policies that are commensurate with The Joint Commission, State and Federal law, and optimal practice.

(b) A medical history and physical examination must be completed and documented by a physician, an oral-maxillofacial surgeon, or other qualified licensed individual with clinical privileges, in accordance with State law, Medical Staff, and Hospital policy on all patients.

(c) The history and physical, including all updates, must be included in the patient's medical record within twenty-four (24) hours of admission for medical admissions, and prior to surgery or a procedure requiring anesthesia services for surgical admissions. If a complete history has been recorded and physical examination performed prior to a patient's admission to the Hospital, a durable, legible copy of this report may be used in the Hospital's medical record in lieu of the admission history and physical examination, provided that the physician who performed such services is a member of the Medical Staff with clinical privileges and the history and physical was done within the past 30 days. In such instances, an interval admission note, including all additions to the history and any subsequent changes in the physical findings, must be recorded, regardless of whether there were any changes in the patient's status, within twenty-four (24) hours after admission, but prior to surgery or a procedure requiring anesthesia services.

(d) Oral surgeons, dentists, and podiatrists granted the specific privilege shall be responsible for recording a detailed history and physical relative to the dental and podiatric condition. A physician member of the Medical Staff shall be responsible for the overall medical care admitted for in-patient surgery. All patients admitted for in-patient care shall have a complete history and physical completed by a medical physician (M.D. or D.O.) member of the Medical Staff. All high-risk patients, classified as ASA Class IV, admitted for in-patient surgery shall have a complete medical history and physical completed by a physician member of the Medical Staff.

(e) AHPs/APPs may be granted the specific privilege for recording a detailed history and physical. The history must contain all the required components outlined in the Medical Staff policy regarding content of the medical record.

### 17.2 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

The Medical Executive Committee shall review and make recommendations to the

Board of Directors regarding quality of care issues related to exclusive arrangements for physician and/or professional services, prior to any decision being made, in the following situations:

(f) The decision to execute an exclusive contract in a previously open department;

(g) The decision to renew or modify an exclusive contract in a particular department; and

(h) The decision to terminate an exclusive contract in a particular department.

17.3 INTERPRETATION OF BYLAWS

When necessary, or in case of dispute, the Medical Executive Committee shall have the authority to interpret the Medical Staff Bylaws and Rules and Regulations. Such interpretation shall be final.

17.4 CONFLICT RESOLUTION

17.4.1 MANAGING CONFLICTS BETWEEN THE MEDICAL STAFF AND MEDICAL EXECUTIVE COMMITTEE

The organized Medical Staff shall engage in the conflict resolution process when significant issues arise between the Medical Staff and the Medical Executive Committee. These situations may include, but are not limited to, proposals to adopt or amend a Rule, Regulation, or policy. In the event of conflict between the Medical Executive Committee and the Medical Staff, as presented by written petition signed by at least fifty percent (50%) of the Active Staff, the following shall occur:

The Medical Executive Committee shall appoint an ad hoc committee that consists of three members of the Medical Executive Committee and three Medical Staff members to represent the petitioners. The ad hoc committee members shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the position of the Medical Staff, the Medical Executive Committee, and the safety and quality of patient care at the Hospital. Resolution at this level requires a majority vote of the Medical Executive Committee representatives and a majority vote of the non-MEC members at a meeting of the ad hoc committee.

17.4.2 MANAGING CONFLICTS BETWEEN THE MEDICAL EXECUTIVE COMMITTEE AND BOARD OF DIRECTORS

The process for managing conflict between the Medical Executive Committee and Board of Directors is set forth in the Hospital's Conflict Management Policy, which is incorporated herein.

## STANFORD HEALTHCARE –TRI-VALLEY

## MEDICAL STAFF BYLAWS

### APPROVED:

DATE: November 8, 2022
BY: Bylaws Committee

DATE: March 14, 2023
BY: Executive Committee

DATE: March 8, 2023
BY: Active Medical Staff Members

DATE: March 16, 2023
BY: Board of Directors

### AMENDMENT DATES:

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