SENECA HEALTHCARE DISTRICT

Medical Staff By-Laws

2016

Medical Chief of Staff		
Governing Board		
	Signature	*Date*

POLICY NUMBER REFERENCE: MDSTF-00B.2016

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SENECA HEALTHCARE DISTRICT

MEDICAL STAFF BYLAWS

2016

PREAMBLE

These Bylaws are adopted in order to provide for the organization of the Medical Staff of Seneca Healthcare District; to provide a framework for self-government that permits the Medical Staff to discharge its responsibilities in matters involving the quality of medical care; to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes; and to account to the Governing Body for the effective performance of Medical Staff responsibilities. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Body, and relations with applicants to and members of the Medical Staff.

Accordingly, the Bylaws address the Medical Staff's responsibility to establish criteria and standards for Medical Staff membership and privileges, and to enforce those criteria and standards; they establish clinical criteria and standards to oversee and manage quality assurance, utilization review, and other Medical Staff activities, including, but not limited to, periodic meetings of the Medical Staff, its committees, and departments and review and analysis of patient medical records; they describe the standards and procedures for selecting and removing Medical Staff officers; and they address the respective rights and responsibilities of the Medical Staff and the Governing Body, including the specific roles and responsibilities of the Medical Executive Committee, which is comprised of the Medical Executive Committee of the Whole and the Medical Executive Officers Committee, in order to best serve the Medical Staff, the Hospital, and its patients.

Finally, notwithstanding the provisions of these Bylaws, the Medical Staff acknowledges that the Governing Body must act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the hospital. In adopting these Bylaws, the Medical Staff commits to exercise its responsibilities with diligence and good faith, and in approving these Bylaws, the Governing Body commits to allowing the Medical Staff reasonable independence in conducting the affairs of the Medical Staff. Accordingly, the Governing Body will not assume a duty or responsibility of the Medical Staff precipitously, unreasonably, or in bad faith; and will do so only in the reasonable and good faith belief that the Medical Staff has failed to fulfill a substantive duty or responsibility in matters pertaining to the quality of patient care.

DEFINITIONS

ALLIED HEALTH PROFESSIONAL or AHP means an individual (other than a licensed physician, dentist or podiatrist) who exercises independent judgment within the areas of his/her professional competence and the limits established by the Governing Body, the Medical Staff, and the applicable State Practice Act; who is qualified to render direct or indirect medical, dental, or podiatric 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 Governing Body, these Bylaws, and the Medical Staff Rules. AHPs are not eligible for Medical Staff membership.

APPELLATE REVIEW BODY means the group designated pursuant to Section 12.08-5 to hear a request for appellate review properly filed and pursued by a Practitioner or the Medical Executive Officers Committee.

CHIEF EXECUTIVE OFFICER means the Administrator of the Hospital.

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

CLINICAL PRIVILEGES or **PRIVILEGES** means the permission granted to a Medical Staff member or Allied Health Professional to render specific patient services.

DATE OF RECEIPT of any notice or other communication shall be deemed to be the date such notice or communication was delivered personally to the required addressee or, if sent by mail, 72 hours after being deposited, postage prepaid, in the United States mail. [See also, definition of NOTICE and SPECIAL NOTICE, below.]

GOVERNING BODY means the board of directors. As appropriate to the context and consistent with the Hospital's Bylaws, it may also mean any Governing Body committee or individual authorized to act on behalf of the Governing Body.

HEARING COMMITTEE means the committee appointed pursuant to Section 12.05-1(a) or (b) to hear a request for an evidentiary hearing properly filed and pursued by a Practitioner.

HOSPITAL means the general acute care hospital operated by the Seneca Healthcare District for the provision of basic hospital services.

INVESTIGATION means a process specifically instigated by the Medical Executive Officers Committee to determine the validity, if any, of a concern or complaint raised against a member of the Medical Staff, and does not include activity of the Well Being Committee.

MEDICAL EXECUTIVE COMMITTEE means the Executive Committee of the Medical Staff, and is comprised of THE MEDICAL EXECUTIVE COMMITTEE OF THE WHOLE (consisting of Active Medical Staff members and other representatives as further described at Section 7.02) and the MEDICAL EXECUTIVE OFFICERS COMMITTEE (consisting of the Chief of Staff, Vice Chief of Staff, and Secretary-Treasurer.

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

MEDICAL STAFF YEAR means the period from July 1 through June 30.

NOTICE means a written communication delivered personally to the addressee or sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the Medical Staff or the Hospital. **SPECIAL NOTICE** means written communication sent by certified or registered mail, return receipt requested. [See also, definition of DATE OF RECEIPT, above.]

PARTIES mean the Practitioner who requested the hearing or appellate review and the body or bodies upon whose adverse action a hearing or appellate review request is predicated.

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

PRACTITIONER means, unless otherwise expressly limited, any physician (M.D. or D.O.), dentist, or podiatrist holding a current license to practice within the scope of his/her license. In the context of fair hearings pursuant to Article XII, it shall also mean clinical psychologists.

NAME, DESCRIPTION, AND PURPOSE OF ORGANIZATION

NAME

The name of this organization shall be the Medical Staff of Seneca Healthcare District ("Medical Staff" or "Staff").

DESCRIPTION

The Medical Staff organization is structured as follows: The members of the Medical Staff are assigned to a Staff category depending upon nature and tenure of practice at the Hospital. New members are assigned to the Provisional Staff (see Section 3.01 for exceptions). Upon satisfactory completion of the provisional period, the members are assigned to one of the Staff categories described in Article III.

There are also Medical Staff committees, which perform staff-wide responsibilities.

Overseeing all of this is the Medical Executive Committee, comprised of the Medical Executive Committee of the Whole and the Medical Executive Officers Committee, as further described at section 7.02.

PURPOSES AND RESPONSIBILITIES

The Medical Staff's purposes are:

To assure all patients admitted or treated in any of the hospital services receive a uniform standard of quality patient care, treatment and efficiency consistent with generally accepted standards attainable within the hospital's means and circumstances.

To provide for a level of professional performance that is consistent with generally accepted standards attainable within the hospital's means and circumstances.

To organize and support professional education and community health education and support services.

To initiate and maintain rules for the Medical Staff to carry out its responsibilities for the professional work performed in the hospital.

To provide a means for the Medical Staff, Governing Body and administration to discuss issues of mutual concern and to implement education and changes intended to continuously improve the quality of patient care.

To provide for accountability of the Medical Staff to the Governing Body.

To exercise its rights and responsibilities in a manner that does not jeopardize the hospital's license, Medicare and Medi-Cal provider status, and accreditation.

The Medical Staff's responsibilities are:

To provide quality patient care;

To account to the Governing Body for the quality of patient care provided by all members authorized to practice in the Hospital through the following measures:

Review and evaluation of the quality of patient care provided through generally accepted valid and reliable patient care evaluation procedures;

An organizational structure and mechanisms that allow on-going monitoring of patient care practices;

A credentials program, including mechanisms of appointment, reappointment and the matching of clinical privileges to be exercised or specified services to be performed with the verified credentials and currently demonstrated performance of the Medical Staff applicant or member;

A continuing education program based at least in part on needs demonstrated through the medical care evaluation program;

A utilization review program to provide for the appropriate use of all medical services;

To recommend to the Governing Body action with respect to appointments, reappointments, staff category and department assignments, clinical privileges and corrective action;

To establish and enforce, subject to the Governing Body approval, generally accepted professional standards related to the delivery of health care within the hospital;

To account to the Governing Body for the quality of patient care through regular reports and recommendations concerning the implementation, operation, and results of the quality review and evaluation activities;

To initiate and pursue corrective action with respect to members where warranted;

To provide a framework for cooperation with other community health facilities and/or educational institutions or efforts;

To establish and amend from time to time as needed Medical Staff Bylaws, rules and policies for the effective performance of Medical Staff responsibilities, as further described in these Bylaws;

To select and remove Medical Staff officers;

To assess Medical Staff dues and utilize Medical Staff dues as appropriate for the purposes of the Medical Staff.

RELATIONSHIP TO HOSPITAL'S GOALS

With respect to the Medical Staff, the goals of the Hospital are to maintain a highly qualified professional staff, to carefully screen and monitor applicants and members of the Medical Staff and other professionals exercising Clinical Privileges; to continually strive to achieve higher standards of patient care; to respond to community needs; and to achieve high confidence and communication among the Medical Staff, the Hospital administration, and the Governing Body. These Bylaws, together with Medical Staff Rules and policies and procedures, constitute the Medical Staff's articulated objectives toward achievement of these goals.

MEDICAL STAFF MEMBERSHIP

NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff and/or Clinical Privileges shall be extended to, and may be maintained by only those professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and the Medical Staff Rules. Except as otherwise provided in the Medical Staff Rules, a Practitioner, including those in a medical-administrative position by virtue of a contract with the Hospital, shall admit or provide medical or health-related services to patients in the Hospital only if he/she is a member of the Medical Staff or has been granted Clinical Privileges in accordance with the procedures set forth in these Bylaws. Appointment to the Medical Staff shall confer only such Clinical Privileges and prerogatives as have been established by the Medical Staff and granted by the Governing Body in accordance with these Bylaws.

QUALIFICATIONS FOR MEMBERSHIP

General Qualifications

Practitioners must demonstrate compliance with the standards set forth in this Section 2.02-1(a), in order to have an application for Medical Staff membership accepted for review. The Practitioner must:

Be licensed in the State of California (or be otherwise legally permitted to practice in the State of California); and, if practicing a range of clinical medicine, dentistry, or podiatry for which prescribing privileges are reasonably necessary, have a federal DEA number.

Except for dentists, be board certified or be actively in the process of acquiring board certification in his/her field or have completed a residency in a program approved by the Accreditation Council for Graduate Medical Education, which program provided complete training in the specialty or subspecialty that the Practitioner will practice in the Hospital.

Be eligible to receive payments from the federal Medicare and state Medicaid (Medi-Cal) programs.

Have liability insurance or equivalent coverage in minimum limits established by the Governing Body, and meeting such other requirements as set forth in Rule XIV-1.

For anesthesiologists/CRNA's, PA's, F.NP's, radiologists, and pathologists, have an employment or independent contractor relationship with the individual or group with whom the Hospital has entered into an exclusive contract for such services or be directly employed by or contracted with the Hospital.

Reside and practice within the primary service area of the Hospital (except for Consulting, Courtesy, and Telemedicine Consulting Staff applicants and physicians assigned specific times to be at the facility; e.g., ancillary service department physicians). The distance to the Hospital may vary depending upon the Medical Staff category, Privileges that are involved, and the feasibility of arranging alternative coverage, and may be defined by the Medical Executive Committee of the Whole in compliance with these Bylaws. Exceptions to this requirement may be granted where the applicant or Medical Staff member provides and maintains in the Medical Staff Services office a written agreement for coverage of his/her patients by an Active Staff member who meets the geographic requirements and who maintains comparable Clinical Privileges on this Medical Staff. This coverage agreement is to be updated at the time of reappointment and must contain the Active Staff member's acknowledgment that he/she must also arrange back up coverage for the non-local physician's patients in the same manner as he/she makes such arrangements for his/her own hospitalized patients.

Pledge to provide continuous care to his or her patients.

In general, a Practitioner who does not meet these basic standards is ineligible to apply for Medical Staff membership and the application shall not be accepted for review; applicants for the Telemedicine Consulting Staff need not comply with Paragraph (a) (7). If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in these Bylaws, but may submit comments and a request for reconsideration of the specific standards that adversely affected such Practitioner. Those comments and requests shall be reviewed by the Medical Executive Committee of the Whole and the Governing Body, which shall have sole discretion to decide whether to consider any changes in the basic standards or to grant a waiver as allowed by Section 2.04.

Particular Qualifications

In addition to meeting the general qualifications set forth above, the Practitioner must:

Document (i) adequate experience, education, and training in the requested Clinical Privileges; (ii) current professional competence; (iii) good judgment; and (iv) adequate physical and mental health status (subject to any necessary reasonable accommodation) to demonstrate to the satisfaction of the Medical Staff that he/she is professionally and ethically competent so that patients can reasonably expect to receive the generally recognized high professional level of quality of care for this community.

Be determined (i) to adhere to the lawful ethics of his/her profession, (ii) to be able to work cooperatively with others in the hospital setting so as not to adversely affect patient care or hospital operations, and (iii) to be willing to participate in and properly discharge Medical Staff responsibilities.

Effect of Other Affiliations

No Practitioner shall be entitled to membership on the Medical Staff merely because he/she holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because he/she had, or presently has, Staff membership or Privileges at another health care facility.

Nondiscrimination

Medical Staff membership or particular Clinical Privileges shall not be denied on the basis of sex, race, creed, color, national origin, or sexual orientation, nor on the basis of a physical or mental impairment that, after any necessary, reasonable accommodation, does not preclude compliance with these Bylaws or the Rules of the Medical Staff and the Hospital.

Administrative and Contract Practitioners

A Practitioner employed by or contracting with the Hospital in a purely administrative capacity with no clinical duties or Privileges is subject to the regular personnel policies of the Hospital and to the terms of his/her contract or other conditions of employment, and need not be a member of the Medical Staff.

A Practitioner contracting with the Hospital in an administrative capacity with clinical duties or Privileges must be a member of the Medical Staff, achieving his/her status by the normal application and appointment procedures described in these Bylaws.

Unless a contract or agreement executed after the adoption of this provision provides otherwise, or unless otherwise required by law, those Privileges made exclusive or semi-exclusive pursuant to a closed-staff or limited-staff specialty policy will automatically terminate, without the right of access to the fair hearing procedures of Article XII of these Bylaws, upon termination for other than medical disciplinary cause or reason or expiration of such Practitioner's contract or agreement with the Hospital.

Contracts between Practitioners and the Hospital shall prevail over these Bylaws, except that the contracts may not reduce any hearing rights granted when an action will be taken that must be reported to the Medical Board of California or the National Practitioner Data Bank.

Practitioners who subcontract with Practitioners or entities who contract with the Hospital will automatically forfeit (without the right of access to the fair hearing procedures of Article XII of these Bylaws) any Privileges that are subject to an exclusive or semi-exclusive arrangement if their relationship with the contracting Practitioner or entity is terminated for other than medical disciplinary cause or reason, or if the contract between the Hospital and the contracting Practitioner or entity is terminated. The Hospital may enforce such automatic termination even if the subcontractor's agreement fails to specifically recognize this right.

BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

Each member of the Medical Staff shall:

Provide his/her patients with care of the generally recognized professional level of quality and efficiency;

Abide by the Medical Staff Bylaws and Rules and lawful standards and policies of the Medical Staff and the Hospital, including, but not limited to, any applicable Medical Staff and/or Hospital policies respecting unlawful harassment and Practitioner conduct;

Abide by all applicable laws and regulations of governmental agencies and comply with applicable hospital policies including but not limited to cooperating and complying with the Hospital's policies and procedures regarding patient complaints and grievances, sentinel events, unanticipated outcomes, and error reporting;

Discharge such Staff, committee, and service functions for which he/she is responsible by appointment, election, or otherwise;

Prepare and complete in a timely manner the medical and other required records for all patients he/she admits or in any way provides care to in the Hospital;

Abide by the ethical principles of his/her profession and the Hospital, which include, but not by way of limitation, a pledge to:

Refrain from fee splitting or other inducements relating to patient referral;

Refrain from any unlawful harassment or discrimination against any person (including any patient, Hospital employee, Hospital independent contractor, Medical Staff member, volunteer or visitor) based on the patient's age, sex, religion, race, creed, color, national origin, health status, ability to pay, or source of payment;

Refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a Practitioner who is not qualified to undertake this responsibility or who is not adequately supervised; and

Coordinate individual patients' care, treatment and services with other Practitioners and Hospital personnel, including but not limited to, seeking consultation as required in the Medical Staff Rules, or whenever warranted by the patient's condition;

Actively and equitably participate in and regularly cooperate with the Medical Staff in assisting the Hospital to fulfill its obligations related to patient care, including but not limited to quality improvement, risk management, and utilization management, and in discharging such other functions as may be required from time to time;

Upon request, provide information from his/her office records as necessary to facilitate the care of or review of the care of specific patients;

Provide information to appropriate Medical Staff officers when he/she obtains reasonable information bearing upon a fellow Staff member who may have engaged in unprofessional or unethical conduct or may have a health condition that poses a significant risk to the well-being or care of patients; and cooperate as reasonably necessary toward the appropriate resolution of any such matter;

Accept responsibility for participating in Medical Staff proctoring as an obligation of Staff membership. Proctoring availability and assignment shall be in accordance with regulations formulated by the Medical Executive Committee of the Whole;

Participate in Continuing Medical Education programs appropriate to his/her specialty. As a minimum, members shall comply with Medical Board of California requirements, or comparable requirements of other applicable licensing agencies;

Work cooperatively with members, nurses, Hospital administration, and others so as not to adversely affect patient care or Hospital operations;

Accept responsibility for emergency care and for support of the Emergency Room, including consultation and/or admission as may be necessary. Availability and assignment shall be in accordance with policies formulated by the Medical Executive Committee of the Whole. Such policies may call for voluntary or mandatory participation in Emergency Room call responsibilities (provided, however, that the Medical Executive Committee of the Whole or the Governing Body may require mandatory participation if voluntary policies fail to assure the necessary coverage); and furthermore the Governing Body may require mandatory participation as necessary to meet legal requirements in the event the Medical Executive Committee of the Whole is not able to achieve compliance with legal requirements;

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

Continuously meet the qualifications for and perform the responsibilities of membership as set forth in these Bylaws. (It is understood that a member may be required to demonstrate continuing satisfaction of any of the requirements of these Bylaws whenever the Medical Executive Committee of the Whole or the Medical Executive Officers Committee, when applicable, has good cause to question whether the member continues to meet such requirements.)

Ensure the regulations set forth by Emergency Medical Treatment Active Labor Act are met.

Assure the completion of a physical examination and medical history on all patients, no more than 7 days before or 24 hours after admission. **This exam and medical history shall be completed and documented by a doctor of medicine or osteopathy, or, for patients admitted only for oromaxillofacial surgery, by an oromaxillofacial surgeon who has been granted such privileges by the medical staff in accordance with state law.**

Notify the Medical Staff office in writing promptly, and no later than 14 calendar days, following any action taken regarding the member's license, DEA registration, privileges at other facilities, changes in liability insurance coverage, any report filed with the National Practitioner Data Bank, or any other action that could affect his/her Medical Staff standing and/or clinical privileges at the Hospital.

WAIVER OF QUALIFICATIONS OR RESPONSIBILITIES

Insofar as is consistent with applicable laws, the Governing Body has the discretion to waive or otherwise deem a Practitioner to have satisfied a qualification for or responsibility of Medical Staff membership, after consulting with the Medical Executive Committee of the Whole, if it determines that the Practitioner has demonstrated he/she has substantially complied with applicable requirements and that this waiver is necessary to serve the best interests of the patients and of the Hospital. There is no obligation to grant any such waiver, and Practitioners have no right to have a waiver considered and/or granted. A Practitioner who is denied a waiver or consideration of a waiver shall not be entitled to any hearing and appeal rights under these Bylaws.

STANDARDS OF CONDUCT

Members of the Medical Staff are expected to adhere to the Medical Staff Standards of Conduct, including but not limited to the following:

Applicable Definitions

“Appropriate behavior” means any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership or activities of the organized medical staff, or to engage in professional practice including practice that may be in competition with the District. Criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior. Appropriate behavior is not subject to discipline under these by-laws.

"Disruptive behavior" is characteristically a chronic or habitual pattern of behavior that creates a hostile environment, the effects of which have serious implications on the quality of patient care and patient safety. Disruptive behavior means any abusive conduct including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised. Personal conduct whether verbal or physical that affects or that potentially may affect patient care negatively constitutes disruptive behavior.

"Sexual or other harassment" means conduct toward others based on their race, religion, sex, sexual identity or orientation, nationality or ethnicity, physical or mental disability, or marital status which has the purpose or direct effect of unreasonably interfering with a person's work performance or which creates an offensive, intimidating or otherwise hostile work environment. Sexual harassment includes unwelcome verbal or physical conduct of a sexual or gender-based nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings or posters). Sexual harassment includes conduct that creates and/or perpetrates an intimidating, hostile, or offensive environment.

"Inappropriate behavior" means conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as "disruptive behavior".

"Medical staff member" means physicians and others granted membership on the Medical Staff and, for purposes of this Code, includes individuals with temporary clinical privileges.

Types of Conduct

A. APPROPRIATE BEHAVIOR
Medical staff members cannot be subject to discipline for appropriate behavior. Examples of appropriate behavior include, but are not limited to the following:

- Advocacy on patient care matters;
- Recommendations or criticism communicated in a reasonable manner and offered in good faith with the aim of improving patient care and safety;
- Encouraging clear communications;
- Expressions of concern about a patient's care and safety;
- Expressions of dissatisfaction with policies through appropriate grievance channels or other civil non-personal means of communication;
- Use of cooperative approach to problem resolution;
- Constructive criticism conveyed in a respectful and professional manner, without blame or shame for adverse outcomes;
- Professional comments to any professional, managerial, supervisory or administrative staff, or members of the Board of Directors about patient care or safety provided by others;
- Fulfilling duties of medical staff membership or leadership;
- Active participation in medical staff and District meetings (i.e., comments made during or resulting from such meetings cannot be used as the basis for a complaint under this Code of Conduct, referral to the Physician Wellbeing Committee, economic sanctions, or the filing of an action before a state or federal agency);
- Exercising rights granted under the medical staff bylaws, rules and regulations or policies;
- Engaging in legitimate business activities, while being mindful of contractual commitments; Membership on other medical staffs; and
- Seeking legal advice or the initiation of legal action for cause.

B. INAPPROPRIATE BEHAVIOR

- Belittling or berating statements;
- Name calling;

- Use of profanity;
- Inappropriate comments written in the medical record;
- Blatant failure to respond to patient care needs or staff requests;
- Deliberate lack of cooperation without good cause;
- Deliberate refusal to return phone calls, pages, or other messages concerning patient care or safety; and
- Intentionally degrading or demeaning comments regarding patients and their families; nurses, physicians, District personnel and/or the District.

C. DISRUPTIVE BEHAVIOR

Disruptive behavior by medical staff members is prohibited. Examples of disruptive behavior include, but are not limited to the following:

- Physical or verbal intimidation or challenge, including disseminating threats or pushing, grabbing or striking another person involved in the District;
- Physically threatening language directed at anyone in the District including physicians, nurses, other medical staff members or any District employee, administrator or member of the Board of Directors;
- Physical contact with another individual that is threatening or intimidating;
- Throwing instruments, charts or other things;
- Threats of violence or retribution; and
- Sexual or other forms of harassment including, but not limited to persistent, inappropriate behavior and repeated threats of litigation

D. INTERVENTIONS

Interventions should initially be non-adversarial in nature, if possible, with the focus on restoring trust, placing accountability on and rehabilitating the offending medical staff member and protecting patient care and safety. The medical staff supports tiered, non-confrontational intervention strategies, starting with informal discussion of the matter with the appropriate section chief or department chairperson. Further interventions can include an apology directly addressing the problem, a letter of admonition, a final written warning or corrective action pursuant to the medical staff by-laws, if the behavior is or becomes disruptive. The use of summary suspension should be considered only where the physician's disruptive behavior presents an imminent danger to the health of any individual. At any time rehabilitation may be recommended. If there is reason to believe inappropriate or disruptive behavior is due to illness or impairment, the matter may be evaluated and managed confidentially according to the established procedures of the medical staff's Physician Wellbeing committee.

2.05-3 Procedure

Complaints about a member of the medical staff regarding allegedly inappropriate or disruptive behavior should be in writing, signed and directed to the Chief of Staff or, if the Chief of Staff is the subject of the complaint, to the Vice-chief of Staff and include to the extent feasible:

1. The date(s), time(s) and location of the inappropriate or disruptive behavior;
2. A factual description of the inappropriate or disruptive behavior;
3. The circumstances which precipitated the incident;
4. The name and medical record number of any patient or patient's family member who was involved in or witnessed the incident;
5. The names of other witnesses to the incident;
6. The consequences, if any, of the inappropriate or disruptive behavior as it relates to patient care or safety, or District personnel or operations; and
7. Action taken to intervene or remedy the incident, including the names of those intervening

At the discretion of the Chief of Staff (or Vice-chief of Staff if the Chief of Staff is the subject of the complaint), the duties here assigned to the Chief of Staff can, from time to time, be delegated to another elected member of the medical staff ("designee").

The complainant will be provided a written acknowledgement of the complaint.

In all cases, the medical staff member subject of the complaint shall be provided a copy of this Code of Conduct and a copy of the complaint in a timely fashion, as determined by the organized medical staff, but in no case more than 30 days from receipt of the complaint by the Chief or Vice-chief of Staff. The medical staff member will be notified that attempts to confront, intimidate or otherwise retaliate against the complainant is a violation of this Code of Conduct and may result in corrective action against the medical staff member. An ad hoc committee, none of the members of which may be economic competitors of the medical staff member, consisting of the Chief or Vice-chief of staff or designee, and at least two additional elected members of the medical executive committee, provided the chairperson is not the subject of the complaint, shall make such investigation as appropriate in the circumstances which may include seeking to interview the complainant, any witnesses and the subject of the complaint. The subject medical staff member shall be provided an opportunity to respond in writing to the complaint.

The ad hoc committee will make a determination of the authenticity and severity of the complaint. The ad hoc committee shall dismiss any unfounded complaint and may dismiss any complaint if it is not possible to confirm its authenticity or severity and will notify both the complainant and the subject of the complaint of the decision reached.

If the ad hoc committee determines the complaint is well founded, the complainant and the subject of the complaint will be informed of the decision, and the complaint will be addressed as follows:

1. If this is the first incident of inappropriate behavior, the appropriate chairperson of the offending medical staff member's assigned department shall discuss the matter with the offending medical staff member, and emphasize that the behavior is inappropriate and must cease. The offending medical staff member may be asked to apologize to the complainant. The approach during this initial intervention should be collegial and helpful.

2. Further isolated incidents that do not constitute persistent, repeated inappropriate behavior will be handled by providing the offending medical staff member with notification of each incident, and a reminder of the expectation the individual comply with this Code of Conduct.

3. If the ad hoc committee determines the offending medical staff member has demonstrated persistent, repeated inappropriate behavior, constituting harassment (a form of disruptive behavior), or has engaged in disruptive behavior on the first offense, a letter of admonition will be sent to the offending medical staff member, and as appropriate, a rehabilitation action plan developed by the ad hoc committee, with the advice and counsel of the medical executive committee.

4. If, in spite of this admonition and intervention, disruptive behavior recurs, the ad hoc committee shall meet with and advise the offending medical staff member such behavior must immediately cease or corrective action will be initiated. This "final warning" shall be sent to the offending medical staff member in writing.

5. If after the "final warning" the disruptive behavior recurs, corrective action (including suspension or termination of privileges) shall be initiated pursuant to the medical staff bylaws of which this Code of Conduct is a part, and the offending medical staff member shall have all of the due process rights set forth in the medical staff bylaws.

6. If a single incident of disruptive behavior or repeated incidents of disruptive behavior constitute an imminent danger to the health of an individual or individuals, the offending medical staff member may be summarily suspended as provided in the medical staff bylaws. The medical staff member shall have all of the due process rights set forth in the medical staff bylaws.

7. If no corrective action is taken pursuant to the medical staff bylaws, a confidential memorandum summarizing the disposition of the complaint, along with copies of any written warnings, letters of apology and written responses from the offending medical staff member, shall be retained in the medical staff member's credentials file for two (2) years and then must be expunged if no related action is taken or pending. Informal rehabilitation, a written apology, issuance of a warning, or referral to the Physician Wellbeing Committee will not constitute corrective action.

8. At any time during this procedure the medical staff member has a right to personally retain and be represented by legal counsel.

2.05-4 Inappropriate or disruptive behavior against a medical staff member

Inappropriate or disruptive behavior which is directed against the organized medical staff or directed against a medical staff member by a District employee, Administrator, Board member, contractor or other member of the District community shall be reported by the medical staff member to the District pursuant to District policy or code of conduct, or directly to the District governing board, the state or federal government, or relevant accrediting body, as appropriate.

2.05-5 Abuse of Process

Threats or actions directed against the complainant by the subject of the complaint will not be tolerated under any circumstance. Retaliation or attempted retaliation by medical staff members against complainants will give rise to corrective action pursuant to the medical staff bylaws. Individuals who falsely submit a complaint shall be subject to corrective action under the medical staff bylaws or District employment policies, whichever applies to the individual.

2.05-6 Promoting awareness of Code of Conduct

The medical staff shall, in cooperation with the District promote continuing awareness of this Code of Conduct among the medical staff and the District community by:

1. Sponsoring or supporting educational programs on disruptive behavior to be offered to medical staff members and District employees;

2. Disseminating this Code of Conduct to all current medical staff members upon its adoption and to all new applicants for membership to the medical staff;

3. Encouraging the Physician Wellbeing Committee to assist members of the medical staff exhibiting inappropriate or disruptive behavior to obtain education, behavior modification, or other treatment to prevent further infractions;

4. Informing the members and the District staff of the procedures the medical staff and District have put into place for effective communication to District administration of any medical staff member's concerns, complaints and suggestions regarding district personnel, equipment and systems.

The Medical Executive Officers Committee may promulgate rules further illustrating and implementing the purposes of this Section.

CATEGORIES OF THE MEDICAL STAFF

CATEGORIES

The Staff shall be divided into Provisional, Active, Consulting, Courtesy, Telemedicine Consulting, Clinic, and Inactive categories. Except for Consulting and Telemedicine Consulting Staff appointments, all initial appointments to the Staff shall be to the Provisional category. Changes in Medical Staff category shall not be grounds for a hearing unless such changes diminish the member's ability to exercise his/her Clinical Privileges.

RESPONSIBILITIES AND PREROGATIVES

The responsibilities and prerogatives of each category of Medical Staff member shall be as set forth in the following chart (Page 12), and further described in Rule III.

RESPONSIBILITIES AND PREROGATIVES OF MEMBERS

		Provisional	Active	Consulting	Courtesy	Clinic	Tele-medicine Consulting	Inactive
PREROGATIVES	Admit Patients	YES	YES [1]	NO	YES [2]	YES [2]	NO	NO
	Clinical Privileges	YES	YES	YES	YES	YES	YES	NO
	Vote	NO	YES	NO	NO	YES	NO	NO
	Hold Office	NO	YES	NO	NO	YES	NO	NO
	Serve on Committees	YES	YES	YES	YES	YES	YES	NO
	Committee Chair	NO	YES	YES	NO	YES	NO	NO
RESPONSIBILITIES	Medical Staff Functions	YES	YES	YES	NO	YES	NO	NO
	Attend Meetings	YES	YES	YES	NO	YES	NO	NO
	Pay Dues	YES	YES	YES	YES	YES	YES	NO
	Application Fee	YES	YES	YES	YES	YES	YES	NO
OTHER REQUIRE-MENTS	Complete Provisional	N/A	YES	NO	YES	YES	NO	YES
	Malpractice Insurance	YES	YES	YES	YES	YES	YES	NO

[1] Must admit/attend at least 6 in-patients per year

[2] Must admit/attend fewer than 6 in-patients per year

PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

APPLICATION FOR INITIAL APPOINTMENT

Membership on the Medical Staff and/or Clinical Privileges shall be extended to, and may be maintained by only those professionally competent Practitioners who apply for and are found to meet and who must continuously meet the qualifications, standards, and requirements set forth in these Bylaws.

Content of Form

The application form, described in Rule IV-1.1, shall be developed by the Credentials Committee and shall be subject to approval by the Medical Executive Committee of the Whole and the Governing Body.

Application

All applicants for Medical Staff membership must complete, sign, and submit to the Chief of Staff, or his/her designee, the Hospital's Application for Medical Staff Membership and Clinical Privileges, together with the nonrefundable application fee established by the Medical Executive Committee of the Whole and approved by the Governing Body.

Procedures for Initial Appointment are described in Rule IV-1.

Effect of Application

By applying for or by accepting appointment or reappointment to the Medical Staff, the applicant:

Signifies his/her willingness to appear for interviews in regard to his/her application for appointment;

Authorizes Medical Staff and Hospital representatives to consult with other hospitals, persons, or entities who have been associated with him/her and/or who may have information bearing on his/her competence and qualifications;

Consents to the inspection, by Hospital representatives, of all records and documents that may be material to an evaluation of his/her professional qualifications and ability to carry out the Clinical Privileges he/she requests as well as of his/her professional ethical qualifications for Staff membership, regardless of who is in possession of these records;

Releases from liability to the fullest extent permitted by law the Medical Staff and the Hospital and their representatives for their acts performed in connection with evaluating the applicant;

Releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives concerning the applicant's ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Staff appointment and Clinical Privileges;

Authorizes and consents to Hospital representatives providing other hospitals, professional societies, licensing boards, and other organizations concerned with provider performance and the quality of patient care with relevant information the Hospital may have concerning him/her, and releases the Hospital and Hospital representatives from liability for so doing;

Consents to undergo and to release the results of a medical, psychiatric, or psychological examination by a Practitioner acceptable to the Medical Executive Committee of the Whole, at the applicant's expense, if deemed necessary by the Medical Executive Committee of the Whole;

Signifies his/her willingness to abide by all the conditions of membership, as stated on the application form, the reappointment application form, and in these Bylaws; and

Pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing continuous care of his or her patients, seeking consultation whenever necessary, refraining from providing "ghost" surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised members.

For purposes of this Section, the term "Hospital representative" includes the Governing Body, its individual Directors and committee members; the Chief Executive Officer, the Medical Staff, all Medical Staff and/or committee members having responsibility for collecting or evaluating the applicant's credentials; and any authorized representative of any of the foregoing.

BASIS FOR APPOINTMENT

Except as next provided with respect to telemedicine Practitioners, recommendations for appointment to the Medical Staff and for granting privileges shall be based upon the Practitioner's training, experience, and professional performance at this Hospital, if applicable, and in other settings, whether the Practitioner meets the qualifications and can carry out all of the responsibilities specified in these Bylaws and the Rules, and upon the Hospital's patient care needs and ability to provide adequate support services and facilities for

the Practitioner. Recommendations from peers in the same professional discipline as the Practitioner, and who have personal knowledge of the applicant, are to be included in the evaluation of the Practitioner's qualifications.

The initial appointment of Practitioners to the Telemedicine Staff may be based upon:

The Practitioner's full compliance with this hospital's credentialing and privileging standards;

By using this Hospital's standards but relying in whole or in part on information provided by the Hospital(s) at which the Practitioner routinely practices;

If the Hospital where the Practitioner routinely practices is JCAHO-accredited and agrees to provide a comprehensive report of the Practitioner's qualifications, by relying entirely on the credentialing and privileging of that other hospital.

DURATION OF APPOINTMENT

The Credentials Committee with approval from the Medical Executive Committee of the Whole, shall develop Rules to implement the following:

All new Staff members shall be appointed to the Provisional Staff and subjected to a period of formal observation and review (except for those appointed to the Consulting and Telemedicine Consulting Staff). Provisional appointments are for not less than one year, and a member may serve no more than two consecutive one-year terms as a Provisional Staff member.

Reappointments to any Staff category shall be for a period of two years. Change in Staff category may be requested at any time during the reappointment period after requirements of Provisional status are met.

If an application for reappointment has been timely submitted, but has not been fully processed by the expiration date of the appointment, the Practitioner may, in the sole discretion of the Medical Executive Committee of the Whole and the Chief Executive Officer, be granted Temporary Privileges for up to 60 days, within which time the processing of the reappointment application must be completed. If the delay is due to the Member's failure to timely return the reappointment application form or provide other documentation or cooperation, the appointment shall terminate as described in Section 4.03 (d) below. Granting of the above-noted Temporary Privileges shall not be deemed to create a right for the member to be automatically reappointed.

Failure without good cause to timely file a completed application for reappointment shall result in the automatic suspension of the member's admitting and other Privileges and prerogatives at the end of the current Medical Staff appointment, unless otherwise extended by the Medical Executive Committee of the Whole with the approval of the Governing Body. If the member fails to submit a completed application for reappointment within the time specified in the Rules, the member shall be deemed to have resigned membership in the Medical Staff. In the event membership terminates for the reasons set forth herein, the member shall not be entitled to any hearing or review.

APPLICATION FOR REAPPOINTMENT

Procedures for Reappointment are described in Rule IV-2.

Basis for Reappointment

Recommendation for reappointment to the Medical Staff and for renewal of privileges shall be based upon a reappraisal of the member's performance at this Hospital and in other settings. The reappraisal is to include confirmation of adherence to Medical Staff membership requirements as stated in these Bylaws, the Medical Staff Rules, the Medical Staff, and Hospital policies. Such reappraisal should also include relevant member-specific information from performance improvement activities and, where appropriate, comparisons to aggregate information about performance, judgment and clinical or technical skills. Where applicable, the results of specific peer review activities shall also be considered. If sufficient review data are unavailable, peer recommendations may be used instead; or in the case of reappointment of a member of the Telemedicine Staff, reappointment may be based upon information provided by the hospital(s) where the Practitioner routinely practices.

Continuing Compliance with Requirements

By applying for reappointment and by accepting reappointment to the Medical Staff, the Staff member signifies his/her continuing acknowledgment and acceptance of the provisions of Section 4.01-4.

Continued membership and exercise of Clinical Privileges shall require at least the following:

Documentation and reappraisal of continuing satisfaction of the General Qualifications set forth at Section 2.02-1; reasonable evidence of current ability to perform Clinical Privileges, including but not limited to consideration of the member's professional performance, judgment, and clinical or technical skills, and of compliance with the requirements applicable from time to time to Medical Staff membership and the exercise of Clinical Privileges, including, if deemed necessary, requirements of additional proctoring with respect to Clinical Privileges that are used so infrequently as to make it difficult or unreliable to assess current competency without additional proctoring;

Satisfactory results in Medical Staff quality improvement reviews (including review of Practitioner -specific information from performance improvement activities and, where appropriate, comparisons to aggregate information about

performance, judgment, and clinical or technical skills), or satisfactory correction of any significant problems identified through such reviews;

Review of information from the state licensing board, the National Practitioner Data Bank, and information from other relevant sources, such as, but not limited to, the Federation of State Medical Board Physician Disciplinary Data Bank.

Satisfaction of the meeting attendance requirements of the Medical Staff and his/her committee responsibilities;

Notification to the Hospital prior to changing insurance companies and documentation of "reporting endorsements" (tail coverage) or "prior acts coverage" (nose coverage) when changing insurance companies; and

Written notification to the Chief of Staff of any subsequently occurring changes in the information submitted in the application or reappointment form.

REQUESTS FOR MODIFICATION OF APPOINTMENT

A Staff member may, at any time, request modification of his/her Clinical Privileges, and a non-Provisional Staff member may request modification of his/her Staff category by submitting a written application to the Chief of Staff on the prescribed form. Such application shall be processed in substantially the same manner as provided in the Rules for reappointment.

The Medical Executive Committee of the Whole may recommend to the Governing Body that a change in Staff category of a current Staff member or the granting of additional Privileges to a current Staff member be made provisional in accordance with procedures similar to those outlined in the Rules for initial appointments. Changes in Medical Staff category shall not be grounds for a hearing unless such changes diminish the member's ability to exercise his/her Clinical Privileges.

LEAVE OF ABSENCE

Staff members in good standing may request a leave of absence for a stated purpose and a stated period, not to exceed one year. The Medical Executive Committee of the Whole shall act on such requests, using its sole discretion as to whether the requested leave of absence is in the best interests of the Hospital and the Medical Staff. There shall be no right to a leave of absence; nor shall there be any procedural rights associated with failure to obtain approval for a requested leave of absence. During the period of absence, the member may not admit patients, exercise Clinical Privileges, or exercise other prerogatives of Medical Staff membership; however, the member shall be required to pay dues (if applicable), unless waived by the Medical Executive-Committee of the Whole. Reinstatement at the end of the leave must be processed in the same manner as described in the Rules for reappointment; and the member must provide information regarding his/her professional activities during the leave of absence. Pending processing of the reappointment application, the member may request temporary Privileges in accordance with Rule V-1.

WAITING PERIOD AFTER ADVERSE ACTION OR RESIGNATION IN LIEU OF MEDICAL DISCIPLINARY ACTION

Who Is Affected

A waiting period shall apply to the following Practitioners:

An applicant who (i) has received a final adverse decision regarding appointment or (ii) has withdrawn his/her application or request for membership or Privileges following an adverse recommendation by the Medical Executive Committee or the Governing Body;

A former member who has (i) received a final adverse decision resulting in termination of Medical Staff membership and/or Privileges or (ii) resigned or relinquished Privileges from the Medical Staff while an investigation was pending, or following the Medical Executive-Committee of the Whole or Governing Body issuing an adverse recommendation; or

A member who has received a final adverse decision resulting in (i) termination or restriction of his/her Privileges or (ii) denial of his/her request for additional Privileges.

Ordinarily the waiting period shall be 24 months. However, for Practitioners whose adverse action included a specified period or conditions of retraining or additional experience, the Medical Executive Committee of the Whole may, in its sole discretion, allow earlier reapplication upon completion of the specified conditions. Similarly, the Executive session of the Medical Executive Committee of the Whole may, in its sole discretion, waive the 24-month period in other circumstances where it reasonably appears, by objective measures, that changed circumstances warrant earlier consideration of an application.

Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as the Staff or the Governing Body may require in demonstration that the basis for the earlier adverse action no longer exists.

When Action is Deemed Adverse, and Date When the Action Becomes Final

An action is considered adverse only if it is based on the type of occurrences that might give rise to corrective action. An action is not considered adverse if it is based upon reasons that do not pertain to medical or ethical conduct, such as actions based on a failure to maintain a practice in the area (which can be cured by a move), or to pay dues (which can be cured by paying dues), or to maintain professional liability insurance (which can be cured by obtaining the insurance).

The action is considered final on the latest date on which the application or request was withdrawn, a member's resignation became effective, or upon completion of: (i) all Medical Staff and Hospital hearings and appellate reviews and (ii) all judicial proceedings pertinent to the action served within two years after the completion of the Hospital proceedings.

Effect of the Waiting Period

Except as provided at Section 4.07-1(b), Practitioners subject to waiting periods cannot reapply for Medical Staff membership or the Privileges affected by the adverse action for at least 24 months after the action became final. After the waiting period, the Practitioner may reapply. The application will be processed like an initial application or request, plus the Practitioner shall document: (i) the basis for the adverse action no longer exists, (ii) he/she has corrected any problems that prompted the adverse action, and/or (iii) he/she has complied with any specific training or other conditions that were imposed.

CONFIDENTIALITY; IMPARTIALITY

To maintain confidentiality, and to assure the unbiased performance of appointment and reappointment functions, Staff members participating in the credentialing process shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws for processing applications for appointment and reappointment.

DETERMINATION OF CLINICAL PRIVILEGES

EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws or the Medical Staff Rules, every Practitioner, Allied Health Professional and approved medical student, or other professional providing direct clinical services at this Hospital shall be entitled to exercise only those Clinical Privileges or services specifically granted to him/her. The Medical Staff shall be responsible to establish and assess compliance with the criteria for exercise of clinical privileges. The process for developing and evaluating AHP clinical privileges shall include participation by the affected categories of AHPs. All privileging criteria shall be subject to approval by the Governing Body.

CRITERIA FOR PRIVILEGES

Subject to the approval of the Governing Body, the Medical Executive Committee of the Whole will be responsible for developing criteria for granting Privileges (including but not limited to identifying and developing criteria for any Privileges that may be appropriately performed via telemedicine). These criteria shall assure uniform quality of patient care, treatment and services. Insofar as feasible and necessary, affected categories of AHPs shall participate in developing the criteria for Privileges to be exercised by AHPs. Such criteria shall not be inconsistent with the Medical Staff or Hospital Bylaws, Rules or other policies. Each department's approved criteria for granting Privileges shall be included in the department's rules.

DELINEATION OF PRIVILEGES IN GENERAL

Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific Clinical Privileges desired by the applicant. A request by a Staff member pursuant to Section 4.04 for a modification of Privileges must be supported by documentation of training and/or experience supportive of the request.

Bases for Privileges Determinations

Requests for Clinical Privileges shall be evaluated on the basis of the Practitioner's education, training, experience, and demonstrated professional competence and judgment, and clinical performance (as confirmed by peers knowledgeable of the applicant's professional performance). The bases for Privileges determinations, in connection with periodic reappointment or otherwise, shall include any observed clinical performance and judgment, performance of a sufficient number of procedures each year to develop and maintain the Practitioner's skills and knowledge, and the documented results of the quality improvement activities required by the Medical Staff Bylaws and Rules. Privileges determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a Practitioner exercises Clinical Privileges. This information shall be added to and maintained in the Medical Staff file established for each Staff member. In the event Privileges have been used so infrequently as to make it difficult or unreliable to assess current competency, reappointments may also be conditioned upon additional proctoring as deemed necessary by the Medical Executive Committee of the Whole.

Medical Students and Allied Health Professional training students shall be considered for Privileges as per process defined in the Medical Staff Rules.

Procedure

All requests for Clinical Privileges shall be processed pursuant to the procedures outlined in the Rules for appointment and reappointment, and may be subject to proctoring requirements as set forth in the Rules.

CONSULTATIONS

Consultations may be required at the discretion of the Chief of Staff in consultation with the Medical Executive Officers Committee.

CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

Admissions

Dentist, oral surgeon, and podiatrist members may only admit patients if a physician member assumes responsibility for the care of the patient's medical problems present at the time of admission or that may arise during hospitalization and that are outside of the limited license Practitioner's lawful scope of practice.

When evidence of appropriate training and experience is documented, a limited license Practitioner may perform the history or physical on his/her own patient. Otherwise, a physician member must conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry or podiatry).

Surgery and High Risk Interventions

The Chair of the Surgery Committee (or the Chair's designee) shall have overall responsibility for the surgery service, including surgery services provided by the dentists and podiatrists.

Additionally, the findings, conclusions, and assessment of risk must be confirmed or endorsed by a Physician Member with appropriate Privileges, prior to diagnostic or therapeutic interventions deemed potentially high-risk.

Medical Appraisal

All patients admitted for care in a Hospital by a dentist, oral surgeon or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and a physician member or a limited license Practitioner with appropriate Privileges shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a physician member and a limited license Practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license Practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate Medical Staff member .

PROCTORING

Proctoring requirements and procedures are outlined at Rule V.

CREDENTIALING OF ALLIED HEALTH PROFESSIONALS

Credentialing of Allied Health Professionals is outlined at Rule V.

CREDENTIALING OF MEDICAL STUDENTS

Credentialing of Medical Students is outlined in the Rules.

CONFIDENTIALITY; IMPARTIALITY

To maintain confidentiality, and to assure the unbiased performance of privilege review functions, Staff members participating in the credentialing process shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws for processing applications for Clinical Privileges.

MEDICAL STAFF OFFICERS

MEDICAL STAFF OFFICERS - GENERAL PROVISIONS

Identification

There shall be the following general officers of the Medical Staff:

Chief of Staff;

Vice-Chief of Staff; and

Secretary-Treasurer.

In addition, all Medical Staff Committee chairpersons shall be deemed Medical Staff officers within the meaning of California law.

Qualifications

All Medical Staff officers shall have:

An understanding of the purposes and the functions of the Medical Staff organization and a demonstrated willingness to assure that patient welfare always takes precedence over other concerns;

An understanding of and willingness to work toward the attainment of the Hospital's lawful and reasonable policies and requirements;

Administrative ability as applicable to the respective office;

An ability to work with and motivate others to achieve the objectives of the Medical Staff organization;

Demonstrated clinical competence in his/her field of practice;

Active Staff status (and must remain in good standing as an Active Staff member while in office); and

An absence of any significant conflict of interest (including, but not limited to such conflicts as may be prohibited by California Local Hospital District Law, Health and Safety Code section 32110).

All nominees for election or appointment to Medical Staff offices shall, at least 30 days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee of the Whole 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. The Medical Executive Committee of the Whole shall evaluate the significance of such disclosures and discuss any significant conflicts with the nominee. If the conflict is one prohibited by California Local Hospital District Law, that nominee shall be replaced. In all other cases, the Medical Executive Committee of the Whole may permit the nominee to remain on the ballot; however, the nature of his/her conflict shall be disclosed in writing and circulated with the ballot.

Method of Selection - Nominating Committee

No later than April of each year, the Medical Staff shall develop a slate of officers to be elected annually at the June medical staff meeting. At least one candidate will be nominated for each of the following position, and the election shall be held at the June meeting.

Chief of Staff

Vice-Chief of Staff; and

Secretary-Treasurer.

The Active Medical Staff shall thereafter elect its general officers. The outcome shall be determined by a majority of the votes cast by oral ballot at the June meeting,

Officers elected in June shall take office in July of the same year.

Term of Office

The term of office shall be one year. An officer may serve a consecutive term upon a majority vote of the Medical Executive Committee of the Whole.

Recall of Officers

An officer may be recalled for good cause, including but not limited to loss of confidence and support of the Medical Staff. Except as otherwise provided, recall of a general Medical Staff officer may be initiated by the Medical Executive Committee of the Whole or by a petition signed by at least one-third of the Medical Staff members eligible to vote for officers; but recall itself shall require a two-thirds vote of the Medical Executive Committee of the Whole or two-thirds vote of the Medical Staff members eligible to vote for general Medical Staff officers.

Filling Vacancies

Vacancies created by resignation, removal, death, or disability shall be filled as follows:

A vacancy in the office of Chief of Staff shall be filled by the Vice-Chief.

A vacancy in the office of Vice-Chief shall be filled by special election held in general accordance with Section 6.01-3.

A vacancy in the office of Secretary-Treasurer shall be filled by appointment by the Medical Executive Committee of the Whole.

THE ROLE OF THE CHIEF OF STAFF

The Chief of Staff is the individual primarily responsible for assisting the Medical Executive Committee of the Whole to assure the effective discharge of the functions of the Medical Staff as set forth in these Bylaws. The Chief of Staff shall receive such administrative support as necessary to the effective performance of his/her responsibilities.

Duties

Subject to the ultimate authority of the Medical Executive Committee of the Whole, the Chief of Staff shall:

Exercise such authority as he/she deems necessary so that at all times patient welfare takes precedence over all other concerns;

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

Recommend the appointment of Practitioners to such committees as he/she deems necessary to perform the functions of the Medical Staff organization;

Report regularly to the Governing Body on the performance of all Medical Staff functions (as further described in Section 6.02-3), and communicate to the Staff any concerns expressed by the Governing Body;

Be chairperson of the Medical Executive Committee of the Whole and the Medical Executive Officers Committee; and

Serve on the Joint Conference Committee.

Authority

The Chief of Staff shall have the authority:

To summarily suspend Medical Staff members;

To initiate appropriate corrective or disciplinary actions;

To require consultations whenever, in his/her discretion, he/she deems it necessary;

Upon approval by the Medical Executive Committee of the Whole, to appoint the chairpersons and members of standing and special committees of the Medical Staff;

To require other Medical Staff officers and committee chairpersons assist him/her in performance of his/her responsibilities as Chief;

To require all Staff members to comply with the Hospital and the Medical Staff Bylaws, Rules, and policies and procedures, or face disciplinary action;

To call special meetings of the Medical Executive Committee of the Whole, the Medical Executive Officers Committee, or any Staff committee, or of the Medical Staff;

To contact Hospital or Medical Staff legal counsel for assistance or guidance; provided, however, to the extent that legal counsel is being provided at Hospital's expense, the Chief of Staff shall communicate and cooperate with the Hospital's CEO in the selection and use of legal counsel as reasonably necessary to assure prudent expenditure of Hospital funds;

To act on behalf of the Medical Executive Committee of the Whole or the Medical Executive Officers Committee whenever he/she determines that action is called for prior to the next regular or special meeting of the Medical Executive Committee of the Whole or the Medical Executive Officers Committee; provided, however, that such actions shall be subject to ratification by the Medical Executive Committee of the Whole or the Medical Executive Officers Committee, as applicable, at the next regular or special meeting of such Committee; and

To take whatever action reasonably necessary to the effective performance of his/her duties.

Delegate and review Medical Executive Committee of the Whole and the Medical Executive Officer Committee minutes, including attendance records.

Accountability and Relationships

The Chief of Staff shall be accountable to the Medical Executive Committee of the Whole, the Medical Executive Officers Committee and to the Governing Body. Accountability shall entail at least the following:

The Chief of Staff shall regularly report to the Governing Body on the activities of the Medical Executive Committee of the Whole and the Medical Executive Officers Committee, as described in Section 7.02-5.

The Chief of Staff shall keep the Chief Executive Officer informed of all violations of Medical Staff Bylaws and Rules, or of Hospital Bylaws or policies that put patient welfare in jeopardy, and shall report on what action is being taken to prevent such incidents from recurring.

The Chief of Staff shall report to the Chief Executive Officer concerning the progress being made toward attaining Medical Staff and Hospital objectives with respect to the Medical Staff organization.

The frequency, type, and channel of reporting shall be determined by the Governing Body, based upon the recommendations of the Chief of Staff and the Chief Executive Officer.

The Chief of Staff shall be the chairperson of the Medical Executive Committee of the Whole and the Medical Executive Officers Committee and shall be the focal point for those Committees':

Communications with the Governing Body.

Communications with other Medical Staff committee chairpersons.

All committee chairpersons shall be accountable to the Medical Executive Committee of the Whole, the Medical Executive Officers Committee and the Chief of Staff.

The Chief of Staff shall be accountable to the Governing Body, in conjunction with the Medical Executive Committee of the Whole and the Medical Executive Officers Committee for the effective performance, by the Medical Staff, of its responsibilities with respect to quality and efficiency of clinical services within the Hospital and for the effectiveness of the quality assurance and utilization review programs.

THE ROLE OF THE VICE-CHIEF OF STAFF (VICE-CHIEF)

The Vice-Chief of Staff is second in charge of the Medical Staff organization.

Duties

The Vice-Chief shall:

In the absence or disability of the Chief of Staff, perform all of the duties of the Chief;

Assist the Chief of Staff in the performance of his/her duties; and

Be a member of the Medical Executive Committee of the Whole and the Medical Executive Officers Committee.

Be a member of the Joint Conference Committee.

Authority

The Vice-Chief shall have the authority:

When acting as the Chief of Staff or at the discretion of the Chief of Staff, to exercise all the authority of the Chief of Staff (including but not limited to the Chief's voting rights on all Medical Staff committees); and

To initiate appropriate corrective or disciplinary actions.

Accountability and Relationships

The Vice-Chief shall be jointly accountable to the Chief of Staff and the Medical Executive Committee of the Whole, and when acting as Chief of Staff, he/she shall be accountable to the Governing Body and relate to the Staff and committees in the same manner as the Chief, as described in Section 6.02-3.

THE ROLE OF THE SECRETARY-TREASURER

The Secretary-Treasurer is third in charge of the Medical Staff organization.

Duties

The duties of the Secretary-Treasurer are to:

Receive and disburse money as directed by the Medical Executive Committee of the Whole and keep an accurate and complete record of receipts and disbursements;

Collect dues (if applicable) and other assessments and notify the Medical Executive Committee of the Whole of any Staff member's failure to pay;

Perform such additional duties as may be assigned from time to time;

Be a member of the Medical Executive Committee of the Whole and the Medical Executive Officers Committee, and

In the absence or disability of the Chief of Staff or the Vice-Chief, perform all the duties of the Chief or the Vice-Chief.

Serve on the Joint Conference Committee.

Authority

The Secretary-Treasurer shall have the authority to:

When acting as the Chief of Staff or Vice-Chief or at the direction of either, the Secretary-Treasurer shall have all the authority of the Chief of Staff or Vice-Chief, as appropriate (including but not limited to the Chief's or Vice-Chief's voting rights on all medical staff committees).

Accountability and Relationships

The Secretary-Treasurer shall be jointly accountable to the Medical Executive Committee of the Whole and to the Chief of Staff.

COMMITTEES

GENERAL

Designation

The Medical Executive Committee and the other committees described in these Bylaws and the Rules shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee of the Whole to perform specified tasks. Any committee, whether staff-wide or other clinical unit-based, or whether standing or ad hoc, that is carrying out all or any portion of a function or activity required by these Bylaws or the Rules is deemed a duly appointed and authorized committee of the Medical Staff.

Appointment of Members

Except as otherwise specifically noted in these Bylaws:

All Medical Staff members of committees shall be appointed by the Chief of Staff with the approval of the Medical Executive Committee of the Whole.

The chairperson of each committee shall be appointed by the Chief of Staff, subject to the approval of the Medical Executive Committee of the Whole.

All representatives of Hospital Administration shall be appointed by the Chief Executive Officer or his/her designee.

All representatives of the Nursing Department shall be appointed by the Nursing Administrator.

All representatives of the Governing Body shall be appointed by the Governing Body.

The committee Chair, after consulting with the Chief of Staff and Chief Executive Officer, when appropriate, may call on outside consultants or special advisors.

Each committee Chair may appoint a temporary substitute to fulfill the duties of an absent committee member. The substitute may discuss and vote on issues presented to the committee.

Attendance of Non-members

Any Medical Staff member who is in good standing may ask the Chair of any committee for permission to attend a portion of that committee's meeting dealing with a matter of importance to that Practitioner. The committee Chair shall have the discretion to grant or deny the request and shall grant the request only if the member's attendance will reasonably aid the committee to perform its function. If the request is granted, the invited member shall abide by all Bylaws and Rules applicable to that committee.

Term and Removal

Ordinarily, committee members will be appointed to serve a two year term and may be reappointed to additional consecutive two year terms.

Any committee member who is appointed by the Chief of Staff may be removed by the Chief of Staff.

The removal of any committee member who is automatically assigned to a committee because he/she is a Staff officer or other official shall be governed by the provisions pertaining to removal of such officer or official. All other committee members may be removed for (i) failure to cooperatively and effectively perform his/her committee responsibilities; or (ii) loss or significant restriction of Clinical Privileges.

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

Duties

Each Staff committee is responsible to:

Develop policies and procedures describing how it will carry out its purpose and, upon approval by the Medical Executive Committee of the Whole and the Governing Body, implement these policies and procedures.

Be aware of and use best efforts to assure compliance with applicable state and federal laws and regulations insofar as they relate to the purview of the committee.

Unless otherwise specified in these Bylaws and Rules, meet as often as necessary to fulfill its purpose.

Unless otherwise provided by Hospital policy, maintain permanent records of its activities in accordance with Section 8.04.

Authority

Each Staff committee shall have the following authority:

To review all records and charts pertinent to the purposes of the committee and to perform quality improvement reviews as requested.

To require the appearance before it of any Practitioner, Allied Health Professional, or nurse whose conduct is being reviewed, or who has information relevant to the purposes of the committee; provided, however, the Hospital CEO shall be immediately notified of and may object to the required appearance of any Hospital employee if reasonably deemed necessary to protect the employee's personal rights.

To request that the Chief of Staff appoint one or more special consultants, who need not be members of the Medical Staff, to assist in any peer review or quality improvement activities.

Accountability and Relationships

Each committee shall be accountable to its chairperson.

Except the Medical Executive Officers Committee, the chairperson of each committee shall be accountable to the Medical Executive Committee of the Whole and the Chief of Staff.

Except the Medical Executive Officers Committee, each chairperson shall regularly report to the Medical Executive Committee of the Whole. This reporting may be accomplished by providing a verbal report of the committee chair, if in attendance.

Action Through Subcommittees

Any standing committee may use subcommittees to help carry out its duties. The Medical Executive Officers Committee shall be informed when a subcommittee is appointed. The committee chair may appoint individuals in addition to or other than members of the standing committee to the subcommittee after consulting with the Chief of Staff.

Conduct and Records of Meetings

Committee meetings shall be conducted and documented in the manner specified in the Rules.

MEDICAL EXECUTIVE COMMITTEE

Purpose/Structure

The purpose of the Medical Executive Committee is to assure the development and implementation of policies, procedures, programs, rules, and regulations that accomplish the purposes and functions of the Medical Staff organization. The Committee shall also serve as the primary forum by which the Medical Staff formally participates in the Hospital's budget, planning, and policymaking processes.

To best achieve the stated purpose in 7.02-1(a) above, the Medical Executive Committee is comprised of: the Medical Executive Committee of the Whole and the Medical Executive Officers Committee. The Medical Executive Committee of the Whole shall be primarily responsible for oversight of the Medical Staff. However, because of the small size of the Medical Staff and in order to improve and enhance the corrective action process, the Medical Executive Committee of the Whole has identified certain responsibilities that are to be exercised solely by a limited part of the committee, referred to as the Medical Executive Officers Committee. All other responsibilities not designated for the Medical Executive Officers Committee will be exercised by the Medical Executive Committee of the Whole.

Composition

The Medical Executive Committee of the Whole shall be comprised of the Active Medical Staff members, the Director of Acute Care Nursing, the Director of Skilled Nursing, the Director of Performance Improvement/Medical Staff, the Director of Pharmaceutical Services, and the Director of Health Information Management, and the Chief Executive Officer. The Chief of Staff shall be chairperson of the Medical Executive Committee. At the discretion of the Chief of Staff, any other person may attend. Only Active Medical Staff members can vote.

The Medical Executive Officers Committee shall include all general medical staff officers: the Chief of Staff, the Vice Chief of Staff, and the Secretary-Treasurer. The Chief Executive Officer shall serve as an ex officio member without vote. Other active members may attend at the discretion of the Chief of Staff, without a vote.

Duties

The Medical Executive Committee of the Whole shall:

With the assistance of the Chief of Staff, supervise the performance of all Medical Staff functions, which shall include:

Requiring regular reports and recommendations from the committees and officers of the Staff concerning discharge of assigned functions;

Issuing such directives as appropriate to assure effective performance of all Medical Staff functions; and

Following up to assure implementation of all directives.

Coordinate the activities of the committees.

Use input and reports from the departments and the Credentials Committee to ensure that the Medical Staff adopts Bylaws, Rules or regulations establishing criteria and standards, consistent with California law, for Medical Staff membership and Privileges (including but not limited to, any Privileges that may be appropriately performed via Telemedicine), and for enforcing those criteria and standards in reviewing the qualifications, credentials, performance, and professional competence and character of applicants and Staff members.

Assure that the Medical Staff adopts Bylaws and Rules establishing the structure of the Medical Staff, the mechanism used to review credentials and to delineate individual Privileges, the mechanism by which membership on the Medical Staff may be terminated, and the mechanism for fair hearing procedures, as well as other matters relevant to the operation of an organized Medical Staff.

Perform the functions of the Medical Staff Performance Improvement Committee as described in Hospital's Performance Improvement Plan.

Perform all utilization review functions for the Medical Staff, including, but not limited to:

Assure that the Medical Staff adopts, as deemed necessary, additional Bylaws, Rules or regulations establishing clinical criteria and standards to oversee and manage quality assessment and improvement activities, utilization review activities and other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff and its committees and departments and review and analysis of patient medical records.

With the assistance of the Chief of Staff, supervise the Medical Staff's compliance with:

The Medical Staff Bylaws, Rules, policies, and procedures;

The Hospital's lawful and reasonable Bylaws, Rules, policies, and procedures; and

State and federal laws and regulations.

Oversee the development of Medical Staff policies and procedures, approve (or disapprove, with guidance) all such policies and procedures, and oversee the implementation of all such policies and procedures.

Implement the reasonable policies and procedures of the Hospital including but not limited to patient complaints and grievances, sentinel events, unanticipated outcomes, error reporting, unlawful harassment and Practitioner conduct, quality improvement, risk management and utilization management.

With the Committee Chairs, set objectives for the establishment, maintenance, and enforcement of professional standards within the Hospital, and for the continuing improvement of the quality of care rendered in the Hospital, and assist in developing programs to achieve these objectives.

Regularly report to the Governing Body, through the Chief of Staff and the Chief Executive Officer, on at least the following:

The outcomes of Medical Staff quality improvement programs with sufficient background and detail to assure the Governing Body that quality of care is consistent with professional standards; and

The general status of any Medical Staff disciplinary or corrective actions in progress.

Make recommendations to the Governing Body regarding the structure of the Medical Staff, the mechanism used to review credentials and to delineate individual Clinical Privileges, the organization of the quality assessment and improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities, the mechanism by which membership on the Medical Staff may be terminated, and the mechanism for fair hearing procedures. (This responsibility may be satisfied by way of Medical Staff Bylaws provisions addressing these issues.)

Review and make recommendations to the Chief Executive Officer regarding quality of care issues related to exclusive contract arrangements for professional medical services.

Review and approve for appropriate scope and quality the sources of patient care provided outside the hospital.

Establish, subject to the approval of the Governing Body, such additional standing committees as necessary to carry out functions described in these Bylaws or otherwise assigned to or assumed by the Medical Staff.

Establish, as necessary, such ad hoc committees that will function for limited times for the performance of circumscribed functions and that will report directly to the Medical Executive Committee of the Whole or Medical Executive Officers Committee, as determined at the time of appointment.

Take reasonable steps to develop continuing education activities and programs for the Medical Staff that incorporate the recommendations and results of Medical Staff quality assessment and improvement activities.

The Medical Executive Officers Committee shall:

Promulgate rules further illustrating and implementing the purposes of Section 2.05, Standard of Conduct, as it deems necessary.

Have the option, in its sole discretion, **and subject to approval by the Governing Board,** to waive the 24-month waiting period following an adverse action, in accordance with Section 4.07-1(b).

Be consulted by the Chief of Staff in making a determination if consultations are necessary before making a determination of a Practitioner 's clinical privileges.

Be informed when a subcommittee or ad hoc committee is appointed and oversee all subcommittees and ad hoc committees.

In accordance with Article XI, initiate and/or pursue disciplinary or corrective actions affecting Medical Staff members and participate in the hearing process in accordance with Article XII.

Cooperate in providing relevant input to notice-and-comment proceedings or other mechanisms that may be implemented by Hospital administration in making exclusive contracting decisions.

In accordance with Section 12.14, invoke the Dispute Resolution Process for disputes between the Medical Staff and the Governing Body and participate in the appropriate dispute resolution forum, as described further in these Bylaws.

Make the final decision on whether to grant a Practitioner's request to correct their credentials file, after the Chief of Staff has reviewed the request and review all practitioner statements when practitioners seek to add such statements to their credential files, in compliance with Section 9.05.

Oversee requests for review of Bylaws, Rules, or policies in accordance with Article XIII herein.

Authority

Both the Medical Executive Committee of the Whole and the Medical Executive Officers Committee, when appropriate, shall have the authority to:

Summarily suspend any Practitioner whenever the personal or professional conduct of that member is such that a failure to take action may result in an imminent danger to the health of any individual.

Require any Practitioner to appear before the Committee whenever the Committee considers it necessary in order to carry out its duties and responsibilities.

Take any action that the Committee deems necessary in discharging its duties and responsibilities.

Evaluate the performance of Practitioners exercising Clinical Privileges whenever there is doubt about an applicant's, member's, or AHP's ability to perform requested Privileges.

Accountability and Relationships

The Medical Executive Committee of the Whole is directly responsible and accountable to the Medical Executive Officers Committee and the Governing Body. The Medical Executive Officers Committee is directly responsible and accountable to the Governing Body. Both the Medical Executive Committee of the Whole and the Medical Executive Officers Committee shall report through the Chief of Staff or designee:

At each Governing Body meeting, discharge of the functions of the Medical Staff organization as stated in the Medical Staff Bylaws;

To any committee of the Governing Body whenever such committee requests a report.

At any other meeting of the Staff when requested to do so by any member.

Meetings

The Medical Executive Committee of the Whole shall be scheduled to meet on a monthly basis and shall meet at least 10 times during the calendar year. A permanent record of its proceedings and actions shall be maintained.

The Chief of Staff may convene as needed a meeting of the Medical Executive Officers Committee. A permanent record of its proceedings and actions shall be maintained.

OTHER COMMITTEES

The following committees, along with the Medical Executive Officers Committee, shall be considered standing committees of the Medical Staff:

Credentials Committee,

Emergency Services and Trauma Committee,

Health Information Management Committee,

Infection Control Committee,

Joint Conference Committee,

Patient Safety Committee, and

Physician Well-Being Committee.

The composition, purpose, accountability/relationships and other matters relating to these committees are outlined in Rule VII.

MEETINGS

GENERAL STAFF MEETINGS

Regular Meetings

There shall be at least 10 Medical Executive Committee of the Whole meetings per year. The June meetings shall be designated as the "Annual Medical Staff Meeting." These shall include provisional and consulting staff.

Special Meetings

Special meetings of the Medical Staff may be called at any time by the Chief of staff or the Medical Executive Officer Committee. The Governing Body may also call a special meeting of the Medical Staff if they first request the Chief of Staff or the Medical Executive Officer Committee do so but they fail to take such action accordingly.

COMMITTEE MEETINGS

Regular Meetings

Committees may, by resolution, provide the time for holding regular meetings and no notice other than the resolution shall then be required. Medical Staff committee meetings will be held as outlined, specific to each Committee, in Rule VII.

Special Meetings

A special meeting of any committee may be called by, or at the request of, the committee Chairperson or the Chief of Staff. The Governing Body may also call a special meeting of any committee if they first request the Chief of Staff or the committee Chairperson do so but they fail to take such action accordingly.

NOTICE OF MEETINGS

Written notice of any general or special Staff meeting not held pursuant to resolution shall be posted in a Medical Staff memo or shall be distributed to each person entitled to be present. Notice of committee meetings may be given orally. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

GENERAL PROVISIONS

General provisions pertaining to quorum requirements, manner of action, minutes and recordkeeping, attendance requirements, and consequences of failing to meet attendance requirements shall be as provided in Rule VIII.

CONFIDENTIAL RECORDS AND INFORMATION

GENERAL

Medical Staff or committee minutes, files and records, including information regarding any member or applicant to this 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 Executive 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 of the Whole (the Medical Executive Officers Committee, when applicable), or its designee, and the Chief Executive Officer.

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, and inasmuch as members and others participate in credentialing, quality improvement, and peer review activities with the reasonable expectation that this confidentiality will be preserved and maintained, any breach of confidentiality of the discussions or deliberations of the Medical Staff 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 and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Officers Committee may undertake such corrective action as it deems appropriate.

ACCESS TO CONFIDENTIAL INFORMATION

Medical Staff records, including confidential committee records and credentials files, shall be accessible by:

Committee members, and their authorized representatives, for the purpose of conducting authorized committee functions.

Medical Staff officials, and their authorized representatives, for the purpose of fulfilling any authorized function of such official.

The Chief Executive Officer, the Governing Body, and their authorized representatives, for the purpose of enabling them to discharge their lawful obligations and responsibilities.

Individuals authorized to access confidential committee records shall maintain the confidentiality of such information and make only such disclosures as are necessary to their effective performance of authorized responsibilities.

ACCESS TO MEDICAL STAFF CREDENTIALS FILE

In addition to the access permitted pursuant to Section 9.03 above, information contained in the credentials file of any member may be disclosed with the member's consent, or to any Medical Staff or professional licensing board, or as required by law.

A Medical Staff member shall be granted access to his/her own credentials file, subject to the following provisions:

Notice of a request to review the file shall be given by the member to the Chief of Staff (or his/her designee) at least three days before the requested date for review.

The member may review and receive a copy of only those documents provided by or addressed personally to the member. A summary of all other information, including peer review committee findings, letters of reference, proctoring reports, complaints, etc., shall be provided to the member, in writing, by the designated officer of the Medical Staff within a reasonable period of time (not to exceed two weeks). Such summary shall disclose the substance, but not the source, of the information summarized.

The review by the member shall take place in the Medical Staff office, during normal work hours, with an officer or designee of the Chief of Staff present.

In the event a Notice of Charges is filed against a member, access to that member's credentials file shall be governed by Section 12.05-5.

MEMBER'S OPPORTUNITY TO REQUEST CORRECTION OF INFORMATION IN FILE

After review of his/her file, a member may address to the Chief of Staff a written request for correction of information in the credentials file. Such request shall include a statement of the basis for the action requested.

The Chief of Staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Officers Committee whether to make the correction as requested, and the Medical Executive Officers Committee shall make the final determination.

The member shall be notified promptly, in writing, of the decision of the Medical Executive Officers Committee.

In any case, a member shall have the right to add to his/her credentials file a statement responding to any information contained in the file. Any such written statement shall be addressed to the Medical Executive Officers Committee, and shall be placed in the credentials file immediately following review by the Medical Executive Officers Committee meeting.

IMMUNITY AND RELEASES

IMMUNITY FROM LIABILITY

For Action Taken

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

For Providing Information

No representative of the Hospital or Medical Staff and no third party shall be liable for damages or other relief by reason of providing information (including otherwise privileged or confidential information) to a representative of this Hospital or Medical Staff or to any other hospital, organization of health professionals, or other health-related organization concerning a Practitioner or Allied Health Professional who is or has been an applicant to or member of the Staff or who did or does exercise Clinical Privileges or provide specified services at this Hospital.

ACTIVITIES AND INFORMATION COVERED

Activities

The 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:

Applications for appointment, Clinical Privileges, or specified services;

Periodic reappraisals for reappointment, Clinical Privileges, or specified services;

Corrective action;

Hearings and appellate reviews;

Quality improvement review, including patient care audits;

Peer review;

Utilization reviews; and

Morbidity and mortality conferences; and

Other Hospital or committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

Information

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

RELEASES

Each Practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article; however, execution of such release shall not be deemed a prerequisite to the effectiveness of this Article.

CUMULATIVE EFFECT

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

INDEMNIFICATION

The hospital shall indemnify, defend, and hold harmless the medical staff and its individual members ("Indemnitee(s)") from and against losses and expenses (including reasonable attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute

relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities including, but not limited to:

As a member of or witness for a medical staff, service, committee, or hearing panel;

As a member of or witness for the Hospital Governing Body or any hospital task force, group or committee; and

As a person providing information to any Medical Staff or Hospital, officer, Governing Body 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 Hospital shall retain responsibility for the sole management and defense of any such claims, suits, investigations or other disputes against Indemnitees, including but not limited to selection of legal counsel to defend against any such actions. The indemnity set forth herein is expressly conditioned on Indemnitees' good faith belief that their actions, inactions, and/or communications are reasonable and warranted and in furtherance of the Medical Staff's peer review, quality assessment or quality improvement responsibilities, in accordance with the purposes of the Medical Staff as set forth in these Bylaws. In no event will the Hospital indemnify an Indemnitee for acts or omissions taken in bad faith or in pursuit of the Indemnitees' private economic interests.

CORRECTIVE ACTION

OVERVIEW

Goals

The Medical Staff is responsible for overseeing the quality of medical care, treatment, and services delivered in the Hospital. An important component of that responsibility is the oversight of care rendered by members and AHPs practicing in the Hospital. The following provisions are designed to achieve quality improvements through collegial peer review and educative measures whenever possible, but with recognition that, when circumstances warrant, the Medical Staff is responsible to embark on informal remedial measures and/or corrective action as necessary to achieve and assure quality of care, treatment, and services.

Members of the Medical Staff are expected to actively participate in the Hospital's quality improvement activities. Peer review is an important component of such activities. Members of the Medical Staff participate in a variety of peer review activities to measure, assess, and improve Medical Staff member performance. The primary goals of peer review are to prevent, detect, and resolve problems and potential problems. The responsibility for peer review is delegated to the Medical Staff. Medical Staff members are responsible to carry out delegated peer review and quality improvement functions in a manner that is consistent, timely, defensible, balanced, and useful.

Participation in Peer Review

The Medical Staff officers and committees are responsible for carrying out delegated peer review and quality improvement functions. Whenever feasible in the context of "peer review," the term "peer" will be interpreted to mean that a majority of the principal reviewers (i.e., the reviewers initially responsible to assess standard of care for that category of Practitioner) will hold the same license as the Practitioner under review, and at least one of the reviewers will practice the same specialty as the Practitioner under review. Where this is not feasible, given the size and composition of the Medical Staff, reasonable efforts should be made to consult with one or more Practitioners not on the Medical Staff to obtain reliable information as to the appropriate standard of care applicable to the involved category of Practitioner.

Types of Corrective Actions

Corrective actions may include, but are not limited to:

Routine monitoring and education, as further described in Section 11.02.

Expedited initial review and investigation, as further described in Section 11.03.

Formal investigation and corrective actions, including:

Routine corrective action in cases where summary or automatic actions are not warranted, as described in Section 11.04.

Summary actions, as described in Section 11.05.

Automatic actions, as described in Section 11.06.

Criteria for Initiation of Corrective Action.

In addition to the specific requirements of Sections 2.03(i) and 11.01-4(b), any person who believes that remedial action may be warranted may provide information to the Chief of Staff, any other Medical Staff officer, any Medical Staff committee, the chair of any Medical Staff committee, the Governing Body, or the Chief Executive Officer about the conduct, performance, or competence of Medical Staff members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct either within or outside of the Hospital, that are reasonably likely to be – (i) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (ii) unethical; (iii) contrary to the Medical Staff Bylaws or Rules; (iv) below applicable professional standards; (v) disruptive of Medical Staff or Hospital operations; (vi) an improper utilization of Hospital resources as determined by the Medical Staff – a request for a formal investigation of or action against such member should be brought to the attention of the Chief of Staff, any other officer of the Medical Staff, the chair of any standing committee of the Medical Staff, the Chief Executive Officer, or the Governing Body, as appropriate.

A recommendation for formal corrective action may also be initiated by any Medical Staff Committee, with respect to activities, conduct, or performance within the scope of authority of that committee. Such recommendation shall be recorded in the minutes of that committee, and shall be reported to the Chief of Staff and the Medical Executive Officers Committee through the committee's chair and/or the minutes.

Ordinarily formal corrective actions will only be initiated after reasonable attempts at informal resolution have failed. However, whenever circumstances reasonably appear to warrant prompt resort to formal action, informal corrective action measures may be dispensed with. Any recommendation of formal corrective action must be based on evaluation of member/applicant-specific information.

ROUTINE MONITORING AND EDUCATION

When circumstances warrant, the responsible peer reviewers may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent proctoring or monitoring in the course of carrying out their duties, without initiating formal corrective action. Comments, suggestions, and warnings may be issued orally or in writing. The Practitioner shall be given an opportunity to respond in writing and may be given an opportunity to meet with the Medical Executive Officers Committee. Any such informal actions shall be documented in the member's file. The actions shall not constitute a restriction of Privileges, nor shall they be grounds for any hearing or appeal rights under Article XII.

EXPEDITED INITIAL REVIEW AND INFORMAL INVESTIGATION

Whenever information suggests that corrective action may be warranted, the Chief of Staff or his/her designee may, on behalf of the Medical Executive Officers Committee, immediately investigate and conduct whatever interviews may be indicated. This initial investigation shall be deemed an "informal investigation." The information developed during this initial review shall be presented to the Medical Executive Officers Committee, which shall decide whether to initiate a formal corrective action investigation. The informal investigation described in this Section 11.03 is generally the appropriate first step in cases involving patient grievances or complaints of harassment or discrimination involving a member of the Medical Staff.

Expedited review shall be conducted on behalf of the Medical Executive Officers Committee by the Chief of Staff, his/her designee, together with representatives of Administration, or by an attorney for the Hospital. In cases of complaints of harassment or discrimination where the alleged wrongdoer is a Medical Staff member, and the complainant is not a patient, an expedited initial review shall be conducted by the Chief of Staff, and the Chief Executive Officer or their designee, or by an attorney for the Hospital.

The expedited initial review may or may not be a Medical Staff proceeding, depending on whether patient care issues are involved. Information obtained during this review may be disclosed as necessary to enable the Hospital to meet its legal obligations in cases involving patient grievance and/or unlawful harassment or discrimination. Additionally, the information gathered from such review may be referred to the Medical Executive Committee if it is determined that corrective action may be indicated against a Medical Staff member.

ROUTINE CORRECTIVE ACTION

Requests for Investigation and Corrective Action

Whenever activities or conduct described in Section 11.01-3 are brought to the attention of any official named in that section, the Chief of Staff shall be notified. The Chief of Staff shall notify the Chief Executive Officer, or his/her designee in his/her absence, and the Medical Executive Officers Committee and shall continue to keep them fully informed of all action taken. In addition, the Chief of Staff shall immediately forward all necessary information to the investigating body; provided, however, that the Chief of Staff or the Medical Executive Officers Committee may dispense with further investigation of matters deemed to have been adequately investigated by or on behalf of a committee, pursuant to Section 11.01-4 (b), 11.03, or otherwise.

Investigation

The investigation shall be conducted promptly by the Medical Executive Officers Committee, by an ad hoc committee appointed by the Medical Executive Officers Committee, or by the Chief of Staff. Additionally, the investigating body may, but is not required to, engage the services of one or more outside reviewers as deemed appropriate or helpful in light of the circumstances (e.g., to help assure unbiased review, to firm up an uncertain or controversial review, or to engage specialized expertise). Within 30 days after completion of the investigation, a written report of the investigation shall be forwarded, together with any recommendations, to the Chief of Staff. If additional time is needed to complete the investigation, an interim report shall be forwarded, which should include a specific request for additional time to complete the investigation. Prior to completing its investigation, the Practitioner against whom corrective action has been requested shall, in most cases, have an opportunity to interview with the investigating body, as more specifically described in Section 12.01.

Whenever a formal investigation (as defined in California Business and Professions Code section 821.5) is initiated of a physician's ability to practice medicine safely, based upon information indicating that the physician may be suffering from a disabling mental or physical condition that poses a threat to patient care, the Medical Executive- Committee shall, within 15 days of initiating the formal investigation, report the physician's name and general nature of the investigation to the diversion program of the Medical Board of California. Upon completion of the investigation, a follow-up report shall be made, as required by law.

The Medical Executive Officers Committee Action

Within 30 days following the Chief of Staff's receipt of the investigative report, the Medical Executive Officers Committee shall consider the report, if it has not done so already as the author of the report, and, where appropriate shall take action, to include, without limitation:

Determining that no corrective action should be taken and, if the Medical Executive Officers Committee determines there was no credible evidence for the complaint in the first instance, clearly documenting those findings in the Practitioner's file.

Deferring action for a reasonable time.

Issuing a warning, or a letter of admonition or reprimand (although nothing herein shall be deemed to preclude committee chairs from issuing informal written or oral warnings outside of the mechanism for corrective action). In the event such letters are issued, the affected Practitioner may make a written response, which shall be placed in his/her file.

Providing for proctors and ongoing review in accordance with Rule V-3.

Recommending terms of probation or special limitation upon continued Medical Staff membership or exercise of Privileges, including without limitation, requirements for co-admissions or monitoring.

Recommending requirements of consultation.

Recommending reduction, modification, suspension, or revocation of Clinical Privileges. If suspension is recommended, the duration and terms of suspension, as well as the conditions precedent to its termination, shall be stated.

Recommending reduction of Staff category or limitation of any Staff prerogatives directly related to patient care.

Recommending suspension or revocation of Staff membership. If suspension is recommended, the duration and terms of suspension, as well as the conditions precedent to its termination, shall be stated.

Recommending other remedial actions as deemed necessary and appropriate under the circumstances.

Procedural Rights

Subject to the provisions of Section 11.05-3 (if applicable), any action by the Medical Executive Committee pursuant to Section 11.04-3(g) with the exception of a reduction in staff category for other than medical disciplinary cause or reason and (h), or (i), or any other action that must be reported to the Medical Board of California pursuant to Business and Professions Code section 805, shall entitle the Practitioner to the procedural rights as provided in Article XII.

There shall be hearing rights as provided in Article XII for actions described in 11.04-3 (d), (e), or (f), if the remedial action is one that must be reported to the Medical Board of California pursuant to Business and Professions Code section 805; otherwise no hearing rights shall apply.

There shall be no hearing rights associated with any action described in Section 11.04-3(a), (b), or (c); nor shall there be hearing rights for consultations imposed by the Rules, or imposed by the Chief of Staff on a case-by-case basis.

There shall be no hearing rights arising out of the Medical Staff's failure to accept and process an application in cases where the applicant is seeking Privileges in an area that is operated by an exclusive contract and the potential applicant is not a member of or contractor with the contracting group.

Provisions elsewhere in these Bylaws shall govern procedural rights in other specific circumstances (e.g. Section 11.06, pertaining to loss of privileges due to automatic actions and Section 11.07-3, pertaining to exclusive contracts).

Other Action

If the Medical Executive Committee's recommended action is as provided in Section 11.04-3(a), (b), or (c), or if it is an action described in Section 11.04-3(d), (e), or (f) or (g) and that need not be reported to the Medical Board of California, such recommendation, together with all supporting documentation, shall be transmitted to the Governing Body. Thereafter, the procedure shall be essentially as described in Rule IV-1.2(j).

Governing Body Initiation of Action

The Medical Staff acknowledges that the Governing Body must act to protect the quality of medical care provided and the competency of its Medical Staff, and to ensure the responsible governance of the Hospital in the event that the Medical Staff fails in any of its substantive duties or responsibilities.

Accordingly, in those instances in which the Medical Executive Officers Committee's failure to investigate or initiate disciplinary action is contrary to the weight of the evidence, the Governing Body shall, after consultation with the Medical Executive Officers Committee, have the authority to direct the Medical Executive Officers Committee to initiate an investigation or corrective action, including specific adverse action as deemed necessary by the Governing Body.

If the Medical Executive Officers Committee fails to take action in response to a direction from the Governing Body, the Governing Body shall have the authority to take action against such Practitioner. Such action shall only be taken after written notice to the Medical Executive Officers Committee, and shall give rise to the procedural rights described in Article XII.

SUMMARY SUSPENSION

Criteria and Initiation

Whenever a Practitioner's conduct is such that a failure to take action may result in an imminent danger to the health of any individual or may result in a severe disruption of Medical Staff or Hospital operations of a type that might result in a danger to the health of an individual, the Medical Executive Officers Committee may summarily suspend or restrict (and hereby authorizes the Chief of Staff to summarily suspend or restrict) the Medical Staff status or Clinical Privileges of such Practitioner. The Governing Body or Chief Executive Officer may summarily

suspend or restrict Privileges of a Practitioner, under the same circumstances, when no person authorized by the Medical Staff is available, provided the Governing Body or Chief Executive Officer has made reasonable attempts to contact the persons so authorized. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition and the person or body responsible therefore shall promptly give written notice of the suspension to the Practitioner, Governing Body, the Medical Executive Officers Committee, and Chief Executive Officer. The notice shall generally describe the reasons for the action. The summary restriction or suspension may be limited in duration in order to permit an investigation to be conducted and shall remain in effect for the period stated or if none, until resolved as set forth herein. The notice of the summary action shall be provided to the Medical Executive Officers Committee, and shall constitute a request to initiate corrective action pursuant to Section 11.04-1. Unless otherwise indicated by the terms of the summary restriction or suspension, the Practitioner's patients shall be promptly assigned to another Practitioner by the Chief of Staff, considering, where feasible, the wishes of the patient and the affected Practitioner in the choice of a substitute Practitioner.

The Medical Executive Officers Committee Action

If the suspension was imposed by the Chief of Staff or the Medical Executive Officers Committee, and if requested by the Practitioner, a meeting of the Medical Executive Officers Committee shall be convened as soon as possible, but no later than 14 days after imposition of such summary suspension, to review the action taken. If the suspension was imposed by the Governing Body or Chief Executive Officer, the Medical Executive Officers Committee must meet (regardless of whether such meeting has been requested by the Practitioner) within two working days, excluding weekends and holidays; and failure of the Medical Executive Officers Committee to ratify the suspension within this time frame shall result in automatic termination of the suspension and reinstatement of the Practitioner. The Medical Executive Officers Committee may recommend modification, continuation, or termination of the summary suspension, as well as, without limitation, any action described in Section 11.04-3. Whenever suspension is sustained, the Medical Executive Officers Committee shall delineate the duration and terms of the suspension, and the conditions of reinstatement or other permanent action.

Procedural Rights

Unless the Medical Executive Officers Committee recommends immediate termination of the suspension or restriction and cessation of all further corrective action (or a suspension imposed by the Governing Body is terminated through lack of Medical Executive Officers Committee ratification within the time frame specified in Section 11.05-2), the Practitioner shall be entitled to the procedural rights as provided in Article XII, and the hearing may be consolidated with the hearing on any corrective action that is recommended so long as the latter hearing is able to be commenced either within 60 days or prior to completion of the summary action hearing (if such hearing is still under way). The terms of the summary suspension as sustained or as modified by t the Medical Executive Officers Committee shall remain in effect pending satisfaction of any conditions of reinstatement or a final decision by the Governing Body. There shall be no procedural rights associated with any suspension or restriction of 14 days or less that is rescinded or not ratified by the Medical Executive Officers Committee.

AUTOMATIC SUSPENSION AND TERMINATION

License

A Staff member or Allied Health Professional whose California license to practice expires without an application pending for renewal, or is revoked or suspended shall immediately and automatically be revoked or suspended (as applicable) from practicing in the Hospital. In addition, whenever restrictions have been placed on a Staff member's or AHP's license, corresponding restrictions shall automatically be placed on the member's or AHP's Privileges in the Hospital. In the case of restrictions of licensure, or at the time a Practitioner or AHP seeks reinstatement following suspension or revocation (and reinstatement) of a license, the Medical Executive Committee will consider the facts under which the license was revoked, suspended, or restricted, and may then take such further corrective action as is appropriate to the facts disclosed in the investigation.

Controlled Drug Number

A Staff member whose permit to prescribe or administer controlled substances is revoked or suspended shall immediately and automatically be divested of his/her right to prescribe medications covered by such permit. In addition, whenever restrictions have been placed on a Staff member's permit, corresponding restrictions shall automatically be placed on the member's prescribing Privileges in the Hospital. The Medical Executive Officers Committee will consider the facts under which the permit was revoked, suspended, or restricted, and may then take such further corrective action as is appropriate to the facts disclosed in the investigation.

Medical Records

Medical Staff members are required to complete medical records within the time prescribed by the Medical Executive Committee of the Whole. After warning of delinquency, an automatic suspension from Staff membership shall be imposed for failure to complete medical records as specified in the Medical Staff Rules. Such suspension shall apply to the Staff member's right to admit, treat, or provide services to new elective patients in the Hospital, but shall not affect his/her right to provide urgent or emergency services or to continue to care for a patient already admitted by or being treated by the affected Staff member. The suspension shall be effective until the medical records are completed. If after 30 consecutive days of suspension the member remains suspended, the member shall be considered to have voluntarily resigned from the Medical Staff.

Liability Insurance

Automatic suspensions from Staff membership shall be imposed for failure to maintain professional liability insurance in accordance with Rule XIV-1. In addition, failure to maintain professional liability insurance for certain procedures shall result in automatic suspension of Clinical Privileges to perform those specific procedures. The suspension shall be effective until appropriate coverage is reinstated, including coverage of any acts or potential liabilities that may have occurred or arisen involving Hospital patients during the period of any lapse in coverage. A failure

to provide evidence of appropriate coverage within six months after the date of automatic suspension shall be deemed a voluntary resignation of the member from the Medical Staff.

Failure to Comply with Government and Other Third Party Payer Requirements

The Medical Executive Officers Committee shall be empowered to determine that certain specific rules and requirements of third party payers, government agencies, and professional review organizations are of a nature that compliance with such requirements by Medical Staff members and Allied Health Professionals is essential to Hospital and/or Medical Staff operations and that compliance with such requirements can be objectively determined. A Practitioner who fails to comply with any such requirement shall be given notice of his/her noncompliance. Thereafter, the Practitioner shall have 30 days to come into compliance or to satisfactorily explain his/her noncompliance to the Medical Executive Officers Committee. Failure to correct or satisfactorily explain noncompliance shall result in automatic suspension for failure to comply with such requirements. The suspension shall be effective until he/she complies with such requirements.

Failure to Satisfy Special Appearance Requirement

A Practitioner who fails without good cause to appear and satisfy the requirements of Rule VIII-4.3 (special appearances) shall be suspended from exercising his/her Clinical Privileges if so determined by the Medical Executive Officers Committee. The Medical Executive Committee of the Whole will determine whether the suspension is deemed "administrative" or "medical disciplinary," depending on the facts and circumstances giving rise to the special appearance requirements.

Automatic Termination

If after six months the Practitioner remains suspended, his/her membership shall be automatically terminated. In addition, membership or Privileges shall also be automatically terminated in the event a Practitioner fails to complete proctoring requirements, as further described in Rule V-3.6. Thereafter, reinstatement to the Medical Staff shall require application and compliance with Section 4.01.

Procedural Rights Associated with Automatic Actions

Whenever the automatic suspension is required to be reported to the Medical Board of California, the Practitioner shall be entitled to a hearing pursuant to Article XII; however, no hearing is required when a member's license or legal credential to practice has been revoked or suspended. In other cases, if a hearing is granted, it shall be limited in scope, and shall not include evidence designed to show that the determination by a licensing or credentialing authority was unreasonable or unwarranted, but only whether the Practitioner should be permitted to continue to practice at this Hospital with those limitations imposed.

In all other cases (i.e., whenever a Medical Board of California report is not required), anyone whose membership has been automatically suspended or terminated shall be entitled at his/her request to meet with the Medical Executive Committee to review the action. The review must be requested within 10 days after notification of action; must be conducted within 90 days of such notification; and shall be limited to whether or not the conditions described in these sections had in fact occurred. There shall be a right to only one Medical Executive Committee review of the reasons for suspension and termination; if there is a review conducted after a suspension, there shall be no right of additional review in the event a suspended Practitioner is later terminated pursuant to Section 11.06-7. The formal hearing procedures described at Article XII shall not apply, and the decision of the Medical Executive Officers Committee shall then become and remain effective pending the final decision of the Governing Body.

PRIVILEGES OF PHYSICIANS WHO ARE UNDER CONTRACT TO THE HOSPITAL

Medical Disciplinary Rights

Any Practitioner whose engagement by the Hospital requires membership on the Medical Staff shall not have his/her Medical Staff Privileges terminated for any "medical disciplinary" cause or reason without the same fair procedure provisions that are provided for other Medical Staff members pursuant to these Bylaws.

Effect of Contract

Privileges of Practitioners who are under contract to the Hospital shall depend on the nature of the contract. If the contract is an exclusive contract, and the affected Practitioner or Practitioners are no longer members of the contracting group, then those Privileges covered by the exclusive contract shall be automatically relinquished, subject to the provisions of Sections 2.02-5 and 11.07-3. If the contract is not an exclusive contract, the affected Practitioner's Privileges shall not automatically be altered or suspended when their contract with the Hospital is terminated.

Termination of Contracts

Termination of Hospital contracts shall be the sole province of the Hospital's administration; provided, however, that if the reason for a Practitioner's contract termination or his/her departure from the contracting group is based on a "medical disciplinary" cause or reason, as determined by the Medical Executive Officers Committee, the Practitioner shall be entitled to the procedural rights specified in Article XII.

CONFIDENTIALITY; IMPARTIALITY

To maintain confidentiality, and to ensure the unbiased pursuit of all Medical Staff disciplinary actions, Staff members participating in the corrective action process shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws for peer review and

discipline. Members of the committees and Staff members shall avoid further discussing the case outside of the committees appointed to investigate or review Medical Staff disciplinary matter.

INTERVIEWS, HEARINGS AND APPELLATE REVIEW

INTERVIEWS

Except as provided in Section 12.01(b), if a committee is going to make a negative recommendation to the Medical Executive Officers Committee regarding a Practitioner, the committee chair shall notify the Practitioner of the pending adverse recommendation as outlined in Sections 12.04-1(b) through (o) and of Section 12.01 of the Medical Staff Bylaws and shall afford the Practitioner an interview before the issue is forwarded to the Medical Executive Officers Committee. At such interview he/she shall be informed of the specific nature of the investigation, and be asked to discuss, explain, or refute the matters at issue. Such interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules set forth in Sections 12.02 through 12.13 shall apply.

The foregoing provision for Practitioner interview may be dispensed with if, in the sole discretion of the investigating body, notice to the Practitioner might reasonably be expected to jeopardize the investigation; however, if such interview is not conducted by the investigating body, the Practitioner must be afforded an interview by the Medical Executive Officers Committee prior to finalizing its recommendation.

When the Medical Executive Officers Committee receives or is considering initiating an adverse recommendation concerning a Practitioner, the Practitioner may be afforded an informal interview with the Medical Executive Officers Committee at the discretion of the Medical Executive Officers Committee; provided, however, that if the Practitioner was not afforded an interview by the investigating body per Section 12.01(b), then the Medical Executive Officers Committee shall afford such an interview. The interview shall not constitute a hearing, shall be preliminary in nature, and need not be conducted according to the procedural rules applicable to hearings. At such interview, the Practitioner will be informed of the general nature of the circumstances and may present relevant information. A record of any such interview shall be made; however, such record need not be verbatim. Nothing in the foregoing shall limit the ability of any authorized individual or body to take summary action when warranted by the circumstances.

HEARINGS AND APPELLATE REVIEW

Review Philosophy

The intent in adopting these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect applicants and Practitioners, and at the same time to protect the peer review participants from liability. It is further the intent to establish flexible procedures that do not create burdens that will discourage the Medical Staff and Governing Body from carrying out peer review. Accordingly, discretion is granted to the Medical Staff and Governing Body to create a hearing process that provides for the least burdensome level of formality in the process, and yet still provides a fair review, and Article XII shall be interpreted in this context. Further, technical, insignificant, or non-prejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken.

Adverse Medical Executive Officers Committee Recommendation

When any Practitioner receives notice of an adverse recommendation of the Medical Executive Officers Committee, he/she shall be entitled, upon request, to a hearing before an ad hoc hearing committee of the Medical Staff or arbitrator(s), as outlined in Section 12.05-1. If the recommendation following such hearing is still adverse to the Practitioner, he/she shall then be entitled, upon request, to an appellate review by a committee of the Governing Body before a final decision is rendered by the Governing Body.

Exceptions

Neither the issuance of a warning, a letter of admonition, a letter of reprimand, nor the denial, termination or reduction of temporary Privileges without medical disciplinary cause, nor any other actions except those specified in Article XII shall give rise to any right to a hearing or appellate review. Further, the fair hearing procedures described in these Bylaws are intended for the resolution of factual disputes, or to challenge whether or not the provisions of these Bylaws have been followed. The provisions of Article XII are not intended as a mechanism to challenge the substantive validity of the Medical Staff or Hospital Bylaws, Rules, regulations, or policies, and the Hearing Committee appointed pursuant to this Article shall not be empowered to hold quasi-legislative, notice-and-comment-type hearings, or to make quasi-legislative determinations, or determinations as to the substantive validity of Bylaws, Rules, regulations, or other intra-organizational legislation. Such challenges shall, instead, be made through the mechanism described at Article XIII of these Bylaws.

Adverse Governing Body Decision

When any Practitioner receives notice of an adverse decision by the Governing Body taken either contrary to a favorable recommendation by the Medical Executive Officers Committee or on the Governing Body's own initiative, such Practitioner shall be entitled, upon request, to a hearing by a committee comprised of Medical Staff and Governing Body members appointed by the Governing Body, or by arbitrator(s), as outlined at Section 12.05-1. If such hearing results in an unfavorable recommendation, he/she shall then be entitled, upon request, to an appellate review by the Governing Body or a committee of the Governing Body before a final decision is rendered.

EXHAUSTION OF REMEDIES

If adverse action is taken with respect to a Practitioner's Staff membership or Privileges, regardless of whether the Practitioner is an applicant or a Medical Staff member, the Practitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action challenging the action or procedures used to arrive at the action or asserting any claim against any participants in the decision-making process.

INITIATION OF HEARING

Recommendations or Actions

Except as otherwise provided in these Bylaws, the following recommendations or actions shall, if deemed adverse pursuant to Section 12.04-2, entitle the affected Practitioner to a hearing:

Denial of initial Staff appointment.

Denial of reappointment.

Suspension of Staff membership, if suspension remains in effect for a cumulative total of 30 days or more within one 12 month period.

Revocation of Staff membership except as otherwise provided in Section 4.06.

Denial of requested advancement of Staff category, unless denial is based on other than medical disciplinary cause or reason.

Reduction in Staff category, unless reduction is based on other than medical disciplinary cause or reason.

Limitation of the right to admit patients.

Denial of requested Clinical Privileges.

Reduction in Clinical Privileges.

Suspension of Clinical Privileges, if suspension remains in effect for a cumulative total of 30 days or more within one 12 month period.

Revocation of Clinical Privileges.

Terms of probation, to the extent the terms of probation constitute a limitation of the practitioner's exercise of clinical privileges.

Summary suspension of clinical privileges and/or medical staff membership for any period in excess of 14 days.

Requirement of consultation (except as imposed by the Rules or on a case-by-case basis).

Any other "medical disciplinary" action or recommendation that must be reported to the Medical Board of California.

When Deemed Adverse

A recommendation or action listed in Section 12.04-1 shall be deemed adverse only when it has been:

Recommended by the Medical Executive Officers Committee;

Taken by the Governing Body contrary to a favorable recommendation by the Medical Executive Committee; or

Taken by the Governing Body on its own initiative without benefit of a prior recommendation by the Medical Executive Committee as described in the Rules.

An action shall not be deemed adverse, for purposes of providing hearing rights, if it involves an action otherwise described in these Bylaws as not giving rise to hearing rights (such as, but not limited to, Practitioners who are not members of or who depart the group holding an exclusive contract, or Practitioners who are subject to certain automatic actions, as described in Section 11.06).

Notice of Adverse Recommendation or Action

A Practitioner against whom adverse action has been taken shall promptly be given Special Notice of such action. Such Notice shall:

Contain a general statement of the reasons or subject matter forming the basis for the adverse recommendation or action, which is the subject of the hearing.

Advise the Practitioner of his/her right to a hearing pursuant to the provisions of Article XII.

Specify the number of days following the date of receipt of Notice within which a request for a hearing must be submitted.

State that failure to request a hearing within the specified time period shall constitute a waiver of rights to a hearing and to an appellate review on the matter.

State that after receipt by the Hospital of his/her hearing request, the Practitioner will be notified of the date, time, and place of the hearing, as well as a more specific Notice of Charges consisting of a concise statement of the Practitioner's alleged acts or omissions, a list by number of the specific or representative patient records in question and/or the other reasons or subject matter forming the basis for the adverse recommendation or action, which is the subject of the hearing.

Contain a summary of the Practitioner's rights in the hearing.

Advise the Practitioner whether the action, if adopted, must be reported to the Medical Board of California pursuant to Business and Professions Code section 805.

Request for Hearing

A Practitioner shall have 30 days following the date of receipt of Special Notice to file a written request for a hearing. Such request shall be delivered to the Chief Executive Officer either in person or by certified or registered mail. The Practitioner shall state, in writing, his or her intentions with respect to attorney representation at the time he or she files the request for a hearing. Section 12.11-2 shall apply.

Waiver by Failure to Request a Hearing

A Practitioner who fails to request a hearing within 30 days from the date of receipt waives any right to such hearing and to any appellate review. Such waiver in connection with:

An adverse action by the Governing Body shall constitute acceptance of that action, which shall then become effective as the final decision of the Governing Body.

An adverse recommendation by the Medical Executive Officers Committee shall constitute acceptance of that recommendation, which shall then become and remain effective pending the final decision of the Governing Body. In considering the matter, the Governing Body shall give great weight to the recommendation of the Medical Executive Officers Committee. If the Governing Body's action on the matter is in accord with the Medical Executive Officers Committee's final recommendation, such action shall constitute a final decision of the Governing Body. If the Governing Body proposes changing the Medical Executive Officers Committee's recommendation, the matter shall be submitted to a joint conference of equal numbers of Medical Staff and Governing Body members selected by the Chief of Staff and Chairman of the Governing Body. The Governing Body's action on the matter following receipt of the joint conference recommendation shall constitute its final decision. The Chief Executive Officer shall promptly send the Practitioner Special Notice informing him/her of each action taken pursuant to this Section, and shall notify the Chief of Staff of each such action.

HEARING PREREQUISITES; APPOINTMENT OF COMMITTEE; NOTICE; EXCHANGE OF WITNESS LISTS; PRODUCTION OF DOCUMENTS; PRE-HEARING MOTIONS

Appointment of Hearing Committee

By Medical Staff: Except as next provided, a hearing based upon the Medical Executive Officers Committee's adverse action or recommendation shall be conducted by a Hearing Committee appointed by the Chief of the Medical Staff and composed of at least three members of the Medical Staff; however, if necessary, Hearing Committee members may be selected who are not Medical Staff members. Alternatively, with the approval of the affected Practitioner, the hearing may be conducted before an arbitrator or arbitrators (who need not be health professionals) selected by a process mutually acceptable to the Medical Executive Officers Committee and the Practitioner. One of the appointees shall be designated as Chair.

By Governing Body: A hearing based upon an adverse action of the Governing Body shall be conducted by a Hearing Committee appointed by the chair of the Governing Body and composed of at least four persons, at least two of whom should be Medical Staff members. Alternatively, the hearing may be conducted before an arbitrator or arbitrators selected by a process mutually acceptable to the Governing Body and the Practitioner. One of the appointees shall be designated as Chair. In circumstances where the Medical Executive Officers Committee opposes the action recommended by the Governing Body, and where appointment of an arbitrator is not the agreed-upon course for the hearing, the Governing Body may appoint a Hearing Committee comprised of Practitioners who are not members of the Medical Staff. One of the appointees shall be designated as Chair. It is specifically acknowledged that any such committee will be performing a fair hearing function on behalf of the Medical Staff, and is thus deemed a Medical Staff Committee for all purposes, including but not limited to the privileges and immunities applicable to the records, proceedings, and participants of Medical Staff Committees. Similarly, whenever a hearing is conducted by an arbitrator (or arbitrators), the arbitrator(s) shall have the same powers and shall be subject to the same procedures and rights as set forth in the Bylaws for Hearing Committees.

Service on Hearing Committee: In order to avoid a possible claim of prejudice by the affected Practitioner, a Hearing Committee shall be composed of individuals who have not acted as an accuser, investigator, fact-finder, or initial decision-maker in the same matter; and who shall gain no direct benefit from the outcome of the hearing. If feasible, the Hearing Committee should include an individual practicing the same specialty as the Practitioner.

Alternates: Alternate Hearing Committee members may be appointed who meet the standards described above and who can serve if a Hearing Committee member becomes unavailable. An alternate may attend all sessions of the hearing, and may attend and, in the discretion of the hearing officer, participate in deliberations. An alternate shall not vote unless a Hearing Committee member is absent from or otherwise unable to vote due to failure to meet the attendance requirements of Section 12.06–10.

Voir Dire: The affected Practitioner shall be notified in writing of his/her right to pose relevant questions to the Hearing Committee and the presiding officer, and to challenge the impartiality of those individuals based upon bias or conflict of interest. Any such challenge must be reasonably supported by facts.

Authority: The Hearing Committee (or arbitrator) shall have such powers and authority as reasonably necessary to discharge its (his/her) responsibilities.

Notice of Time and Place for Hearing; Notice of Charges

Within 10 days after receipt by the Chief Executive Officer of the Practitioner's request for a hearing, the Chief of Staff or the Chief Executive Officer (on behalf of the Governing Body) shall schedule a hearing; provided, however, this time frame may be extended for good cause by the Chief of Staff (or Chief Executive Officer on behalf of the Governing Body). The Chief Executive Officer shall send the Practitioner Special Notice of the time, place, and date of the hearing, as well as the names of the Hearing Committee members and the hearing officer. The hearing date shall be not less than 30 days or more than 60 days from the date of receipt of the request.

Together with the notice stating the place, time, and date of the hearing, there shall be sent a notice of charges that states clearly and concisely, in writing, the reasons for the proposed action or recommendation, including the acts or omissions with which the Practitioner is charged and a list of the charts in question, where applicable.

Witness Lists

If known at the time of the notice of hearing, the Practitioner shall be given a list of witnesses (if any) who are expected to testify at the hearing. Within five days of receipt of a request from the Medical Executive Officers Committee, the Practitioner shall forward his/her list of anticipated witnesses. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. The failure to have provided the name of a witness at least 10 days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

Amendments to Notice of Charges/Witness Lists

The Medical Executive Officers Committee may amend its notice of charges and/or its list of witnesses; provided, however, that such amendment shall be provided to the Practitioner as soon as reasonably possible under the circumstances; and provided, further, that the Practitioner shall be entitled to a continuance if any such amendment substantially changes the scope of the hearing or substantially affects the Practitioner's ability to adequately prepare for the hearing. The hearing officer shall determine whether any such continuance is necessary.

Discovery Rights

The Practitioner shall have the right to inspect and copy, at his/her expense, any documentary information relevant to the charges that the Medical Executive Officers Committee has in its possession or under its control, as soon as practicable after delivery of his/her request for a hearing.

The Medical Executive Officers Committee shall have the right to inspect and copy, at its expense, any documentary information relevant to the charges that the Practitioner has in his/her possession or control, as soon as practicable after receipt of the Medical Executive Officers Committee's request therefore.

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. Repeated failure to comply shall be good cause for the hearing officer to limit the introduction of any documents not provided to the other side in a timely manner.

The right to inspect and copy by either party does not extend to confidential information referring to individually identifiable Practitioners, other than the Practitioner under review; nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information.

Documents to be Introduced at Hearing

At the request of either side, the parties shall exchange copies of all documents expected to be introduced at the hearing. Failure to produce such copies at least 10 days before the commencement of the hearing shall constitute good cause for a continuance.

Pre-hearing Motions and Procedural Disputes

As provided by Section 12.05-1(e), the parties shall be entitled to challenge the impartiality of the hearing officer and/or the Hearing Committee. Such a challenge shall be made as soon in advance of the hearing as possible after the challenging party becomes aware of a possible cause of bias or conflict of interest. Challenges may be made in writing, or may be made orally during a prehearing conference. The Hearing Officer will rule on any challenges.

The parties shall be entitled to file pre-hearing motions as deemed necessary to give full effect to rights established by these Bylaws, and to resolve such procedural matters as the hearing officer determines may properly be resolved outside the presence of the full Hearing Committee. It shall be the duty of the Practitioner and the Medical Executive Officers Committee (or its representative) to exercise

reasonable diligence in notifying the hearing officer of any pending or anticipated motion or 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. Such motions or procedural disputes shall be raised in writing and shall specifically state the request, all relevant factual information, and any supporting authority for the motion. The requesting party shall deliver a copy to the opposing party, who shall have five working days to submit a written response to the hearing officer, with a copy to the moving or complaining party.

The hearing officer shall determine whether to allow oral argument on any such motion or procedural dispute. The hearing officer's ruling shall be in writing and shall be provided to the parties promptly upon its rendering. All requests, and rulings thereon, shall be entered into the hearing record by the hearing officer. Objections to any pre-hearing decisions may be succinctly made at the hearing.

Continuance or Postponement of the Hearing

The hearing officer shall use his/her best efforts and discretion to assure that the hearing is commenced as scheduled. Subject to the foregoing, continuances or postponements may be affected by agreement of the parties or by action of the hearing officer. Requests for continuance or postponement of a hearing shall be addressed to the hearing officer as soon as the need therefore is reasonably known to the party, and shall be supported with a written statement demonstrating good cause for the continuance or postponement. Such a request may be granted by the hearing officer upon a showing of good cause. (If a hearing officer has not yet been appointed, the request for continuance shall be addressed to and acted upon by the Chief Executive Officer.) A ruling on the request shall be in writing, stating the basis for the granting or denial of the requested postponement or continuance.

HEARING PROCEDURE

Personal Presence

The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails, without good cause, to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner and with the same consequence as provided in Section 12.04-5, above.

Presiding Officer

The hearing officer, who shall be an attorney appointed in accordance with Section 12.11-1, shall be the presiding officer. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence in an efficient and expeditious manner. If the presiding officer determines that either party is not proceeding in an efficient and expeditious manner, the presiding officer may take such discretionary action as seems warranted by the circumstances. He/she shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence, including but not limited to:

Rulings on challenges to the impartiality of any of the Hearing Committee members or of the presiding officer himself/herself.

Rulings on requests for access to information pursuant to Section 12.05-5. The hearing officer, upon the request of either side, may deny a discovery request when justified to protect peer review or justice.

In making such rulings, the presiding officer may impose any safeguards to protect the peer review process and justice. Moreover, in making such rulings and determining the relevancy of the requested information, the presiding officer shall, among other factors, consider the following:

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

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

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

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

Representation

The Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a member of the Medical Staff in good standing or by a member of his/her local professional society. The Medical Executive Officers Committee or the Governing Body, depending on whose recommendation or action prompted the hearing, shall appoint an individual to represent it at the hearing, to present the facts in support of its adverse recommendation or action, and to examine witnesses. Representation of either party by an attorney at law (including Medical Staff or professional society members who are also attorneys) shall be governed by Section 12.11-2.

Rights of Parties

Each of the parties shall have the right (if exercised in an efficient and expeditious manner) to:

Pose relevant questions to the hearing panel and the presiding officer, and to challenge the impartiality of any member or the presiding officer, in accordance with Sections 12.05-1(e), 12.05-7(a), and 12.06-2.

Call and examine witnesses.

Introduce relevant evidence.

Cross-examine any witness on any matter relevant to the issues.

Impeach any witness.

Rebut any relevant evidence.

Be provided with all of the information provided to the Hearing Committee.

Have a record made of the hearing, in accordance with Section 12.06-8.

Submit memoranda concerning any issue of law or fact, including proposed findings of fact and conclusions of law, prior to, at, or within 10 days after the close of the hearing. Such memoranda shall become a part of the hearing record.

The affected Practitioner may be called and examined as if under cross-examination. These rights shall be exercised in an efficient and expeditious manner and within reasonable limitations imposed by the presiding officer.

Procedure and Evidence

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Subject to the provisions of Section 12.06-6, any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall, prior to, during, or within 10 days after the close of the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become a part of the hearing record. The presiding officer may order that oral evidence be taken only on oath or affirmation.

Official Notice

In reaching a decision, the Hearing Committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the State of California. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be noted in the hearing record. Any party shall be given the opportunity, on timely request, to request that a matter be officially noticed and to refute the officially noticed matters by evidence or by written or oral presentation of authority (the manner of such refutation to be determined by the hearing officer).

Burden of Producing Evidence; Burden of Proof

When a hearing relates to an adverse action or recommendation as set forth in Section 12.04-1, the body making the adverse action or recommendation shall have the initial obligation to present evidence in support of that action or recommendation. The Practitioner shall then be obligated to present evidence in response; however, Practitioners shall not be permitted to introduce information not produced upon request of the peer review body during the application process, unless the Practitioner establishes that the information could not have been produced previously in the exercise of reasonable diligence.

Thereafter:

Initial applicants (including Staff members requesting new Privileges) shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, of their qualifications by producing information that allows for adequate evaluation and resolution of reasonable doubts concerning their current qualifications for Staff Privileges or membership.

Except as provided above for initial applicants, the Medical Executive Officers Committee shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that the action or recommendation is reasonable and warranted.

Record of Hearing

To facilitate Governing Body and possible judicial review, a record of the hearing (including such pre-hearing proceedings as deemed appropriate by the hearing officer) shall be made by a court reporter. The cost of the court reporter shall be borne by the Hospital and the cost of the transcript shall be borne by the requesting party.

Continuances; Completion of the Hearing

The hearing officer shall use his/her best efforts and discretion to assure that the hearing is completed in an expeditious manner. Subject to the foregoing, continuances may be affected by agreement of the parties or by action of the hearing officer. Requests for continuance shall be processed as described in Section 12.05-8. The hearing shall be completed within a reasonable time under the circumstances unless the hearing

officer issues a written decision finding that the Practitioner failed to comply with requests to produce documentary evidence, pursuant to Section 12.05-5, in a timely manner, or consented to the delay.

Presence of Hearing Committee Members and Vote

A majority of the Hearing Committee must be present throughout the hearing and deliberations. In unusual circumstances where a committee member must be absent from any part of the proceedings, he/she shall not be permitted to participate in the deliberations or the decision unless and until he/she has read or heard the entire transcript of the portion of the hearing from which he/she was absent. The final decision of the Hearing Committee must be sustained by a majority vote of the number of members appointed.

Recesses and Adjournment

The Hearing Committee may recess and reconvene the hearing, without additional notice, for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing record shall be closed. The Hearing Committee shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties. To facilitate preparation of the Hearing Committee's report, the hearing officer may attend deliberations. His/her participation in deliberations shall be limited to facilitating discussion and helping assure that the Hearing Committee follows procedures and addresses all relevant issues. Upon the conclusion of its deliberations, the hearing shall be declared finally adjourned.

HEARING COMMITTEE REPORT AND FURTHER ACTION

Hearing Committee Report

Within 30 days (five working days if a summary suspension is involved) after final adjournment of the hearing, the Hearing Committee shall render its decision in writing. The decision of the Hearing Committee shall be based on the evidence and written statements introduced at the hearing, including all logical and reasonable inferences from the evidence and testimony. The decision shall include the Hearing Committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. The hearing officer may assist in preparation of the Hearing Committee report; however, the final report must be approved by the Hearing Committee.

Report

The Hearing Committee report shall be sent to the parties to the hearing together with the Notice of a right to appeal and a written explanation of the procedure for appealing the decision.

Request for Appeal

Either party may request appeal of the findings and recommendations of the Hearing Committee, as provided in Section 12.08-2, below.

No Appeal

If an appellate review is not requested within 10 days, the decision of the Hearing Committee shall be forwarded to the Governing Body for final action. The Governing Body shall give great weight to the decision of the Hearing Committee.

INITIATION AND PREREQUISITES OF APPELLATE REVIEW

Request for Appellate Review

The parties shall have 10 days following receipt of a Notice as provided for in Section 12.07-2 to file a written request for an appellate review. Such request shall state the grounds for the appeal (see Section 12.08-2) and shall be delivered to the Chief Executive Officer either in person or by certified or registered mail. The Practitioner may also request a copy of the report and record of the Hearing Committee and all other material, favorable or unfavorable, if not previously forwarded, that was considered by the Hearing Committee or by a subsequently reviewing body in making the adverse recommendation.

Grounds for Appeal

An appeal shall be based upon one or more of the following grounds:

The recommendation of the Hearing Committee is arbitrary, capricious, or not supported by substantial evidence.

The substantial failure to follow the procedures outlined in the Medical Staff Bylaws.

The request for appeal shall state the specific manner in which the decision is arbitrary, capricious, or lacking in substantial basis, or in which the applicable procedures were not followed.

Waiver by Failure to Request Appellate Review

A party who fails to request an appellate review within the time and in the manner specified above waives any right to such review. Such waiver shall have the same force and effect as failure to request a hearing, as provided in Section 12.04-5.

Notice of Time and Place for Appellate Review

Upon receipt of a timely request for appellate review, the Chief Executive Officer shall deliver the request to the Governing Body. As soon as practicable, the Governing Body shall schedule an appellate review, which shall be held not less than 30 days nor more than 60 days from the date of receipt of the request; however, an appellate review for a Practitioner who is under a suspension then in effect shall be held as soon as the arrangements may reasonably be made, but not later than 30 days from the date of receipt of the request. At least 15 days prior to the appellate review, the Chief Executive Officer shall send the

Practitioner Special Notice of the time, place, and date of the review. The time for the appellate review may be extended by the presiding officer for good cause and if the request for extension is made as soon as is reasonably practical, provided that the appellate review shall be held as promptly thereafter as possible under the circumstances.

Appellate Review Body

The Governing Body shall determine whether an appeal shall be conducted by:

The Governing Body as a whole, with or without the assistance of an appellate hearing officer;

A committee composed of at least three members of the Governing Body, appointed by the Chair of the Governing Body, with or without the assistance of an appellate hearing officer; or

An appellate hearing officer only.

Whenever members of the Governing Body have had prior involvement, such as initiating, investigating, or reporting on matters at issue in the appeal, such members shall be excluded from serving on the appellate review body, or an appellate hearing officer should be appointed. If an appellate hearing officer is appointed to hear the appeal by himself/herself, references throughout Sections 12.08 and 12.09 to an "Appellate Review Body" shall be deemed to mean "appellate hearing officer."

Presiding Officer

The Chair of the Appellate Review Body or a hearing officer shall be the presiding officer. At the discretion of the Chair of the Appellate Review Body, a hearing officer may also be engaged to assist the Appellate Review Body by serving (in lieu of the Chair) as the presiding officer of the appellate review. The presiding officer shall determine the order of procedure during the review, make all required rulings, and maintain decorum, and shall endeavor to assure that the appeal is conducted in an efficient and expeditious manner. If the presiding officer determines that either party is not proceeding in an efficient and expeditious manner, the presiding officer may take such discretionary action as seems warranted by the circumstances.

APPELLATE REVIEW PROCEDURE

Nature of Proceedings

The proceedings by the review body shall be in the nature of an appellate review based upon the record of the Hearing Committee, that committee's report, the written statements, if any, submitted as provided below, and such other material as may be presented and accepted within the terms of this Plan.

The appeal proceeding shall, unless otherwise ordered by the Governing Body upon request of the Practitioner, be held in private or executive session. Prior to exercising its discretion on any request for a public hearing, the Governing Body shall seek and consider the comments of the Medical Executive Officers Committee as to the implications and feasibility of conducting such a hearing in public. Thereafter, the Governing Body shall determine whether public or private hearing is in the best interests of the Hospital, and the hearing shall be conducted accordingly.

Written Statements

The party seeking the review may submit a written statement detailing the findings, conclusions, and procedural matters with which he/she/it disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the Appellate Review Body and the opposing party through the Chief Executive Officer at least 10 days prior to the scheduled date of the appellate review, or later if this time limit is waived by the presiding officer of the Appellate Review Body. A written statement in reply may be submitted by the opposing party and if submitted, the Chief Executive Officer shall provide a copy to the appealing party at least three days prior to the appellate review.

Appearance

The parties or their representatives shall have the right to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be expected to answer questions put to him by any member of the Appellate Review Body.

Consideration of New or Additional Matters

Except for new material provided pursuant to Section 12.08-1, new or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review level only in the discretion of

the Appellate Review Body, following a foundational showing that such evidence could not have been made available in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the hearing. Alternatively, the Appellate Review Body may remand the matter to the Hearing Committee for the taking of further evidence and a reconsidered decision in light of such further evidence.

Powers

The Appellate Review Body and presiding officer shall have all powers granted to the Hearing Committee and hearing officer, and such additional powers as are reasonably appropriate to the discharge of their responsibilities.

The Appellate Review Body and the appellate hearing officer shall have the authority to issue subpoenas and subpoenas duces tecum as provided by the California Local Hospital District Law. This authority shall be exercised in a manner consistent with the provisions of these Bylaws pertaining to rights of access to information (including Section 12.05-5) and to consideration of new or additional matters on appeal (Section 12.09-4).

Recesses and Adjournment

The Appellate Review Body may recess and reconvene the review proceedings, without additional notice, for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements and submission of any written statements within the time frame established by the presiding officer, the appellate review record shall be closed. The Appellate Review Body shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties. To facilitate preparation of the Appellate Review Body's report, the appellate hearing officer may attend deliberations. His/her participation in deliberations shall be limited to facilitating discussion and helping assure that the Appellate Review Body follows procedures and addresses all relevant issues. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned.

Burden of Proof; Action by the Appellate Review Body

The Appellate Review Body shall sustain the decision of the Hearing Committee unless it finds that the decision is not supported by substantial evidence, that it is arbitrary, unreasonable, or capricious; or that there has been a substantial failure to follow the procedures outlined in the Bylaws. If the decision is not sustained, the Appellate Review Body may recommend that the Governing Body modify or reverse the recommendation of the Hearing Committee or, in its discretion, the Appellate Review Body may refer the matter back to a Hearing Committee for further review and recommendation to be returned to it within 30 days (15 days if summary suspension is involved) and in accordance with its instructions. Within 10 days (five days if summary suspension is involved) after receipt of a recommendation after referral, the Appellate Review Body shall make its recommendation to the Governing Body. The Appellate Review Body's recommendation shall be in writing, shall include findings of fact and a conclusion articulating the connection between the evidence produced during the hearing and appeal process and the decision reached, and shall be provided to the Governing Body and the parties. The appellate hearing officer may assist in preparation of the Appellate Review Body's report; however, the final report must be approved by the Appellate Review Body.

Conclusion

The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Plan have been completed or waived.

FINAL DECISION OF THE GOVERNING BODY

Within 30 days (15 days if summary suspension is involved) after the conclusion of the appellate review, the Governing Body shall render its final decision in writing. The decision shall include the Governing Body's findings of fact and a conclusion articulating the connection between the evidence produced during the hearing and appeal process and the decision ultimately reached. The Chief Executive Officer shall send notice of the decision of the Governing Body to the Practitioner (by Special Notice), to the Chief of Staff, and to the Medical Executive Officers Committee. This decision shall be immediately effective and final.

GENERAL PROVISIONS

Hearing Officer Appointment and Duties

The use of a hearing officer to preside at a hearing is mandatory. The Medical Executive Committee of the Whole may establish hearing officer selection procedures subject to approval by the Governing Body. In the absence of specific procedures, the hearing officer will be selected by the Hospital Administrator, taking into consideration any comments from the Medical Executive Committee of the Whole or the affected Practitioner. A 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 foregoing shall not be construed to prevent using the same hearing officer from hearing to hearing so long as that individual does not regularly render other legal service to the Hospital.) The hearing officer shall not be biased for or against any party, and shall gain no direct financial benefit from the outcome of the hearing (i.e., the hearing officer's remuneration shall not be dependent upon or vary upon the outcome of the hearing. The hearing officer shall not act as a prosecuting officer or advocate, and shall not be entitled to vote. The cost of the hearing officer shall be borne by the Hospital.

Attorneys

Neither the affected Practitioner nor the Medical Executive Officers Committee nor the Governing Body shall be represented in any phase of the initial hearing by an attorney at law unless the Hearing Committee Chair agrees in his/her sole discretion to allow both sides to be represented by legal counsel. Further, except as otherwise permitted by law with respect to dentists, if the affected Practitioner elects not to be represented by an attorney, then the Medical Executive Officers Committee shall not be represented by an attorney.

The hearings contemplated by this Article XII are intended for resolution of professional matters, and it is the general policy of the Medical Staff that attorneys should not be in attendance at these hearings. Therefore, the Hearing Committee chair should generally disallow the attendance of attorneys unless the chair determines that a fair hearing could not be held absent the attorneys' presence, and in making such a determination, the chair should consider the affected Practitioner's ability to represent himself/herself. Requests for attorneys' presence must accompany the request for hearing, and must state the unusual circumstances necessitating their presence. The foregoing shall not be deemed to deprive the parties of the right to legal counsel in connection with preparation for a hearing.

Any time attorneys are allowed to represent the parties at a hearing, the hearing officer shall have the discretion to limit the attorneys' role to advising their clients rather than presenting the case.

Both parties shall have the right, at their own expense, to be represented by an attorney or any other representative designated by the party at any appellate review hearing. If the affected Practitioner elects not to be represented by an attorney at this stage, the Medical Executive Officers Committee may nonetheless elect to have attorney representation in the appellate review hearing.

Waiver

If at any time after receipt of Special Notice of an adverse recommendation or action, a Practitioner fails to make a required appearance or otherwise fails to proceed or to comply with Article XII, he/she shall be deemed to have consented to such adverse recommendation or action and to have voluntarily waived all rights to which he/she might otherwise have been entitled under the Medical Staff Bylaws and Rules or under this Article.

Number of Reviews

No Practitioner shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to an adverse recommendation or action.

Confidentiality; Impartiality

To maintain confidentiality, and to ensure the unbiased performance of peer review, disciplinary, and credentialing functions, Staff members participating in any stages of the fair hearing process shall limit their discussion of the matters involved to the formal avenues provided in the Medical Staff Bylaws and Article XII.

Release

By requesting a hearing or appellate review under this Article XII, a Practitioner agrees to be bound by the provisions in the Medical Staff Bylaws relating to immunity from liability.

GOVERNING BODY

In the event the Governing Body should delegate some or all of its responsibilities described in this Article to one of its committees, the Governing Body shall nonetheless retain ultimate authority to accept, reject, modify, or return for further action or hearing, the recommendations of its committee.

PEER REVIEW BODIES

The Medical Staff, the Governing Body, and their officers, committees, and agents hereby constitute themselves as peer review bodies under the Federal Health Care Quality Improvement Act of 1986 and the California Business and Professions Code, and claim all privileges and immunities afforded by the federal and state laws.

DISPUTES WITH GOVERNING BODY

In the event of a dispute between the Medical Staff and the Governing Board relating to the independent rights of the Medical Staff, as further described in California Business and Professions Code section 2282.5, the following procedures shall apply:

Invoking the Dispute Resolution Process

The Medical Executive Officers Committee may invoke formal dispute resolution, upon its own initiative, or upon written request of 25% of the members of the Active Staff.

In the event the Medical Executive Officers Committee declines to invoke formal dispute resolution, such process shall be invoked upon written petition of 50% of the members of the Active Staff.

Dispute Resolution Forum

Ordinarily, the initial forum for dispute resolution shall be a meeting of the Chief of Staff, one other active Staff member selected by the Chief of Staff, and two members of the Governing Body.

However, upon request of at least 2/3 of the members of the Medical Executive Officers Committee, the meet and confer will be conducted by a meeting of the full Medical Executive Officers Committee and the full Governing Body. A neutral mediator acceptable to both the Governing Body and the Medical Executive Officers Committee may be engaged to further assist the dispute resolution upon request of (a) at least a majority of the Medical Executive Officers Committee plus two members of the Governing Body; or (b) at least a majority of the Governing Body plus two members of the Medical Executive Officers Committee. This meeting will take place in closed session.

If the parties are unable to resolve the dispute the Governing Body shall make its final determination giving great weight to the actions and recommendations of the Medical Executive Officers Committee. Further, the Governing Body determinations shall not be arbitrary or capricious, and shall be in keeping with its legal responsibilities to act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the Hospital.

REVIEW OF BYLAWS, RULES, AND MEDICAL STAFF POLICIES

REQUEST FOR REVIEW

Subject to the limitations set forth below, any Medical Staff member, or applicant against whom an adverse action has been taken (as described in Sections 12.04-1 and 12.04-2) may request review leading to amendment or repeal of the underlying Bylaw, Rule, or Medical Staff or applicable Hospital policy on the basis that it is believed to be substantively irrational. Such review shall be initiated by the submission of a written request, together with the substantiating rationale for such request. A Practitioner shall have 30 days following the date of receipt of Special Notice of such adverse action to file a written request for review of such Bylaw, Rule, or policy. Such request shall be delivered to the Chief of Staff either in person or by certified or registered mail and shall include the substantiating rationale for such request.

COMMITTEE REVIEW

The Medical Executive Committee of the Whole or an ad hoc committee appointed by the Medical Executive Committee of the Whole shall consider such request within 30 days. The committee shall either:

Recommend amendment of the Bylaws, Rules, or policy;

Request further information from the Practitioner and/or appropriate Medical Staff committees or representatives (which information should be provided within 30 days), following receipt of which it shall recommend amendment or denial of the request for amendment; or

Recommend denial of the request.

If an ad hoc committee is appointed to review the matter, its recommendation shall be forwarded to the Medical Executive Officers Committee for recommendation.

THE MEDICAL EXECUTIVE OFFICERS COMMITTEE ACTION

If the Medical Executive Officers Committee recommendation is to amend the Bylaws, Rules, or policy substantially as requested, the amendment shall be processed as set forth in Article XV of these Bylaws.

If the Medical Executive Officers Committee recommendation is to not amend the Bylaws, Rules or policy substantially as requested, and subject to Section 13.04 below, the affected Practitioner shall be informed of such decision. Thereafter, the Practitioner may, within 10 days, request that the Medical Executive Officers Committee convene an appropriate notice-and-comment forum for consideration of the involved provision. Such forum shall occur within 45 days of the request therefore, and shall enable all interested Medical Staff members, adversely affected applicants, and Medical Staff Executive Committees or representatives, and Hospital administration an opportunity to present information relating to the involved provision.

Thereafter, the Medical Executive Officers Committee shall make its final recommendation upon the matter, considering all information presented in conjunction with the above review.

LIMITATION ON FREQUENCY OF REVIEW

Notwithstanding the above, the Medical Executive Officers Committee need not reconsider any request for amendment of any provision that has been the subject of a formal review (or that is then under review) within the immediately preceding two-year period. "Formal review" shall mean any proceeding (including, but not limited to a notice-and-comment proceeding) that has afforded the involved Practitioner, or other similarly situated Practitioners reasonable opportunity to receive notice of the intended action, and to provide input (in the form of written or oral comments) prior to final decision on the matter(s) at issue.

TIME FRAMES

Requests pursuant to this Article shall be processed as expeditiously as reasonably possible, and, except for good cause, each action or recommendation described above should occur, respectively, at the next regularly scheduled meeting of each involved committee.

GENERAL PROVISIONS

OVERVIEW

These Bylaws describe the fundamental principles of Medical Staff self-governance and accountability to the Governing Body. Accordingly, the key standards for Medical Staff membership, appointment, reappointment and privileges are set out in these Bylaws. Additional provisions, including but not limited to administrative procedures for implementing the Medical Staff standards may be set out in Medical Staff or department Rules, or in policies adopted or approved as described below. Upon proper adoption, as described below, all such Rules and policies shall be deemed an integral part of the Medical Staff Bylaws.

STAFF RULES

Rules shall be developed as necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Staff member or Allied Health Professional in the Hospital. The Rules may be adopted, amended, or repealed by majority vote of the Medical Executive Committee of the Whole, and approval by the Governing Body. Upon adoption, they shall be deemed part of these Medical Staff Bylaws. Such rules shall not be inconsistent with the Medical Staff or hospital Bylaws, rules, or policies.

MEDICAL STAFF POLICIES

Policies shall be developed as necessary to implement more specifically the general principles found within these Bylaws and the Medical Staff Rules. The policies may be adopted, amended, or repealed by majority vote of the Medical Executive Committee of the Whole and approval by the Governing Body. Upon adoption, they shall be deemed part of these Medical Staff Bylaws. Such rules shall not be inconsistent with the Medical Staff or hospital Bylaws, rules, or policies.

MEDICAL STAFF PARTICIPATION IN HOSPITAL DELIBERATIONS

General

Medical Staff representatives, as designated by the Chief of Staff, shall participate in Hospital deliberations affecting the discharge of Medical Staff responsibilities.

The Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management, and physical plant safety by providing Medical Staff representation on Hospital committees established to perform such functions.

Exclusive Contracting Decisions

The Medical Executive Committee of the Whole shall review and make recommendations to the Chief Executive Officer regarding quality of care issues related to exclusive contract arrangements for professional medical services. In addition, the Medical Executive Committee of the Whole and individual members of Medical Staff shall cooperate in providing relevant input to notice-and-comment proceedings or other mechanisms that may be implemented by Hospital administration in making exclusive contracting decisions.

STAFF DUES

The Medical Executive Committee of the Whole shall have the authority to initiate and set the amount of reasonable annual dues for Staff membership, if any, and to determine the manner of expenditure of funds received. However, such expenditures must be appropriate to the purposes of the Medical Staff, and shall not jeopardize the public entity status of the Hospital.

FORMS

Application forms and any other prescribed forms required by these Bylaws for use in connection with Staff appointments, reappointments, delineation of Clinical Privileges, corrective action, notices, recommendations, reports, and other matters shall be developed by the Credentials Committee, with approval by the Medical Executive Committee of the Whole and the Governing Body. Upon adoption, they shall be deemed part of these Medical Staff Bylaws.

LEGAL COUNSEL

The Medical Staff may, at its expense, retain and be represented by independent legal counsel. If, in accordance with Section 12.11-2, attorney representation is allowed during the hearing process, then the Hospital shall arrange and pay for attorney representation.

AUTHORITY TO ACT

Any member who acts in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee of the Whole or the Medical Executive Officers Committee may deem appropriate.

ADOPTION AND AMENDMENT OF BYLAWS
EFFECT OF BYLAWS

MEDICAL STAFF RESPONSIBILITY AND AUTHORITY

The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend Medical Staff Bylaws and amendments, which shall be effective when approved by the Governing Body, which approval shall not be unreasonably withheld, or automatically within 60 days if the Governing Body has not taken action within that time. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely, and responsible manner, reflecting the interests of providing patient care of the generally professionally recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Governing Body. Amendments to these Bylaws may be submitted for vote by the Medical Executive Committee of the Whole or by petition signed by at least 10% of the Active Staff; provided, however, proposed amendments shall be submitted to the Governing Body for comments before they are distributed to the Medical Staff for a vote. The Governing Body has the right to have its comments regarding the proposed amendments circulated with the proposed amendments.

METHODOLOGY

Medical Staff Bylaws may be adopted, amended, or repealed by the following combined actions:

The affirmative vote of a majority of the Active Staff members obtained by voice vote, and

The approval of the Governing Body, which shall not be unreasonably withheld. If approval is withheld, the reasons for doing so shall be specified by the Governing Body in writing, and shall be forwarded to the Chief of Staff and the Medical Executive Committee of the Whole.

In recognition of the ultimate legal and fiduciary responsibility of the Governing Body, the organized Medical Staff acknowledges, in the event the Staff has unreasonably failed to exercise its responsibility and after notice from the Governing Body to such effect including a reasonable period of time for response, the Governing Body may impose conditions on the Staff that are required for continued State licensure, approval by accrediting bodies or to comply with a court judgment. In such event, Staff recommendations and views shall be carefully considered by the Governing Body in its actions.

TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Executive Committee of the Whole shall have the power to adopt such amendments to the Bylaws as are in its judgment technical modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression, or inaccurate cross-references. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Governing Body within 90 days after adoption by the Medical Executive Committee of the Whole. The action to amend may be taken by motion acted upon in the same manner as any other motion before the Medical Executive Committee of the Whole. After approval, such amendments shall be communicated in writing to the Staff and to the Governing Body.

BYLAWS NOT A CONTRACT

These Bylaws describe the intended relationship between the Medical Staff and its members, as well as between the Medical Staff (including its members) and the Hospital. It is intended that all affected parties and entities shall conduct themselves in good faith conformance with these Bylaws. However, these Bylaws are not intended to be a contract, and technical, insignificant, or non-prejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken or for seeking remedies that are contractual in nature.