BYLAWS

OF

THE PROFESSIONAL/AHP STAFF

PROVIDENCE SAINT JOSEPH MEDICAL CENTER

501 SOUTH BUENA VISTA

BURBANK, CA 91505

(Incorporates amendments through February 18, 2021)

Table of Contents

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THE PROFESSIONAL/AHP STAFF

PROVIDENCE SAINT JOSEPH MEDICAL CENTER

PREAMBLE

BECAUSE Providence Saint Joseph Medical Center of Burbank, a Catholic Institution, is operated by a not-for-profit corporation organized under the laws of the State of California; and BECAUSE its purpose is to serve as a general hospital providing patient care, education, and research; and

BECAUSE the Governing Board of the Medical Center has assigned to the organized Professional/AHP Staff the responsibility and authority for the quality of medical care in the Medical Center; and BECAUSE the cooperative efforts of the Professional/AHP Staff, the Administrator, and the Governing Board are necessary to fulfill the Medical Center's obligations to its patients; THEREFORE the Professional/AHP Staff who practice in this Medical Center hereby organize themselves to carry out these functions in conformity with these Bylaws.

(EP1) Bylaws of the Professional/AHP Staff, together with the Rules and Regulations and policies developed, adopted and amended by the organized Professional/AHP Staff are the organizational rules and structure by which the Professional/AHP Staff shall function and govern itself. (EP 3) All requirements of The Joint Commission elements of performance 12-36 are contained in these Bylaws. Some details of such requirements may reside in the Rules and Regulations and in policies. Adoption of such details and where they reside are determined by the Organized Professional/AHP Staff. For those elements of performance 12-36 that require a process, these bylaws shall include the basic steps as the Professional/AHP Staff determines and as the Governing Body approves that are required for implementation of these requirements.

(EP4) These Bylaws, Rules and Regulations and policies, the Governing Body Bylaws, and the Hospital policies are to be compatible with each other and compliant with law and regulation.

(EP5) The Professional/AHP Staff is to comply with the Professional/AHP Staff Bylaws, Rules and Regulations, and policies.

(EP6) The Organized Professional/AHP Staff will enforce its Bylaws, Rules and Regulations, and policies variously by recommending actions to the Governing Body or by taking action itself.

(EP7) The Governing Body will uphold the Professional/AHP Staff Bylaws, Rules and Regulations, and policies that have been approved by the Governing Body.

(EP8) The Organized Professional/AHP Staff will adopt Staff Bylaws, Rules and Regulations, and policies and amendments thereto, and propose them directly to the Governing Body.

DEFINITIONS

ADMINISTRATOR is that individual appointed by the Governing Board to act in its behalf in the overall management of the Medical Center. The Professional/AHP Staff may rely upon all actions of the Administrator as representing the authority of the Governing Board.

ADVERSE DISCIPLINARY ACTION shall refer to any action taken by the Professional/AHP Staff or any Officer, Committee or Department, which entitles the affected individual to request a hearing pursuant to Article VI of these Bylaws, and which by law, must be reported to the Medical Board of California pursuant to Business and Professions Code Section 805.

ALLIED HEALTH PROFESSIONAL or AHP means an individual, who either does not seek or is not entitled to apply for membership on the Professional/AHP Staff; who exercises independent judgment within the areas of his professional competence and the limits established by the Governing Board, the Professional/AHP Staff, and the applicable State Practice Acts; and who may be eligible to exercise practice privileges in conformity with the rules adopted by the Governing Board, these Bylaws, and the Professional/AHP Staff Rules and Regulations.

CLINICAL PRIVILEGES and PRIVILEGES means the permission granted to a Professional/AHP Staff member to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services.

EP is defined as the Joint Commission Elements of Performance. EP XX appears throughout the Bylaws to denote conformance with the variously numbered elements of performance. The entire list of Elements of Performance is contained in Appendix A.

EXECUTIVE COMMITTEE, MEC and Medical Executive Committee refers to the Medical Executive Committee of the Professional/AHP Staff as set forth in these Bylaws.

EXECUTIVE SESSION shall refer to that portion of a Professional/AHP Staff meeting which may be attended only by those individuals who are expressly entitled by these Bylaws to attend and vote or whose attendance is specifically requested by the meeting's Chairman. An executive session may be conducted at the discretion of the Chairman or presiding officer of the meeting or upon majority vote of those present and authorized to vote at the meeting.

EX OFFICIO AND EX OFFICIO MEMBER shall refer to those individuals who are entitled to attend a Professional/AHP Staff meeting but who are not entitled to vote at such meeting.

GOOD STANDING, a member in "good standing" holds full and unrestricted Professional/AHP Staff membership and privileges. Further, the member is not under investigation or has a disciplinary proceeding pending. A member under suspension based upon a failure to complete medical records is not in good standing during the period of suspension.

GOVERNING BOARD refers to the Governing Board of Sisters of Providence in California. The composition of the Governing Board shall be as defined in the corporate bylaws. The Governing Board has the ultimate responsibility and authority for the Medical Center. Governing Body and Governing Board refers to the San Fernando Valley Service Area Board and shall have the same meaning.

HE = he/she
HIM = him/her

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

PRACTICE PRIVILEGES means the permission granted to an Allied Health Professional to participate in the provision of certain patient care services.

PROFESSIONAL/AHP STAFF RULES AND REGULATIONS refers to the rules and regulations defined by staff committees, approved by the Medical Executive Committee and kept on file in the Professional/AHP Staff Office.

PROFESSIONAL/AHP STAFF or STAFF means the formal organization of licensed physicians, dentists, and podiatrists who are privileged to attend patients at Providence Saint Joseph Medical Center.

The terms "Professional Staff" and the "Professional /AHP Staff" shall be interchangeable.

PROVIDENCE SAINT JOSEPH MEDICAL CENTER is a part of a not-for-profit California corporation owned and operated by the Sisters of Providence as a health care facility.

STAFF YEAR extends from January 1 to December 31 of any given year.

ARTICLE I
NAME

The name of this organization shall be the Professional/AHP Staff of Providence Saint Joseph Medical Center of Burbank.

ARTICLE II
PURPOSE

The purpose of the organization shall be:

1. To ensure that all patients admitted to or treated in any of the facilities, departments, or services of the Medical Center shall receive good care;

2. To provide a means for communication between the Professional/AHP Staff, Administration, and the Governing Board in order to discuss and resolve problems of a medico-administrative nature.

3. To initiate and maintain self-government.

4. To provide education and maintain professional standards.

Finance Committee

1. Committee Composition
The Finance Committee shall be composed of 5 Active members of the Professional Staff

2. Term of Service and Selection
The Committee members shall serve a 5-year term. Membership shall select the new members three months prior to the completion of their term. Vacancies occurring during the 5-year term shall be filled be a majority vote of the committee. The initial committee members shall be appointed by the Chief of Staff.

3. Committee Responsibility
The Committee shall evaluate any request by the Chief of Staff which individually or collectively exceeds five thousand dollars ($5000) to any one vendor, entity or individual during the calendar year, also included for review and approval shall be proposals for changes that affect Professional/AHP Staff revenue by amounts that exceed five thousand dollars ($5000) per year. Disbursement of any amount exceeding five thousand dollars ($5000), or changes that affect revenue as described above shall require a majority support from the Finance Committee members.
The Professional Staff attorney, legal fees and expenses incurred by the annual Professional Staff Gala are excluded and shall not require the approval of the Finance Committee.
All actions taken by the Finance Committee related to disbursal of funds or changes that affect revenue of Professional/AHP Staff funds exceeding five thousand dollars ($5000) as described above and approved by the Finance Committee will be reported to the Medical Executive Committee

ARTICLE III
PROFESSIONAL/AHP STAFF MEMBERSHIP, CREDENTIALING, AND GRANTING OF CLINICAL PRIVILEGES

Application for and Appointment to Membership on the Professional/AHP Staff is distinct from the granting of Clinical Privileges.

Credentialing is that process of assessing and confirming the qualifications of a Physician, Dentist, Podiatrist, or Allied Health Professional.

Granting of Clinical Privileges is based upon:

The evaluation by Professional/AHP Staff Committees of the information and references provided by way of the Initial Application and subsequent Reappointment Applications, addressing formal training, clinical experience, and demonstrated ability, and recommendations made by these same Professional/AHP Staff Committees when finalized by approval of the Governing Board.

Membership on the Professional/AHP Staff of Providence Saint Joseph Medical Center is a privilege which shall be extended only to those physicians, dentists, and podiatrists who meet and continue to meet the standards and requirements set forth in these Bylaws and in the Rules and Regulations of the Professional/AHP Staff. In extraordinary circumstances (such as to reflect long-standing service to the Professional/AHP Staff), the Medical Executive Committee, in its sole discretion, may recommend that licensed individuals other than physicians, dentists, and podiatrists, be admitted to membership on the Professional/AHP Staff.

No applicant shall be denied Professional/AHP Staff membership or clinical privileges on the basis of sex, race, creed, color, or national origin, or disability for which reasonable accommodation can be provided.

3.1 (EP27) Qualifications for Membership

(EP13) The applicant for membership on the Staff shall be legally licensed to practice in the State of California and in practice located close enough (office and residence) to the Medical Center to provide continuous care to his or her patient. The distance may vary depending upon the Staff category and privileges that are involved and may be further defined in the Rules. Applicants must document their background, experience, training, judgment, individual character, demonstrated competence, physical and mental capabilities, adherence to the ethics of their profession, and ability to work with others with sufficient adequacy to assure the Professional/AHP Staff and the Governing Board that any patient treated by them in the Medical Center will be given good medical care. No applicant shall be entitled to membership on the Professional/AHP Staff or to the exercise of particular clinical privileges in the Medical Center merely by virtue of the fact that he is duly licensed to practice in this state, or that he is a member of any professional organization, or that he had in the past, or presently has, such privileges at another hospital.

The privileging of Professional/AHP members listed by a Federal agency as debarred, excluded or otherwise ineligible for participation in federal or state funded health care programs, or who have been convicted of a criminal offense related to health care is prohibited. Members and/or ~~a~~applicants for privileges have an affirmative obligation to notify Professional/AHP Staff Administration in a timely manner if they receive notice the OIG or GSA is excluding, intends to exclude, or proposes to exclude them from participation in Medicare and/or other federal or state health care programs.

Applicants convicted of a healthcare criminal offense on the OIG or GSA list will not be considered for membership and applications shall not be accepted for processing.

3.2 Rights of Membership

Members of the Staff may apply for privileges to provide patient care, may vote and hold office when eligible under these Bylaws, may serve on committees, and may utilize the educational resources and participate in the educational activities of the Medical Center. The member shall also have the right to a hearing before his peers and an appeal before the Governing Board wherever appropriate, as set forth in these Bylaws.

3.3 Responsibilities of Membership

3.3.1 Provide Patient Care

Each member of the Professional/AHP Staff agrees to provide his patients with care at recognized professional levels of quality and efficiency and abide by the Professional/AHP Staff Bylaws and Rules and all other lawful standards, policies and Rules of the Professional/AHP Staff and the hospital. Each member shall be available for emergencies and to provide follow-up care to his or her patients, and when unavailable shall arrange for another Staff member or Locum Tenens physician with equivalent qualifications and clinical privileges to provide continuous care. Any member or locum tenens physician providing coverage for a member shall also comply with the continuous care requirements of this section. He shall prepare and complete medical and other required records for all patients he cares for in the Medical Center.

3.3.2 Staff Functions

Each member agrees to perform his staff, department, committee, Focused Practitioner Performance Evaluation (FPPE) responsibilities as defined by an accrediting entity and other Medical Center functions and to abide by the Professional/AHP Staff Bylaws, and Professional/AHP Staff and Departmental Rules and Regulations.

3.3.3 Continuing Education

It is expected that members of the Professional/AHP Staff shall participate in continuing professional educational activities. These activities may include medical school sponsored teaching programs, Providence Saint Joseph Medical Center Continuing Education programs, and programs qualifying for credit under the American Medical Association and California Medical Association continuing education certification. It will be the responsibility of each member to appropriately document these activities with the Professional/AHP Staff Office.

3.3.4 Ethics

Acceptance of membership on the Professional/AHP Staff shall constitute the staff member's agreement that he will strictly abide by the Principles of Medical Ethics as promulgated by the American Medical Association or by the ethical standards of other appropriate professional organizations. Professional/AHP Staff members shall not engage in disruptive behavior, harassment, or fee splitting.

3.3.5 Catholic Institution

Each member of the Professional/AHP Staff recognizes and, as a condition to this appointment, agrees to respect the fact that the Medical Center is a Catholic institution and will be administered in accordance with the Ethical and Religious Directives for Catholic Health Facilities and that no medical conduct or procedures within the Medical Center will be permitted which are contrary to or incompatible with said Directives.

3.3.6 Confidentiality of Professional/AHP Staff Records and Proceedings

A. Authorization and Conditions

By applying for or exercising clinical privileges and practice privileges within this Medical Center, a practitioner:

(1) Authorizes representatives of the Medical Center and the Professional/AHP Staff to solicit, provide, and act upon information bearing upon, the applicant's professional ability and qualifications.
(2) Authorizes persons and organizations to provide information concerning such practitioner to the Professional/AHP Staff.
(3) Agrees to be bound by the provisions of this Section and to waive all legal claims against any representatives of the Professional/AHP Staff or the Medical Center who acts in accordance with the provisions of this article.
(4) Acknowledges that the provisions of this Section are express conditions to an application for Professional/AHP Staff membership, the continuation of such membership, and to the exercise of clinical privileges and practice privileges at this Medical Center.

B. Confidentiality of Information

(1) **General**

Professional/AHP Staff department, specialty section, or committee minutes, files, records and oral discussions, including information regarding any member or applicant to this Professional/AHP Staff shall, to the fullest extent permitted by law, be confidential. Dissemination of such information and records shall be made only where expressly required by law, pursuant to officially adopted policies of the Professional/AHP Staff or, where no

officially adopted policy exists, only with the express approval of the Medical Executive Committee or its designee.

(2) **Breach of Confidentiality**

Inasmuch as effective peer review and consideration of the qualifications of Professional/AHP Staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions, deliberations or confidential information of Professional/AHP Staff departments, specialty sections, or committees, except in conjunction with other professional society, or licensing authority, is outside appropriate standards of conduct for this Professional/AHP Staff and will be deemed disruptive to the operations of the Medical Center. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

(3) **Confidentiality Agreement**

As a condition precedent to any practitioner's appointment or reappointment to the Professional/AHP Staff, and as a condition to the assignment of any practitioner to a Clinical Department or to a Committee of the Professional/AHP Staff, each applicant and practitioner shall indicate by his signing the application form for appointment or reappointment or such other document as the Medical Executive Committee may designate that he agrees to be bound by the confidentiality provisions of this Section; that he agrees to notify the Professional/AHP Staff Office of any request or demand made to him (whether by subpoena or otherwise) to disclose confidential information related to his participation as a member of the Staff or any committee thereof; and that he will not voluntarily disclose confidential Professional/AHP Staff information except as specifically provided in this Section.

3.3.7 Professional Liability Actions

All applicants shall provide proof of current malpractice insurance. A minimum level of coverage of $1 million per incident and $3 million per annum is required. Shared liability policies are not permitted. Upon application, the applicant shall list and provide detail of all medical malpractice lawsuits within the past five (5) years. Thereafter at each reappointment, the Professional/AHP Staff member shall advise of any judgments or settlements that have occurred since the last reappointment.

4.3.8 EPIC Training

All members of the Professional/AHP Staff are subject to mandatory EPIC training unless they have documentation of previous training.

3.4 (EP 26) (EP 27) Initial Appointment, Credentialing and Granting of Clinical Privileges

3.4.1 Application for membership on the Staff shall be presented on the prescribed application form, which shall also signify the applicant's agreement to abide by the Bylaws, rules, regulations, and ethics of the Staff. When an applicant receives an application form, he will also receive a copy of these Bylaws as well as the Ethical and Religious Directives for Catholic Health Facilities and the Principles of Medical Ethics of the American Medical Association.

3.4.2 The completed application form for membership on the Staff with requests for clinical privileges shall be presented to the Administrator of the Medical Center who shall transmit it to the Professional/AHP Staff. A completed application is one with respect to which the Medical Center has received written responses to all requests for references; verification of references and other information necessary to evaluate the application; and responses to all inquiries which the Medical Center or Staff makes regarding the application. The applicants shall furnish information on their application or reappointment form regarding any challenges to any licensure or registration, voluntary or involuntary relinquishment of licensure, registration**,** any voluntary or involuntary relinquishment of membership in a Professional/AHP Staff, voluntary or involuntary limitation, reduction, or loss of clinical privileges. In

accordance with CMS regulations regarding the verification of legal status of foreign-born healthcare professionals, the Medical Center shall verify that the physician or non-physician practitioner is: (1) a United States citizen; (2) a legal resident of the United States, or (3) otherwise legally authorized to work in the United State*s.* If the Medical Center or Professional/AHP Staff requests additional information relevant to the application after the review process has commenced, the application will be deemed incomplete, and the time for processing it will be suspended until such additional information is received. The applicant shall have the burden of producing adequate information for a proper evaluation of his experience, background, training, demonstrated ability, physical and/or mental health status; and of resolving any doubts about these or other basic qualifications.

3.4.3 The completed application shall be referred to the Credentials Committee. The Credentials Committee will evaluate the application with requests for clinical privileges and assign the application for investigation to the most appropriate Clinical Departmental Committee. The Clinical Departmental Committee shall submit the report of findings and recommendations for the distinct areas of membership and granting of clinical privileges to the Credentials Committee. The Credentials Committee shall evaluate the application, the recommendations of the Clinical Departmental Committee and make a final recommendation to the Medical Executive Committee. In no case shall these reports be delayed for more than three (3) months after completion of the application.

3.4.4 Within three (3) months from receipt of the Credentials Committee's report the Medical Executive Committee shall recommend that the application be accepted, deferred, or rejected. In no case shall a recommendation be deferred for more than 90 days. If the Medical Executive Committee's recommendation is to accept the application, the recommendation shall be forwarded to the Governing Board for final action. To provide new physicians with the opportunity to familiarize themselves with Providence St. Joseph Medical Center, the facility, the staff, the services provided by the hospital, and the standards and expectations set forth in the Professional/AHP Staff Bylaws and Rules and Regulations, **mandatory attendance** at New Physician Orientation is required prior to issuance of Hospital I.D., and exercising privileges. If the Medical Executive Committee's recommendation is to reject the application the Administrator shall promptly notify the applicant of the recommendation and of his right to request either: (a) an informal Credentials Committee review of the recommendation as provided in Subsection 5, below, with the option, following that informal Credentials Committee review, of requesting a hearing before a Special Hearing Board as provided in Subsection 7 below; or (b) a hearing before a Special Hearing Board as provided in Subsection 7 without an informal Credentials Committee review meeting as provided in Subsection 5. The applicant shall be notified in writing of the decision, and if adverse, the reason for the denial of the application or request for clinical privileges.

3.4.5 If the applicant fails to request an informal Credentials Committee review within fifteen (15) days following receipt of such notice, the application shall be deemed to be withdrawn. If the applicant does request an informal Credentials Committee review within such time, a meeting shall be scheduled within a reasonable time with the applicant, the Chairman of the Credentials Committee, the Chairman of the Clinical Department, and the Administrator. This informal Credentials Committee review shall not constitute a hearing. At the meeting the Chairman of the Credentials Committee and the Chairman of the Clinical Department shall explain the basis upon which the application was reviewed and the process followed in connection with the review. The applicant may ask questions about the review process and the reasons for rejection. He may at that time review any reference materials or other documentary evidence relied upon in recommending against his application.

3.4.6 Following the informal Credentials Committee review, the applicant may within fifteen (15) days of receipt of notice thereof, request a hearing before a Special Hearing Board. The Special Hearing Board shall consist of up to five members of the Professional/AHP Staff appointed by the Chief of Staff who have not previously participated in formulating a recommendation regarding the application.

3.4.7 If the applicant does request a hearing within such time, a hearing shall be scheduled within a reasonable time. Prior to the hearing the applicant shall be given a written statement of the reasons for the adverse recommendation. The hearing shall be informal. Neither the applicant nor the Professional/AHP Staff shall be represented by legal counsel. A record of the hearing shall be kept by tape recorder or other means specified by the Chief of Staff. At the hearing the Chairman of the

Credentials Committee and the Chairman of the Clinical Department or their delegates shall first explain the reasons for the adverse recommendation and may introduce witnesses and documents. Thereafter, it shall be the applicant's burden to demonstrate that the recommendation is arbitrary, capricious, nor supported by substantial evidence or otherwise improper. Within ten (10) days after the hearing, the Special Hearing Board shall inform the applicant and the Medical Executive Committee of its recommendation to uphold, modify or overturn the Medical Executive Committee's recommendation.

3.4.8 Within fifteen (15) days from receipt of the Special Hearing Committee's decision, either the Medical Executive Committee or the applicant may request an appellate review of the decision by the Governing Board. Such request for review shall be submitted to the Administrator in writing and shall state with particularity all aspects of the application review or hearing process, including any errors alleged to have occurred therein, which the applicant wishes the Governing Board to review. Within thirty (30) days following receipt of such request, the Governing Board shall decide, in its sole discretion, whether to grant such an appellate review and shall notify the applicant and the Medical Executive Committee as to whether a review will be allowed. If an appeal is allowed, it shall be conducted in accordance with the procedure set forth in Article VI, Sections 5 and 6 of the Bylaws.

3.4.9 Initial appointments shall be for a period of two (2) years as set forth in Article VII, 2.1.

3.5 (EP 26) (EP 27) Reappointment to Membership, Re-credentialing, Re-evaluation of Privileging and Determination of Category

3.5.1 The reappointment review process shall be regularly performed on at least a two (2) year basis for all staff members and Allied Health Professionals. Any member may be reviewed annually at his request or at the discretion of the Clinical Departmental Committee or the Credentials Committee.

(EP 27) 3.5.2 A reappointment application will be sent at the appropriate time to those members of the Staff who will be considered for reappointment. With the reappointment form, Staff members will receive a list of their current clinical privileges. The reappointment form will request additional information regarding clinical activity at other institutions, additional educational activities, change in board certification, and other pertinent information.

3.5.2.1 Timeline for event submission (07/2018)

For patient and caregiver safety and to preserve memory of an event for fair and objective evaluation, all behavioral incident reports involving physicians or allied health professionals will be provided to the Chief of Staff concurrently but in no event later than twenty one (21) calendar days following their initial submission. The goal is for the professional staff to be able to begin its evaluation and investigation as soon as possible in conjunction with the evaluation process of the hospital administration.
The Chief of Staff will have access to the hospital behavioral incident reporting system to reduce the time to receive the reports.

Management of untimely submitted complaints
Complaints not received within 21 calendar days must include the reason for the delay in writing. All complaints received beyond 21 calendar days will undergo the following process with the exception of the following types of complaints for which there is no time limitation for review. All complaints involving sexual harassment or physical violence or clear and distinct threats of physical violence will always be reviewed in the manner described in these bylaws regardless of submission delay. The threats of physical violence should be immediately reported to a supervisor and documented in writing as such at the time of the incident. However it is the reasonable expectation of the professional staff that these types of complaints would be immediately brought to the chief of staff's attention.
Complaints received beyond 21 days but less than 45 days will have the reason for the delay noted in writing and maintained as part of the permanent file. The reason for the delay in submission will be presented by the chief of staff to the MEC voting members without any identifying information at the executive session. If the reason for the delay in submission is deemed reasonable, meaning fair and sensible by a majority of MEC voting members, the complaint will be evaluated by the professional staff.

Monitoring of untimely submitted complaints
All complaints submitted beyond 21 calendar days will be tracked, recorded, and the number of untimely submissions and cause for the delay will be presented at every Valley Community Ministry Board meeting for their monitoring and governance.

Response from the professional staff member
The Chief of Staff or his/her designee will provide a de-identified copy of the behavioral incident report to the Professional Staff member within five (5) working days of the receipt of the report unless the intended recipient is unavailable, in which case it shall be presented at the earliest possible time the individual becomes available. The Professional Staff member will be advised of their opportunity to provide a written response within ten (10) working days. If a response is provided it will be attached to the behavioral incident report and will be kept in the Professional Staff file.

Management of new information in the behavioral incident report
Any new information added, subtracted or changed within the initial incident report during the review period must be immediately forwarded to the Chief of Staff and the Professional Staff member.

Investigation by the Professional Staff
Following receipt of the Professional Staff member's response, if it is provided, and completion of any further fact finding and discussion deemed necessary, the Chief of Staff or his/her designee will evaluate and investigate the behavioral incident report. After the investigation is completed, a written summary of the findings, recommendations, and disposition will be done. This will be attached to the incident report and maintained in the physician file.

Event maintenance
All complaints, the reason for any delay in submission beyond 21 days, the physician response if provided, and the Professional Staff adjudication of the incident will be maintained together in the Professional Staff member's file. The Professional Staff member will be provided with a de-identified exact copy of all of the above for their personal records.

3.5.3 The Clinical Departmental Committee shall be responsible for reviewing the reappointment application, especially dealing with patient care activities, any departmental actions taken in regard to the applicant, requested clinical privileges and an evaluation of the applicant's ability to continue to provide quality patient care. Guidelines as developed by the departmental committee for review will be used to make recommendation to the Credentials Committee regarding continuation of or change of staff category and clinical privileges (See Article IV).

3.5.4 The Credentials Committee shall consider these recommendations, the information contained in the reappointment application, any recommendations from other departments, participation in staff activities, adherence to staff bylaws and rules and regulations, continuing education activities, health status, information that may be available from outside sources such as other hospitals, medical societies, state agencies, and malpractice actions. Any applicant may be asked to verify information, provide additional information, appear for an interview, or verify physical and mental capabilities.

3.5.5 At least sixty (60) days prior to reappointment dates, the Credentials Committee shall make its report to the Medical Executive Committee.

3.5.6 At least fifteen (15) days prior to reappointment, the Medical Executive Committee shall make its report to the Administrator regarding recommendations the reappointment and staff category (also privileges - see Article IV), for each member of the ensuing appointment period.

3.5.7 The Administrator, as the representative of the Governing Board, may accept, reject, or modify the recommended reappointments and staff categories. If the Administrator concurs with the recommendation for reappointment, continuation, or advancement in status, he shall so notify the Staff member and the Professional/AHP Staff.

3.5.8 If the recommendation of the Medical Executive Committee is not to reappoint or is for demotion in staff category and the Administrator concurs, the member shall have the right to a hearing and appeal as set forth in Article VI of these Bylaws.

3.5.9 If the Administrator's decision is contrary to the Medical Executive Committee's recommendation, he shall meet the Medical Executive Committee and present his reasons. If the differences cannot be reconciled, the Medical Executive Committee may appeal to the Governing Board before final action can be taken.

3.5.10 If a member is not reappointed or is demoted in staff category by the Administrator contrary to the Medical Executive Committee's recommendation, he shall have the right to appeal to the Governing Board.

3.5.11 When final action has been taken by the Governing Board, the Board shall so notify the Staff member and the Professional/AHP Staff.

3.5.12 If the reappointment application has not been fully processed due to Professional/AHP Staff Administrative error before the member's appointment expires, the Professional/AHP Staff member may be granted a limited, time-specific reappointment by the Medical Executive Committee until the review is completed. Such time-specific reappointment does not create a vested right for full reappointment.

ARTICLE IV
CLINICAL PRIVILEGES

(EP 14) Clinical privileges are rights to render medical care in the Medical Center. The requests for privileges are evaluated by the Professional/AHP Staff and their recommendations are submitted to the Governing Board. These privileges are based upon the practitioner's training, licensure, certification, competence, ability, judgment, and health. Privileges will be reviewed by the appropriate Clinical Departmental Committees which will make their recommendations to the Credentials Committee. The Credentials Committee will subsequently make a recommendation to the Medical Executive Committee which will make its final recommendation to the Governing Board. Privileges shall include general and specialty privileges. They are subject to a regular review and evaluation as part of the PSJMC Quality and Patient Safety Program and may be modified according to the practitioner's performance, utilization, and adherence to the Rules and Regulations, and the Bylaws.

4.1 General and Specialty Privileges

4.1.1 General Privileges

General privileges shall include admitting and discharging patients, writing orders, completing history and physical examinations, and participating in ongoing patient care.

General privileges for members of the Professional Service Department shall be recommended by the other appropriate Clinical Departmental Committees.

4.1.2 Specialty Privileges

Specialty privileges are department specific, require special training, and shall include the performance of specific medical and/or surgical procedures. Each clinical department other than the General and Family Practice Department shall have a list of those procedures by category over which it has jurisdiction, and the practitioner shall apply for those procedures for which he considers himself qualified. This application for privileges shall be reviewed by the Clinical Departmental Committee and recommendations made to the Credentials Committee. A Staff member may have specialty privileges in more than one department, in which case the evaluation of his performance will be by each department in which he has privileges.

Specialty privileges for members of the General and Family Practice Department shall be recommended by the appropriate Clinical Departmental Committees. The responsibility for the review, renewal, and/or modification of

these privileges shall be that of the Clinical Departmental Committees in liaison with the General and Family Practice Committee.

4.2 Supervised Privileges

Initial privileges shall be granted supervised, subject to a period of observation so that the Professional/AHP Staff may determine the practitioner's professional competence and suitability to continue to exercise the privileges initially granted in the respective departments. The granting of these supervised privileges in no way assures progression to unsupervised regular or unsupervised specialty privileges.

4.2.1 The applicant when applying for membership, shall indicate on the appropriate forms the general and specialty privileges requested.

4.2.2 The application for privileges shall be referred by the Credentials Committee to the appropriate Clinical Departmental Committees. Determination of supervised general and specialty privileges shall be based upon the applicant's training, experience, and competence. This may in part be based upon an examination of the records of previous cases and other relevant information. It shall be the responsibility of the applicant to provide any information as requested.
The Clinical Departmental Committees shall evaluate all pertinent data and then make recommendations for supervised privileges to the Credentials Committee.

4.2.3 The Credentials Committee shall accept this recommendation of supervised privileges, use this recommendation in completing the application, and make final recommendation to the Medical Executive Committee. The Medical Executive Committee shall review the recommendations and accept, reject, or modify the supervised privileges to be granted.

4.2.4 The recommendation of the Medical Executive Committee shall be transmitted to the Administrator as the representative of the Governing Board who may accept, reject, or modify the privileges recommended.

4.2.5 Should the Administrator wish to modify or refuse to grant privileges contrary to the recommendation of the Medical Executive Committee, the Administrator shall so advise the Medical Executive Committee, stating reasons and asking for recommendations as to further action. The administrator cannot grant privileges in excess of those recommended by the Medical Executive Committee. If the Administrator wishes to reject or grant privileges less than those recommended by the Medical Executive Committee, the Medical Executive Committee shall have the right to appeal to the Governing Board.

4.2.6 When the final action has been taken, the Administrator shall so notify the applicant and the Professional/AHP Staff. If the privileges granted are less than the applicant requested and for reasons of medical disciplinary cause or reason as recommended by the Medical Executive Committee, he shall have the right to a Formal Hearing as set forth in Article VI. If the privileges granted are less than the applicant requested and for reasons other than disciplinary cause as recommended by the Medical Executive Committee, he shall have the right to an Informal Review as set forth in Article VI. A practitioner shall not be entitled to any Formal Hearing, Informal Review or Appellate Review rights for failure to meet minimum qualifications (Article VI, Section 6, Subsection 4).

Medical disciplinary cause or reason is defined as that aspect of a member’s competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care as set forth in Business and Profession (B and P) Code Section 805 (a)(b).

4.2.7 General and specialty privileges shall remain supervised until the appropriate Clinical Departmental Committees can make adequate observations, as defined in their departmental rules and regulations. Supervised privileges shall be reviewed either annually or at the request of the practitioner.

4.2.8 If within a reasonable period of time, the member has not made sufficient use of the hospital in order that the appropriate Clinical Departmental Committee can adequately evaluate his performance, it may recommend that he be terminated. He may reapply for staff membership at a future date.

4.2.9 In order to obtain additional privileges, a member of the Staff shall submit a written request to the appropriate Clinical Departmental Committee. This request shall state the type of privileges desired, appropriate training and experience, and a resume of cases where applicable. Such a request shall be acted upon by the committee within a reasonable period of time and its recommendations for new supervised privileges shall be forwarded to the Credentials Committee.

4.3 Regular Privileges

4.3.1 General and specialty regular privileges may only be granted subsequent to supervised privileges, as above. They shall be reviewed and renewed on a regular basis at the time of reappointment. At the time of reappointment, the practitioner is responsible for requesting the specific privileges he wishes continued.

4.3.2 Re-evaluation and renewal of these privileges shall be done by the appropriate Clinical Departmental Committees. In evaluating each member's performance and competence, the committees shall take into consideration the member's credentials, direct observation of patient care provided, the records of patients treated in this or other hospitals, the records of the Professional/AHP Staff, other relevant information which documents the member's participation in the delivery of patient care, and any specific criteria developed by the departments. The Clinical Departmental Committees shall forward their recommendations to the Credentials Committee for its consideration.

4.3.3 The final recommendations of the Credentials Committee shall be processed as set forth in this Article (IV) under Section 2, Subsections 3 through 6.

4.4 Temporary Privileges

Temporary privileges are those granted under unusual circumstances to practitioners who are not members of the Professional/AHP Staff. They must meet the same eligibility requirements for membership as defined in Article III. All professional activities performed under these privileges shall be in accordance with the Professional/AHP Staff Bylaws and Rules and Regulations. These practitioners shall provide all required information for the privileges being requested. Temporary privileges may be granted for a period up to 120 days.

4.4.1 The Administrator, upon recommendation of the appropriate Clinical Departmental Committee Chairman or his designee, shall have the authority to grant temporary privileges to a practitioner who is not a member of the Staff. If a practitioner's request for temporary privileges is refused or if all or any portion of his temporary privileges are terminated or suspended, he is not entitled to the procedural rights afforded in these Bylaws because he is not a member of the Staff.

In the exercise of such privileges, he shall be under direct supervision of the Chairman of the appropriate Clinical Departmental Committee, or his designee as set forth in the Clinical Departmental Rules and Regulations.

The Administrator may, at any time, upon the recommendation of the Chairman of the appropriate Clinical Departmental Committee or his designee, terminate a practitioner's temporary privileges. If necessary, the Clinical Departmental Committee Chairman or his designee shall assign a member of his department to assume responsibility for the care of the practitioner's patients.

4.4.2 Temporary privileges shall be granted in one of the following categories and in accordance with the requirements and time limitations set forth below:

A. **Pre-Membership Temporary Privileges**

These temporary privileges will allow unusually qualified applicants, when the need of the Professional/AHP Staff or Medical Center warrants it, to attend patients in the Medical Center. Upon positive recommendation of the Medical Executive Committee and approval by the Chief Executive pending final approval by the Governing Board, the applicant may request Temporary clinical privileges. All practitioners exercising pre-membership temporary privileges shall be subject to monitoring requirements adopted by the applicable Clinical Departments.

B. **Specific Patient Privileges**

These temporary privileges may be granted to appropriately licensed professionals to attend a specific patient during his hospital stay.

C. **Special Category Privileges**

The Medical Executive Committee, where there is need, may establish special categories of privileges and will set the duration and the limitation of the privileges.

4.5 Consultation Privileges by Non-Staff Professionals

Any member of the Staff shall have the privileges to request a consultation from any licensed practitioner who is not a member of the Professional/AHP Staff provided such practitioner is a licensed physician, dentist or podiatrist. The consulting practitioner shall have consultation privileges only and may not write orders or care for the patient.

4.6 Emergency Privileges

In case of emergency, any member of the Staff, regardless of departmental affiliation, staff status, or clinical privileges shall be expected to do all in his power and to the degree permitted by his license to save the life of any critical patient, and in doing so is considered to have emergency privileges, including the calling of such consultation as may be available. For the purposes of this section, an emergency is defined as a condition in which the life of the patient is in immediate danger and in which any delay in administering treatment would increase that danger.

4.7 Disaster Privileges

To comply with the Professional/AHP Staff Bylaws and TJC Standards for credentialing in the event of an emergency or disaster, TJC Standard MS. 4.110 *Disaster privileges may be granted when the emergency management plan has been activated and the hospital is unable to handle the immediate patient needs*.

During disaster(s), in which the emergency management plan has been activated, the CEO or Professional/AHP Staff Chief of Staff or their designee(s) has the option to grant disaster privileges.

4.7.1 The Chief Executive Officer (CEO) -or- Professional/AHP Staff Chief of Staff -or- their designee(s) may grant disaster privileges upon presentation of a valid picture ID issued by a state, federal, or regulatory agency and at least one of the following:

a. Current license to practice as issued by the Medical Board of California (MBC)
-OR-
b. A current license to practice and a valid picture ID issued by another state, federal, or regulatory agency
-OR-
c. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or other valid emergency response entity
-OR-
d. Identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances, (such authority having been

granted by a federal, state or municipal entity)
-OR-

e. Presentation by current hospital or Professional/AHP Staff member(s) with personal knowledge regarding practitioner's identity and both of the following:
f. Current malpractice insurance coverage information
g. Name of current hospital affiliation(s) where the practitioner maintains medical staff membership (if applicable)

4.7.2.1 Verification of Information:

a) Primary source verification of licensure, malpractice insurance coverage and hospital affiliation(s) shall be done as soon as feasible by the Professional/AHP Staff Office/designee(s), but no later than 72 hours from the time such volunteer professional presents to the hospital. If such verification cannot be completed as required due to extraordinary circumstances, the following shall be documented:

1) Reasons why verification could not be performed,
2) Evidence of the volunteer professional's demonstrated ability to continue to provide adequate care, treatment, and services,
3) Evidence of attempts to perform such verification

A written record of this information and verification(s) shall be retained in the Professional/AHP Staff Office utilizing the established Application for Disaster Privileges form.

b) The National Practitioner Data Bank (NPDB) and Office of the Inspector General (OIG) will be queried as soon as feasible utilizing the above process.

c) In the event the verification process reveals any adverse information or suggests the practitioner is not capable of rendering services in a disaster privileges shall be immediately terminated.

4.7.3 Conditions of Disaster Privileges:

a) The practitioner granted disaster privileges shall practice under the direction and supervision of an existing member of the Providence Saint Joseph Professional/AHP Staff, in the same specialty if possible, with whom to collaborate in the care of patients

b) The practitioner granted disaster privileges shall, by signed statement, attest that all information provided by him/her is true and accurate

c) The practitioner granted disaster privileges shall, by signed statement, be bound by all hospital policies & procedures, rules & regulations and the Professional/AHP Staff Bylaws, and any directives from the Clinical Service Chairman, supervising physician or any other hospital or Professional/AHP Staff leader

d) Disaster privileges shall be valid only for the duration of the disaster and shall automatically terminate at the end of needed services

e) Based upon oversight of each volunteer professional, with 72 hours of such volunteer professional's arrival, a determination will be made as to whether such privileges should continue.

4.7.4 Record of Patients Seen

The Emergency Department and/or applicable Nursing Unit shall keep a daily record of patients seen by practitioner utilizing the RECORD OF PATIENTS SEEN BY PRACTITIONER DURING DISASTER form. This form shall be returned to the Professional/AHP Staff Office at the end of each

shift or day.

Reference(s) TJC Standard MS.4.110 - Business & Professions Code Section 900 Disaster Privileges Application (appended)

4.8 Locum Tenens Privileges

In accordance with the requirements of Section 4, Subsection 1, upon receipt of a written application for delineated temporary privileges, a practitioner with equivalent qualifications and documented competence may serve as a locum tenens for an Active or Associate Professional/AHP Staff member. Such applicant, without applying for membership on the Staff, may be granted temporary privileges for an initial period of sixty (60) days. Such privileges may be renewed for two (2) successive periods of thirty (30) days each, but shall not exceed his services as locum tenens, and shall be limited to treatment of the patients of the practitioner for whom he is serving as locum tenens.

4.9 COMMUNITY STAFF MEMBERSHIP WITHOUT PRIVILEGES

4.9.1 QUALIFICATIONS

The Community Staff Membership category shall consist of Members who:

a) Meet the general Medical Staff qualifications set forth in Section 3.2-1 (a-b), and;

b) Are in Active practice in the community and require Hospital affiliation but do not admit or consult on patients at this Hospital.

4.9.2 PREROGATIVE AND DUTIES

Community Staff Members without privileges:

a) May refer patients for diagnostic tests and procedures;

b) May attend CME activities and earn CME credit;

c) May not write orders or make entries into a PSJMC patient medical record;

d) May not exercise any Clinical Privileges at the Hospital, and;

e) May not use their Affiliate Staff Membership in public marketing materials.

f) May have read-only access to Epic for review of results and the hospital course for patients they refer. In order to have Epic access, the member must have completed the mandatory Epic training.

g) Annual dues $300.00

4.9.3 RELINGUISHMENT OF AFFILIATE STAFF STATUS

Community Staff Members who do not meet the requirements stated above will be considered to have resigned their membership.

ARTICLE V
DISCIPLINARY ACTION

5.1 Routine Monitoring and Education

5.1.1 Responsibility

It shall be the responsibility of the Chairmen of the clinical departments and specialty sections, working through department and section committees and with the assistance, as appropriate, of the standing committees, to design and implement an effective program (1) to monitor and assess the quality of professional practice in each department and section, and (2) to promote high quality of practice in each department and section by (a) providing education and counseling, (b) issuing letters of admonition, warning or censure, as necessary, and c) requiring routine monitoring when deemed appropriate by department or section committees.

5.1.2 Procedure

A. **Review and Studies**: Each department or section committee shall conduct regular patient care reviews and studies of practice within the department or section in conformity with the PSJMC Quality and Patient Safety Program and shall investigate complaints and practice-related incidents.

B. **Informal Counseling**: In order to assist department or section members to conform their conduct or professional practice to the standards of the Professional/AHP Staff and Medical Center, department or section chairmen may issue informal comments or suggestions, either orally or in writing. Such comments or suggestions shall be subject to the confidentiality requirements of all Professional/AHP Staff information and may be issued by department or section chairmen with or without prior discussion with the recipient and with or without consultation with the department or section committee. Such comments or suggestions shall not constitute a restriction of privileges, shall not be considered to be corrective action as provided in Section 2 of this Article, and shall not give rise to hearing, review or appeal rights under Article VI.

C. Following discussion of identified concerns with any department or section member, any department or section committee may authorize the chairman to issue a letter of admonition, warning or censure, or to require such member to be subject to routine monitoring for such time as may appear reasonable. The term "routine monitoring," as used in this Section, shall mean review of a member's practice for which the member's only obligation is to provide reasonable notice of admissions, procedures or other patient care activity. All members of the Professional/AHP Staff, regardless of status, shall be subject to potential routine monitoring. The discussions of such actions with individual members shall be informal. Such action shall not constitute a restriction of privileges, shall not be considered to be corrective action as provided in Section 2 of this Article, and shall not give rise to hearing, review or appeal rights under Article VI.

D. Actions taken pursuant to Subsection B of this Section need not be reported to the Medical Executive Committee. Actions taken pursuant to Subsection C of this Section shall be reported to the Medical Executive Committee promptly after such actions are taken.

5.2 Corrective Action

5.2.1 Criteria for Initiation

Any person may provide information to the Medical Center or Professional/AHP Staff about the conduct, performance, or competence of any member. When reliable information indicates a member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the Medical Center; (2) unethical; (3) contrary to Professional/AHP Staff or Medical Center Bylaws, rules, regulations or standards; or (4) below applicable Professional/AHP Staff or Medical Center professional standards; a request for an investigation or action against such member may be initiated by the Chief of Staff, the Administrator, a department chairman or the Medical Executive Committee.

5.2.2 Initiation

A request for an investigation must be submitted to the Medical Executive Committee with a copy to the Administrator and supported by reference to specific activities or conduct alleged. If the Medical Executive Committee initiates the request, it shall record the reasons.

5.2.3 Investigation

If the Medical Executive Committee concludes that an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself or may assign the task to an appropriate staff officer, department, or standing or ad hoc committee of the Professional/AHP Staff. If the investigation is delegated to an officer or committee other than the Medical Executive Committee, such officer or committee shall promptly investigate the matter and forward a written report on the findings from the investigation to the Medical Executive Committee as soon as practicable. The report may include

recommendations for appropriate corrective action. If corrective action is being contemplated, the member shall be notified by the Medical Executive Committee or its designee that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating individual or body deems appropriate. The individual or body investigating the matter may, but is not obligated to, interview the persons involved. Such interviews shall not constitute a formal hearing or informal review as those terms are used in Article VI nor shall any of the procedural rules for hearings, reviews or appeals apply. Despite the status of any investigation, at all times the Medical Executive Committee retains its authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension or termination of the investigative process. At the request of the Governing Board or upon its own motion, the Medical Executive Committee may at any time within its discretion, terminate the investigative process and proceed with action as provided in Subsection 4 below.

5.2.4 Medical Executive Committee Action

As soon as is practicable after the conclusion of the investigation, the Medical Executive Committee shall determine whether to recommend any corrective action, and, if so, whether the corrective action recommended is for a "medical disciplinary cause or reason." Actions which the Medical Executive Committee may recommend, shall include, without limitation:

A. Determining no corrective action should be taken;

B. Deferring action for a reasonable time not to exceed ninety days (90) where circumstances warrant;

C. Issuing a letter of warning, admonition, reprimand, or censure, although nothing herein shall be deemed to preclude Professional/AHP Staff, department or section officers or committee chairmen from issuing informal written or oral warnings outside of the mechanism for corrective action; in the event such letters are issued, on the recommendation of the Medical Executive Committee, the affected member may make a written response which shall be placed in the member's file;

D. Recommending the imposition of terms of probation or special limitation upon continued Professional/AHP Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring;

E. Recommending reduction, modification, suspension or revocation of clinical privileges;

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

G. Recommending suspension, revocation or probation of Professional/AHP Staff membership; or

H. Taking other actions deemed appropriate under the circumstances.

5.2.5 Subsequent Actions

A. If the Medical Executive Committee recommends any corrective action which would entitle the practitioner to request a formal hearing (Article VI, Section 3) or an informal review (Article VI, Section 4) the Medical Executive Committee shall give the practitioner written notice of its recommendation as provided in Article VI, Section 3, Subsection 1 or Article VI, Section 4, Subsection 1. A copy of that notice shall be sent to the Governing Board for information only. Unless the Medical Executive Committee has decided to impose a summary suspension or limitation of the practitioner's privileges as provided in Article VI, Section 3, the Medical Executive Committee's recommended action shall not go into effect until the practitioner has either completed or waived any applicable hearing, review or appeal rights provided in Article VI. Any Medical Executive Committee action which has become effective shall remain in effect until it expires according to its own terms or is modified or terminated by the Medical Executive Committee, a Judicial Hearing Committee, Review Committee or the Governing Board.

5.3 (EP 29) (EP 32) Summary Suspension or Restriction

5.3.1 Authorization to Impose Summary Suspension or Restriction

The following individuals and entities are hereby authorized to impose summary suspension or restriction of Professional/AHP Staff membership or clinical privileges, subject to the limitations and requirements of this Section:

A. The Chief of Staff (or his or her designee);
B. The chairman of an applicable clinical department (or his or her designee); and
C. The Administrator (or his or her designee); but only if he or she makes a good faith effort to consult with the Chief of Staff prior to taking such action.

5.3.2 Initiation of Summary Action

Whenever the failure to immediately suspend or restrict a practitioner's clinical privileges may result in an imminent danger to the health of any individual, any of the individuals or entities identified in Article V, Section 3, Subsection 1 above shall have the authority to summarily suspend or restrict the Professional/AHP Staff membership or all or any portion of the clinical privileges of such practitioner. Such summary suspension shall become effective immediately upon imposition. The person responsible therefore shall immediately notify each of the other persons authorized to impose a summary suspension (or their designees), shall give oral notice of the suspension to the practitioner and shall promptly (within no more than five (5) days) give written notice of the suspension to the practitioner, the Medical Executive Committee, and Administrator. The written notice should inform the practitioner of his or her right to request the Medical Executive Committee to review the suspension under Article V, Section 3, Subsection 3. The notice of the suspension given to the Medical Executive Committee shall constitute a request for investigation under Article V, Section 2, Subsection 3. Following such notice the Medical Executive Committee shall complete its corrective action investigation under Section Article V, Section 2, Subsection 4 and shall make its corrective action recommendation and report under Article V, Section 2, Subsection 5 within thirty (30) days following the notice of summary suspension.

In the event of any suspension, the practitioner's patients whose treatment is affected by the summary suspension shall be assigned to another practitioner by the Chief of Staff or department chairman. The wishes of the patient and the physician shall be considered, where feasible, in choosing a substitute practitioner.

5.3.3 Medical Executive Committee Action

A practitioner who has been summarily suspended may request an interview with the Medical Executive Committee. Such interview shall be informal between the practitioner and the Medical Executive Committee and shall not constitute a hearing or review as provided in Article VI. The interview shall be convened as soon as reasonably possible under all of the circumstances, not to exceed thirty (30) days. The Medical Executive Committee may thereafter modify, continue, or terminate the terms of the summary suspension order and it shall give the practitioner written notice of its decision.

5.3.4 Procedural Rights

A. If the Medical Executive Committee does not terminate the summary suspension within fourteen (14) days from the date on which it was imposed, the Administrator shall give the practitioner written notice of his or her right to request a formal hearing pursuant to Article VI. If the practitioner then fails to timely request a formal hearing, those privileges subject to the summary suspension shall be permanently terminated with no further right of hearing, review or appeal. If the practitioner does timely request a formal hearing under Article VI, Section 3, the suspension shall remain in effect until the hearing and appeal are completed. In that case the Medical Executive Committee shall also complete its corrective action investigation and give prompt notice of its corrective action recommendation in order to assure that the formal hearing to review the summary suspension is combined with any formal hearing or review to which the practitioner may be entitled because of the Medical Executive Committee's corrective action recommendation.

5.4 (EP 28) (EP 31) Automatic Suspension

Each member of the Professional/AHP Staff is obligated to inform the Professional/AHP Staff Office promptly and in writing of any change in his or her professional license status, Drug Enforcement Administration certification or professional liability insurance coverage.

5.4.1 License

A. **Revocation or Expiration**: Whenever a practitioner's license authorizing him or her to practice in this State is revoked or has expired, his or her Professional/AHP Staff membership, prerogatives, and clinical privileges shall be immediately and automatically terminated.

B. **Restriction**: Whenever a practitioner's license authorizing him or her to practice in this state is limited or restricted by the applicable licensing authority, those clinical privileges which he or she has been granted rights to perform that are within the scope of said limitation or restriction shall be immediately and automatically terminated.

C. **Suspension**: Whenever a practitioner's license authorizing him or her to practice in this state is suspended, his or her Staff membership and all affected clinical privileges shall be automatically suspended effective upon and for the term of the suspension.

D. **Probation**: Whenever a practitioner is placed on probation by the applicable licensing authority, his or her applicable membership status, prerogatives, privileges and responsibilities, if any, shall at a minimum automatically become subject to the terms of the probation effective upon and for at least the term of the probation.

5.4.2 Drug Enforcement Administration (DEA) Controlled Substance Certificate

A. **Revocation or Expiration**: Whenever a practitioner's DEA certificate is revoked or has expired, he or she shall immediately and automatically be divested of his or her right to prescribe medications covered by the certificate.

B. **Suspension**: Whenever a practitioner's DEA certificate is suspended, he or she shall be divested, at a minimum, of his or her right to prescribe medications covered by the certificate effective upon and for at least the term of the suspension.

C. **Probation**: Whenever a practitioner's DEA certificate is subject to an order of probation, his or her right to prescribe medications covered by the certificate shall automatically become subject to the terms of the probation effective upon and for at least the term of the probation.

5.4.3 Medical Executive Committee Deliberation on Matters Involving License or Drug Enforcement Administration Action

As soon as practicable after action is taken as described in Article V, Section 4, Subsection 1 or Article V, Section 4, Subsection 2, the Medical Executive Committee shall convene to review and consider the facts upon which such action was predicated. The Medical Executive Committee may then recommend such further corrective action as may be appropriate based upon information disclosed or otherwise made available to it and/or it may direct that an investigation be undertaken pursuant to Article V, Section 2, Subsection 3. The Medical Executive Committee review and any subsequent hearing and appeal shall not address the propriety of the licensure or DEA Certificate action, but shall address instead what action the Medical Center should take.

5.4.4 Medical Records

Members of the Professional/AHP Staff are required to complete medical records within such reasonable time as described in the General Rules and Regulations of the Professional/AHP Staff or as required by accrediting or licensing entities whichever is sooner. Failure to complete outstanding medical records in accordance with the requirements described in the General Rules and Regulations may result in the automatic suspension of the practitioner's privileges. Such suspension shall not constitute grounds for hearing and appeal rights of Article VI.

(EP 16) A medical history and physical examination must be completed and documented for each patient no more 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy. The specific elements of a history examination appear in the Professional/AHP Staff Rules & Regulations.

For medical history and physical examination-that were performed within 30 days prior to admission or registration, an updated examination of the patient, including any changes in the patient's condition, must be completed and documented with 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient's condition, must be completed an documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

5.4.5 Malpractice Insurance

For failure to maintain the required amount of professional liability insurance, a practitioner's membership and clinical privileges, after written warning of delinquency shall be automatically suspended and shall remain so suspended until the practitioner provides evidence to the Medical Executive Committee that he or she has secured professional liability coverage in the amount required. A failure to provide such evidence within six (6) months after the date the automatic suspension became effective shall be deemed to be a voluntary resignation of the practitioner's Professional/AHP Staff membership.

5.4.6 Failure to Pay Dues

Dues are due January 1. Second and final request shall be sent February 1 *by Registered/Certified U.S. Mail* to the practitioner who has not submitted his/her annual dues and if not received by March 1, failure to submit dues shall be considered a voluntary resignation from the Professional/Allied Health Professional/AHP Staff and Hearing Rights shall not apply.

5.4.7 Placement on OIG or GSA list, Conviction for Healthcare Related Fraud

Members confirmed to be on the OIG or GSA list or who have been convicted of healthcare related fraud are subject to automatic suspension. In the event of an automatic suspension of membership and privileges, appropriate measures shall be taken to assure patients are not adversely affected by the automatic suspension. Additionally, verbal or written orders may not be accepted from these providers. No hearing or appeal rights pertain to the automatic suspension. However, the MEC may review the suspension through an informal review and may continue or remove the suspension at its sole discretion.

5.4.8 Failure to Designate Alternate Coverage

All Professional/AHP Staff members with clinical privileges must designate an alternate practitioner who has agreed to be prepared to respond and provide coverage if the member is unavailable. The designation must be submitted in writing to the Professional/AHP Staff Administration office. The designated alternate must possess the same clinical privileges and have the appropriate education, training, and experience and current clinical competence to serve as an alternate as determined by the Medical Executive Committee or its designee. Should there be any dispute as to the scope of clinical privileges, adequacy of education, training and current clinical competence of the designated alternate, the practitioner may request a hearing pursuant to Section VI for the sole purpose of determining whether that individual meets the requirements to be designated as an alternate.

Failure to designate and continually maintain on file a current qualified alternate shall constitute grounds for automatic suspension of clinical privileges. Said automatic suspension shall not be deemed to have been instituted for medical disciplinary cause or reason and is not reportable to the Medical Board of California under Business and Professions Code Section 805.

5.4.9 Procedural Rights -- Medical Records, Malpractice Insurance, and Failure to Pay Dues

Practitioners whose clinical privileges are automatically suspended and/or who have resigned their Professional/AHP Staff membership pursuant to the provisions of Article V, Section 4, Subsection 4 (failure to complete medical records) shall not be entitled to the procedural rights set forth in Article VI unless the suspension is reportable under Business and Professions Code

Section 805. Practitioners whose clinical privileges are automatically suspended and/or who have resigned their Professional/AHP Staff membership pursuant to the provisions of Article V, Section 4, Subsection 5 (failure to maintain malpractice insurance), or Article V, Section 4, Subsection 6 (failure to pay dues) shall not be entitled to the procedural rights set forth in Article VI.

5.4.10 Notice of Automatic Suspension; Transfer of Patients

Whenever a practitioner's privileges are automatically suspended in whole or in part, notice of such suspension shall be given to the practitioner, the Medical Executive Committee, the Administrator, and the Governing Board. Giving of such notice shall not, however, be required in order for the automatic suspension to become effective. In the event of any such suspension, the practitioner's patients whose treatment is affected by the automatic suspension shall be assigned to another practitioner by the Chief of Staff or Department Chairman. The wishes of the patient and the practitioner shall be considered, where feasible, in choosing a substitute practitioner.

5.5 Interviews

Interviews shall neither constitute nor be deemed a hearing or review as those terms are used in Article VI, shall be preliminary in nature, and shall not be conducted according to the procedural rules applicable with respect to hearings. The Medical Executive Committee shall be required, at the practitioner's request, to grant him or her an interview only when so specified in this Article VI. In all other cases and when the Medical Executive Committee or the Governing Board has before it an adverse recommendation, as defined in Article VI, Section 2, it may, but shall not be required to, furnish the practitioner an interview. In the event an interview is granted, the practitioner shall be informed of the general nature of the circumstance leading to such recommendation and may present information relevant thereto. A record of the matters discussed and findings resulting from such interview shall be made.

ARTICLE VI
HEARINGS, REVIEWS AND APPEALS

6.1 General Provisions and Definitions

6.1.1 Duty to Exhaust Remedies

The purpose of this Article is to permit the Professional/AHP Staff and Medical Center to resolve issues related to professional practice and qualifications for clinical privileges fairly, expeditiously and with due regard for both the need to protect patients and the interests of practitioners. Each applicant and member, agrees to follow and complete the procedures set forth in this Article, including appellate procedures, before attempting to obtain judicial relief related to any issue or decision which may be subject to a hearing, review or appeal under this Article.

6.1.2 Individual Evaluations vs. Requests to Review Rules and Requirements

The sole purpose of the formal hearings, informal reviews and appeals provided in this Article is to evaluate individual practitioners on the basis of bylaws, rules, regulations, requirements, policies and standards of the Professional/AHP Staff and Medical Center. The hearing and review committees provided for in this Article have no authority to modify, limit or overrule any established bylaw, rule, regulation, policy or requirement (collectively "rules or requirements"), and shall not entertain challenges to such "rules and requirements." Any practitioner wishing to challenge an established "rule or requirement" must notify the Medical Executive Committee and the Governing Board of the rule or requirement he or she wishes to challenge and of the basis for the challenge. The Governing Board shall then consult with the Medical Executive Committee regarding the request. No practitioner shall initiate any judicial challenge to a "rule or requirement" until the Governing Board, following consultation with the Medical Executive Committee, has either decided not to reconsider, or has upheld, the particular "rule or requirement."

6.1.3 Definitions

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

A. "Body whose decision prompted the hearing" refers to the Medical Executive Committee in all cases where the Medical Executive Committee or authorized Professional/AHP Staff officers, members or committees took the action or rendered the decision which resulted in a hearing being requested. It refers to the Governing Board in all cases where the Governing Board or authorized officers, directors or committees of the Governing Board took the action or rendered the decision which resulted in a hearing being requested.

B. "Medical Disciplinary Cause" refers to a basis for disciplinary action involving an aspect of a practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

C. "Practitioner" refers to the practitioner who has requested a formal hearing or informal review pursuant to Section 3, Subsection 2 or Section 4, Subsection 2 of this Article.

D. "Date of Receipt" of any notice or other communication shall be deemed to be the date it was delivered personally to the addressee or, if sent by regular or certified mail, five (5) working days after it was deposited, postage prepaid, in the United States mail. Professional/AHP Staff members shall inform the Professional/AHP Staff Office of all changes in office address.

6.1.4 Substantial Compliance

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

6.2 (EP 34) Grounds for a Formal Hearing or Informal Review

6.2.1 Grounds for a Formal Hearing

Except as is provided in Article VI, Section 6, below, any one or more of the following actions or recommended actions shall constitute grounds to request a formal hearing:

A. Denial of Professional/AHP Staff membership based on the Professional/AHP Staff's independent determination that medical disciplinary cause exists;

B. Denial of Professional/AHP Staff reappointment based on the Professional/AHP Staff's independent determination that medical disciplinary cause exists;

C. Suspension of Staff membership or clinical privileges for more than thirty (30) days in any twelve (12) month period for a medical disciplinary cause;

D. Summary suspension of Staff membership or clinical privileges for more than fourteen (14) days for a medical disciplinary cause;

E. Expulsion from Staff membership based on the Professional/AHP Staff's independent determination that medical disciplinary cause exists;

F. Reduction or limitation of clinical privileges based on the Professional/AHP Staff's independent determination that medical disciplinary cause exists;

G. Denial or termination of clinical privileges (including termination of temporary privileges) if such denial or termination is expressly based on the Professional/AHP Staff's independent determination that medical disciplinary cause exists;

6.2.2 Grounds for Informal Review

Except as is provided in Article VI, Section 6, below, any one or more of the following shall be grounds to request an informal review according to the procedure set forth in Article VI, Section 4 below:

A. Denial of Professional/AHP Staff reappointment for reasons other than medical disciplinary cause;

B. Suspension of Staff membership or clinical privileges for less than thirty (30) days in any twelve (12) month period or for reasons other than medical disciplinary cause;

C. Expulsion from Professional/AHP Staff membership for reasons other than medical disciplinary cause;

D. Denial of requested clinical privileges for reasons other than medical disciplinary cause;

E. Reduction or limitation of clinical privileges for less than thirty (30) days in any twelve (12) month period or for reasons other than a medical disciplinary cause;

F. Termination of non-temporary privileges for reasons other than a medical disciplinary cause;

G. Reduction or denial of advancement in Professional/AHP Staff category;

H. Summary suspension or restriction of clinical privileges for fourteen (14) days or less.

6.3 (EP 34) Formal Hearing Procedure

6.3.1 Notice of Action or Proposed Action

A body that has the authority to take any of the actions constituting grounds for a formal hearing set forth in Article VI, Section 2, Subsection 1 shall give written notice of its recommendation or action to the affected practitioner of his or her right to request a formal hearing. The notice shall state:

A. what corrective action has been proposed against the practitioner;

B. that the action, if adopted, must be reported under Business and Professions Code, Section 805;

C. a brief indication of the reasons for the proposed action;

D. that the practitioner may request a formal hearing;

E. that a hearing must be requested within thirty (30) days; and

F. that the practitioner has the hearing rights described in these Bylaws

6.3.2 Request for Hearing

The practitioner shall have thirty (30) days following the date of receipt of a notice of an adverse action to request a formal hearing. Said request must be submitted in writing to the Chief of Staff with a copy to the Administrator. If the practitioner does not request a hearing within the time and in the manner hereinabove set forth, he or she shall be deemed to have accepted the recommendation, decision, or action involved and it shall become final.

6.3.3 Time and Place for Hearing

Upon receiving a timely request for hearing, the Chief of Staff, within thirty (30) days after he or she receives the request, shall schedule and arrange for a hearing. He or she shall give the practitioner notice of the time, place, and date of the hearing. The date of the commencement of the hearing shall be not less than thirty (30) days, nor more than sixty (60) days from the date the Chief of Staff received the request for a hearing; provided, however, that when the request is received from a practitioner who has been summarily suspended, the hearing shall be held as soon as the arrangements may reasonably be made consistent with the goal of also completing any corrective action proceedings and holding a single hearing.

6.3.4 Notice of Charges and Witnesses

As a part of, or together with the notice of hearing required by Article VI, Section 3, Subsection 3 above, the Chief of Staff, or the Administrator on behalf of the body whose decision prompted the hearing, shall state in writing the reasons for the adverse action and specifically the acts or omissions with which the practitioner is charged. This notice shall include a list of any charts being questioned or the grounds upon which the application was denied, where applicable.

6.3.5 Witness Lists

At the request of either party, each party, at least ten (10) days prior to the hearing, shall furnish to the other a written list of the names and addresses of the individuals, so far as is then actually anticipated, who will give testimony or evidence in support of that party at the hearing. The witness list shall be amended when additional witnesses are identified. A failure to comply with this requirement or to identify a witness within ten (10) days prior to the hearing may be good cause to postpone the hearing.

6.3.6 Judicial Hearing Committee

(EP 35) The Chief of Staff (if the Medical Executive Committee initiated the action) or the Administrator (if the Governing Board or its Professional Review Committee initiated the action) shall appoint a Judicial Hearing Committee consisting of at least three (3) Professional/AHP Staff members, and alternates as appropriate, who have requisite expertise to ensure an efficacious, fair and responsive peer review system. The hearing panel members shall be unbiased, shall not have actively participated in the formal consideration of the matter at any previous level (i.e., they shall not have acted as an accuser, investigator, fact finder or initial decision-maker in the same matter), shall not be in direct economic competition with the affected practitioner, and shall stand to

gain no direct financial benefit from the outcome. Whenever possible, at least one (1) member should practice the same specialty as the affected practitioner.
The Chief of Staff or Administrator shall designate a Chairman who shall preside in the manner described in Article VI, Section 3, Subsection 8 below, and handle all pre-hearing matters and preside unless or until a hearing officer, as described in Article VI, Section 3, Subsection 7 below, is appointed.

If the Chief of Staff or Administrator concludes that the appointment of a hearing panel is impossible, an arbitrator may be used who is selected using a process mutually accepted by the body whose decision prompted the hearing and the affected practitioner. The arbitrator need not be a health professional. The arbitrator shall carry out all the duties assigned to the Presiding Officer and Judicial Hearing Committee.

6.3.7 The Hearing Officer

At the request of the practitioner, the Medical Executive Committee, the Judicial Hearing Committee, or the Governing Board, the Chief of Staff (if the Medical Executive Committee recommended the adverse action), or the Administrator (if the Governing Board or Professional Review Committee recommended the adverse action) may appoint a hearing officer to preside at the hearing. The hearing officer shall be an attorney at law or judge qualified to preside over a formal hearing and preferably have experience in Professional/AHP Staff matters. He or she shall not be biased for or against the practitioner, will gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate for any party. He or she may participate in the deliberations, act as a legal advisor, and assist in the preparation of a written decision, but he or she shall not be entitled to vote.

6.3.8 The Presiding Officer

The presiding officer at the hearing shall be a hearing officer as described in Article VI, Section 3, Subsection 7 or, if no such hearing officer has been appointed, the Chairman of the Judicial Hearing Committee. The presiding officer shall act to assure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence, and that proper decorum is maintained. He or she shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing. He or she shall have the authority and discretion, in accordance with these Bylaws, to grant continuances, to rule on disputed discovery requests, to decide when evidence may not be introduced, to rule on challenges to hearing committee members, to rule on challenges to himself or herself serving as a hearing officer, and to rule on questions which, are raised prior to or during the hearing pertaining to matters of law, procedure, or the admissibility of evidence.

6.3.9 Pre-Hearing Procedure

It shall be the duty of practitioner and the body whose decision prompted the hearing to exercise reasonable diligence in notifying the Presiding Officer of any pending or anticipated procedural irregularity or any objection to the hearing panel or to the Hearing Officer, as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may expeditiously be made. Objection to any such pre-hearing decisions shall be raised at the judicial hearing and when so raised shall be preserved for consideration at any appellate review hearing which thereafter might be requested.

6.3.10 Discovery

A. **Rights of Inspection and Copying**

The affected practitioner may inspect and copy at (his or her expense) any documentary information relevant to the charges that the Professional/AHP Staff has in its possession or under its control. The body whose decision prompted the hearing may inspect and copy (at its expense) any documentary information relevant to the charges that the affected practitioner has in his or her possession or under his or her control. The requests for discovery must be fulfilled as soon as practicable. Failure to provide access to documents reasonably requested at least thirty (30) days prior to the hearing shall be good cause for a continuance of the hearing.

B. **Limits on Discovery**

The Presiding Officer, upon the request of either side may deny or limit a discovery request on any of these grounds:

(1) The information refers solely to individually identifiable practitioners other than the affected practitioner.

(2) Denial is justified to protect peer review.

(3) Denial is justified to protect justice.

In ruling on requests the facts that may be considered include:

(1) Whether the information sought may be introduced to support or defend the charges.

(2) Whether the information is "exculpatory" in that it would dispute or cast doubt upon the charges or "inculpatory" in that it would prove or help support the charges and/or recommendation.

(3) The burden on the party of producing the requested information.

(4) What other discovery requests the party has previously made.

C. **Objections to Introduction of Evidence Previously Not Produced for the Professional/AHP Staff.** The body whose decision prompted the hearing may object to the introduction of evidence that was not provided by the practitioner during an appointment, reappointment or privilege application review or during corrective action. The information will be barred from the hearing by the Presiding Officer unless the practitioner proves he or she previously acted diligently and could not have submitted the information.

6.3.11 Pre-Hearing Document Exchange

At the request of either party, the parties must exchange documents that are expected to be introduced at the hearing. The documents must be exchanged at least ten (10) days prior to the hearing. A failure to comply with this rule is good cause for the presiding officer to grant a continuance. Repeated failures to comply shall be good cause for the presiding officer to limit introduction of any documents not provided to the other side in a timely manner.

6.3.12 Representation

The hearings provided for in these Bylaws are for the purpose of inter-professional resolution of matters bearing on conduct or professional competency. Accordingly, neither the petitioner, the Medical Executive Committee, nor the Governing Board shall be represented at the judicial hearing unless the Governing Board in its discretion, permits both sides to be represented by legal counsel. The foregoing shall not be deemed to deprive any party of its right to the assistance of legal counsel for the purpose of preparing for the hearing. When attorneys are not allowed, the practitioner and the body whose decision prompted the hearing may be represented at a hearing by a licensed practitioner who preferably is a member of the Medical Center's Professional/AHP Staff and is not an attorney-at-law.

6.3.13 Failure to Appear

Failure without good cause of the practitioner to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions involved and it shall thereupon become the final recommendation of the Professional/AHP Staff. Such final recommendation shall be considered by the Governing Board at its next regularly scheduled meeting. The recommendation shall be given great weight but shall not be binding on the Governing Board.

6.3.14 Postponements and Extensions

Postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by any affected person and shall be permitted by the Presiding Officer on a showing of good cause.

6.3.15 Record of the Hearing

The Judicial Hearing Committee shall maintain a record of the hearing by using a certified shorthand reporter to record the hearing or by tape recording the proceedings. The practitioner shall be entitled to receive a copy of the transcript or recording upon paying the reasonable cost for preparing the record. The Presiding Officer may, but is not required to, order that oral evidence shall be taken only on oath administered by any person designated by such body and entitled to notarize documents in this State or by affirmation under penalty of perjury to the Presiding Officer.

6.3.16 Rights of the Parties

At a hearing both sides shall have the following rights: to ask Judicial Hearing Committee members and/or the Hearing Officer questions which are directly related to determining whether they meet the qualifications set forth in these bylaws and to challenge the impartiality of such members or the Hearing Officer, to call and examine witnesses, to introduce relevant documents and other evidence, to receive all information made available to the Judicial Hearing Committee, to cross-examine or otherwise attempt to impeach any witness who testified orally on any matter relevant to the issues, and otherwise to rebut any evidence. The practitioner may be called by the body whose decision prompted the hearing and examined as if under cross-examination. The Judicial Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. Each party has the right to submit a written statement in support of his or her position at the close of the hearing. The Judicial Hearing Committee may request such a statement to be filed following the conclusion of the presentation of oral testimony.

6.3.17 Rules of Evidence

The rules of law relating to the examination of witnesses and presentation of evidence shall not apply in any hearing conducted hereunder. Any relevant evidence, including hearsay, shall be admitted by the presiding officer if it is the sort of evidence which responsible persons are accustomed to rely on in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

6.3.18 Basis of Decision

If the Judicial Hearing Committee should find any or all of the charge(s) to be true, it shall recommend such action as it finds warranted. If the recommended action is more stringent than that recommended by the body whose decision prompted the hearing, the practitioner shall be notified by the hearing committee and be given a further opportunity to submit evidence to the Judicial Hearing Committee in support of his or her position if he or she demonstrates he or she previously was unaware of the possible severity of the consequences and fairness requires that he or she have a further chance to respond. The decision of the Judicial Hearing Committee shall be based on the evidence produced at the hearing and any written statements submitted to the Judicial Hearing Committee.

6.3.19 Burden of Going Forward and Burden of Proof

In all cases, the body whose decision prompted the hearing shall have the burden of initially presenting evidence to support the charges and its recommendation. Thereafter the burden differs, depending upon whether the practitioner is applying for membership or privileges or is a member who already has the membership or privileges. At any hearing involving denial of Professional/AHP Staff membership or denial of initial or additional privileges, the practitioner has the burden of proving by a preponderance of the evidence that he or she is qualified for membership or for the denied initial or additional privileges. The practitioner must produce information which allows for an adequate evaluation and resolution of any reasonable doubts concerning his or her current qualifications.

In all other cases involving members who already have been granted membership and privileges, the body whose decision prompted the hearing shall have the burden of proving by a preponderance of the evidence, that the action or recommendation is reasonable and warranted.

6.3.20 Adjournment and Conclusion

The Presiding Officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. The hearing shall be concluded within a reasonable time and the Presiding Officer may set guidelines for introduction of evidence to achieve a timely conclusion. Upon conclusion of the presentation of oral and written evidence and argument, the hearing shall be closed. The Judicial Hearing Committee shall thereupon, outside of the presence of the parties, conduct its deliberations and render a decision and accompanying report. Final adjournment shall not occur until the hearing committee has completed its deliberations.

6.3.21 Decision of the Judicial Hearing Committee

Within fifteen (15) days after final adjournment of the hearing (or within ten (10) working days if the practitioner is currently under suspension) the Judicial Hearing Committee shall render a decision. The decision shall be accompanied by a written report that contains findings of fact and conclusions that articulate the connection between the evidence produced at the hearing and the decision. The report shall include sufficient detail to enable the parties, any appellate review board and the Governing Board to determine the basis for the Judicial Hearing Committee's decision on each matter contained in the notice of charges. The decision and report shall be delivered in person, to the Medical Executive Committee, the Administrator, the Governing Board and the affected practitioner. The practitioner's copy of the report shall be delivered by registered or certified mail, return receipt requested. The decision of the Judicial Hearing Committee shall be considered final, subject only to the right of review by or appeal to the Governing Board as provided in Article VI, Section 5.

6.4 Informal Review Procedure

6.4.1 Notice of Action

A body that has the authority to take any of the actions that constitute grounds for an informal review listed in Article VI, Section 2, Subsection 2 shall give notice of its recommendation or action to the affected practitioner and of his or her right to request informal review. The notice should:

A. Identify the proposed actions;

B. State the reasons for the actions;

C. State that any informal review must be requested within thirty (30) days in writing; and

D. Reference or include a copy of the informal review procedure from these bylaws.

6.4.2 Procedure for Informal Reviews

The procedure for requesting, arranging and conducting informal reviews shall be the same as that applicable to formal hearings (as set forth in Article VI, Section 3, Subsection 2 through Article VI, Section 3, Subsection 20) except as follows:

A. **Notice of Review and Charges**

Notice of the review and notice of charges shall be sent by mail, telecopy or personal delivery at least ten (10) working days prior to the informal review.

B. **Informal Review Panel**

The Chief of Staff shall appoint three (3) Professional/AHP Staff members who are not biased against the affected practitioner and who have no previous involvement in the same manner to serve as the Informal Review Panel. One member shall be designated to serve as the Presiding Officer. The Medical Executive Committee shall appoint a Hearing Officer pursuant to Section 6.3.7

C. **Pre-Hearing Procedure**

(1) **Discovery**

There is no right of discovery in informal reviews.

(2) **Pre-Hearing Document and Witness List Exchange**

Both parties should exchange the names of all witnesses known at that time and copies of all documents expected to be introduced at the informal review at least three (3) working days prior to the review. The Presiding Officer may bar the introduction of any documents that were not exchanged prior to the informal review if the parties were given written notice of this requirement least ten (10) working days prior to the informal review.

(3) **Objection to Introduction of Evidence Not Previously Made Available During the Investigation**

The Professional/AHP Staff may object to the introduction of any evidence that was specifically requested during an investigation but not produced. Such evidence will be barred unless the practitioner can prove it was not available during the investigation, despite reasonable attempts to secure it.

D. **Representation**

Neither party may be represented by an attorney at an informal review. The Professional/AHP Staff and the affected practitioner may each be represented by a licensed practitioner who is not an attorney and who preferably is a member of the Professional/AHP Staff. Any party may consult with an attorney to prepare for the hearing.

E. **Rights of the Parties**

The parties shall have the rights set forth in Article VI, Section 3, Subsection 16; provided that the Informal Review Panel shall decide whether the parties shall submit written statements at the conclusion of the hearing.

F. **Basis of Decision**

If the Informal Review Panel should find any of the charges to be true, it shall recommend such form of discipline as it finds warranted. If the recommended discipline is more stringent than that recommended by the body whose decision prompted the hearing, the practitioner shall be notified by the Informal Review Panel and be given a further opportunity to submit evidence to that hearing panel in support of his or her position if he or she can demonstrate he or she

previously was unaware of the possible severity of the consequences and fairness requires that he or she have a further chance to respond.

The decision of the Informal Review Panel shall be based upon the evidence produced at the hearing.

G. **Burden of Going Forward and Burden of Proof**

The body whose decision prompted the informal review shall have the burden initially of introducing evidence to support the changes and recommendation. If this evidence supports the recommendation then the burden shifts to the affected practitioner. The applicant or member must then prove that the adverse recommendation is unsupported by the evidence or is otherwise arbitrary, unreasonable or capricious.

H. **Appeal**

The Governing Board shall conduct appellate review using the procedure established for formal hearing appeals in Article VI, Section 5, except there shall be no automatic right of representation by an attorney at any oral argument that may be allowed.

6.5 Appeals to the Governing Board

6.5.1 Time for Appeal

Within forty (40) days after the date of receipt of the Judicial Hearing Committee decision, either the practitioner, the body whose decision prompted the hearing, or the Governing Board (on its own motion) may request an appellate review by the Governing Board. Said request shall be delivered to the Administrator in writing either in person, or by certified or registered mail, return receipt requested, and it shall briefly state the reasons for the appeal. If appellate review is not requested within this period, both sides shall be deemed to have accepted the action involved and it shall thereupon become the final recommendation of the Professional/AHP Staff. Such final recommendation shall be considered by the Governing Board at its next regularly scheduled meeting. The recommendation shall be given great weight, but shall not be binding on the Governing Board.

6.5.2 Time, Place and Notice

When appellate review is requested, the Governing Board shall, within forty-five (45) days after the date of receipt of such an appeal notice, schedule and arrange for an appellate review. The Governing Board shall give the practitioner notice of the time, place, and date of the appellate review. The date of appellate review shall be not less than fifteen (15) nor more than ninety (90) days from the date of receipt of the request for appellate review. If, however, a practitioner is under suspension, the appellate review shall be held as soon as the arrangements may reasonably be made, but not more than forty-five (45) days from the date of receipt of the request for appellate review. The time for appellate review may be extended for good cause.

6.5.3 Appeal Board

When an appellate review is requested, the Governing Board may sit as the appeal board or it may appoint an appeal board composed of at least three (3) persons, of at least one should be a member of the Governing Board. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not participate in the matter at any previous level, (e.g., as an accuser, investigator, fact finder, or initial decision-maker). For the purposes of this Section, participating in an initial decision to recommend an investigation shall not be deemed to constitute participation in a prior hearing on the same matter. The appeal board may select an unbiased attorney to assist it.

6.5.4 Hearing Procedure

The proceedings by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Hearing Committee or Informal Review Panel. The appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Judicial Hearing Committee or Informal Review Panel in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the formal hearing or informal review; or the appeal board may remand the matter to the Judicial Hearing Committee or Informal Review Body for the taking of further evidence and for decision. Each party to a formal hearing has the right to be represented by an attorney or any other representative the party chooses. Each party has the right to present a written statement in support of his or her position on appeal. In its sole discretion, the appeal board may allow each party or representative to personally appear and present oral arguments. If oral argument is not allowed, the party who requested appellate review must be given a chance to respond to the other party's written statement. This "reply" is not required if oral argument is allowed. At the conclusion of oral argument, if allowed, the appeal board may thereupon conduct, at a convenient time, deliberations outside the presence of the parties and their representatives.

If an appeal board is appointed, the appeal board shall present to the Governing Board its written recommendations as to whether the Governing Board should affirm, modify, or reverse the Judicial Hearing Committee or Informal Review Panel decision, or remand the matter for further review and decision. If no appeal board is appointed, the procedures outlined in this subsection shall apply to a hearing before the Governing Board.

6.5.5 Decision

Within fifteen (15) days after adjournment of the appellate review proceedings, the Governing Board shall render a final decision in writing. Final adjournment shall not occur until the Governing Board has completed its deliberations. The Governing Board may affirm, modify, or reverse the Judicial Hearing Committee or Informal Review Panel decision, or, in its discretion, remand the matter for further review and recommendation. The Governing Board shall give great weight to the recommendation of the Professional/AHP Staff and shall not act arbitrarily or capriciously. The Governing Board is allowed, however, to exercise its independent judgment in determining whether a practitioner was afforded a fair hearing, whether the decision is reasonable and warranted, and whether any bylaws, rule or regulation relied upon by the hearing committee in reaching its decision is reasonable and warranted. Copies of the decision shall be delivered to the practitioner and to the Medical Executive Committee, by personal delivery or by mail.

6.5.6 Further Review

Except when the matter is remanded for further review and recommendation, the final decision of the Governing Board following the appeal procedures set forth in this Article shall be effective immediately and shall not be subject to further review. If the matter is remanded to the Judicial Hearing Committee, Informal Review Panel or any other body or person, said committee, body, or person shall promptly conduct its review and make its recommendations to the Governing Board in accordance with the instructions given by the Governing Board. The time for a further review and report shall not exceed ninety (90) days except as the parties may otherwise stipulate.

6.5.7 Right to One Hearing

Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of action by either the Medical Executive Committee or the Governing Board or by both.

6.6 Exceptions to Hearing Rights

6.6.1 Termination of Temporary Privileges

No practitioner is entitled to the hearing, review or appeal rights provided in this Article resulting from the termination of temporary clinical privileges, unless such action is expressly stated to be for a medical disciplinary cause.

6.6.2 Closed Staff or Exclusive Use Departments, Medical Center Contract Physicians and Medico-Administrative Officers

A. **Closed Staff or Exclusive Use Departments**. The fair hearing provisions of this Article do not apply to a practitioner whose application for Professional/AHP Staff membership and privileges was denied or whose privileges were terminated or limited because the privileges he or she seeks are granted only pursuant to a closed staff or exclusive use policy. Such practitioners shall have the right, however, to request that the Governing Board review the denial and the Governing Board shall have the discretion to determine whether to review such a request and, if it decides to review the request, to determine whether the practitioner may personally appear before and/or submit a statement in support of his or her position.

B. **Medical Center Contract Physicians and Medico-Administrative Officers**. The fair hearing rights of this Article do not apply to practitioners serving as Medical Center contract physicians or in medico-administrative capacities. Removal of these practitioners from office shall instead be governed by the terms of their individual contracts and agreements with the Medical Center. The hearing rights of this Article, however, shall apply to the extent that an action is taken which must be reported under Business and Professions Code Section 805 and to the extent that Professional/AHP Staff membership status or clinical privileges which are independent of the practitioner's contract are also removed or suspended.

6.6.3 Allied Health Professionals

Allied Health Professionals are not entitled to the formal hearing or informal review rights set forth in this Article.

6.6.4 Denial of Applications for Failure to Meet Minimum Qualifications

A practitioner shall not be entitled to any formal hearing, informal review, or appellate review rights if his or her membership or privileges, application or request is denied because of his or her failure to document the initial application material.

6.6.5 Automatic Suspensions and Resignations

Practitioners whose clinical privileges are automatically suspended and/or who have resigned their Professional/AHP Staff membership for any of the reasons specified in Article V, Section 4 above, are not entitled to any formal hearing, informal review, or appellate review rights.

ARTICLE VII
PROFESSIONAL/AHP STAFF, CATEGORIES, PROMOTION, CONTRACTUAL PROFESSIONAL SERVICES, AND DUES

7.1 Professional/AHP Staff

Professional/AHP Staff membership is granted by the Governing Board and based upon the recommendation of the Medical Executive Committee. The Medical Executive Committee will base its recommendation upon the recommendation of the Credentials Committee.

All new members of the Professional/AHP Staff shall be appointed for an initial two year period to the Provisional Category.

7.1.1 Physician Members

The Credentials Committee shall assign all physicians to the most appropriate Clinical Department of the Professional/AHP Staff. The assignment shall depend upon the applicant's request, information contained in the application, and privileges requested.

7.1.2 Dentist Members

Dentist Members shall consist of licensed dentists and oral surgeons who participate in dental care in the Medical Center. Such members shall consult with physicians of appropriate specialties when needed. Dentist members shall be assigned to the Department of Surgery. Their privileges and review of performance shall be considered in the same manner as provided for other members of the Professional/AHP Staff.

7.1.3 Podiatrist Members

Podiatrists shall be assigned to the Department of Surgery. Such members shall consult with physicians of appropriate specialties when needed. Their privileges and review of performance shall be considered in the same manner as provided for other members of the Professional/AHP Staff.

7.1.4 Ph.D. and Clinical Psychologists

Ph.D., and Clinical Psychologists shall be assigned to the Department of Medicine. Such members shall consult with physicians of appropriate specialties when needed. Their privileges and review of performance shall be considered in the same manner as provided for other members of the Professional/AHP Staff.

7.1.5 Honorary Staff

The Honorary Staff shall consist of those professionals who are not active in the Medical Center and are being recognized for their outstanding reputations or previous long-standing service to the Medical Center. They shall not be eligible to vote, hold office, serve on committees, or have privileges, nor are they subject to reappointment. Honorary Staff status may be revoked at the discretion of the Medical Executive Committee. Since Honorary status confers no privileges or rights, an individual may be removed by the Medical Executive Committee at any time without hearing rights.

7.1.6 Leave of Absence

Any member of the Active or Associate Categories of the Professional/AHP Staff may request a leave of absence from his Professional/AHP Staff duties and responsibilities for up to one year. Upon showing of good cause the Medical Executive Committee may in its sole discretion, grant such leaves of absence subject to such conditions as it may require. Any member returning to the Professional/AHP Staff following a leave of absence must be reviewed by the Chairman of his clinical department and approved by the Medical Executive Committee. If the leave of absence was secondary to a medical or psychiatric problem, the Medical Executive Committee may require a letter from the treating physician to the effect that the member of the medical staff is

cleared to return to clinical duties. The Medical Executive Committee may also require an evaluation from a physician or practitioner that it designates prior to reinstatement of clinical privileges.

7.2 Staff Categories.

(EP 15) The Professional/AHP Staff shall be divided into Provisional, Associate, Active and Courtesy Categories based on clinical activity, participation in staff activities, and qualifications for such appointment, included are the duties and rights of each category.

7.2.1 Provisional Category

(EP 17) The Provisional Category shall consist of all new Staff members, (except those on the Honorary and Consulting Staffs), who shall be appointed for an initial period of two (2) years. Provisional members shall be assigned to the appropriate clinical departments where their performances will be observed by the chairman of the department or his designee. The Provisional Category member must spend a minimum of six (6) months on Provisional Category. After the initial six (6) months, the member may request from his/her Clinical Departmental Committee early advancement in staff category. The Clinical Departmental Committee may also advance members at the one-year point, in conjunction with their one-year reappraisal. For advancement in category, each Clinical Departmental Committee must establish its criteria for advancement. Advancement in category does not alter the reappointment cycle. The appropriate Clinical Departmental Committee will conduct a reappraisal of each member's patient care activities and compliance with Provisional Category requirements at the one-year point in membership. At the two (2) year point, the member must be terminated or continued in either the Courtesy or Associate Category. They are not eligible to vote for Professional/AHP Staff Officers or on Bylaws amendments, hold office, or serve as chairmen of any committee. They may serve and vote on all committees except the Executive, Credentials, Bylaws, and Nominating Committees. Denial of advancement before two years does not entitle the member to request Informal Review pursuant to Article VI, Section 2, Subsection 3.

7.2.2 Associate Category

(EP 17) The Associate Category shall consist of those Staff members whose duration of membership and/or participation in Medical Center and Staff activities shall warrant their appointment from the Provisional Category or those members previously on the Active Category who become less active in Medical Center and Staff activities. Members of this category may serve as subcommittee chairmen, must attend Staff Meetings, and are eligible for promotion to the Active Category. Associate Category members are not eligible to vote at Staff Meetings or hold office but may serve and vote on all committees except the Executive, Credentials, Bylaws, and Nominating Committee. Appointment to this category shall be for a minimum of three (3) years.

7.2.3 Active Category

(EP 17) The Active Category shall consist of those Staff members who have been members of the Associate Category for at least three (3) years, and who's attendance at Staff Meetings, whose utilization of the hospital facilities, and whose participation in committee and medical center functions shall warrant their promotion from the Associate Category. Only members of the active category shall be eligible to vote and transact the business of the Staff, hold office, enjoy the special privileges of Active Category membership, serve on the Medical Executive Committee, and serve as chairmen of Staff committees as set forth in Article X.

7.2.4 Courtesy Category

(EP 17) The Courtesy Category shall consist of those Staff members who are minimally active in patient care activities and less active in the Medical Center and Professional/AHP Staff activities. Members may be appointed directly to this category from the Provisional Category or from the Associate or Active Categories on the recommendation of the Credentials Committee. They may be promoted from this category to the Associate or Active Categories when clinical and/or Professional/AHP Staff activities warrant it at the recommendation of the Credentials Committee. Members may stay in the Courtesy Category for an indefinite period; these members shall normally be active members at another hospital. Courtesy Category members are not eligible to vote, hold office, or serve as chairmen of committees, but may serve and vote on all committees except the Executive, Credentials, Bylaws, and Nominating Committees.

7.2.5 Consulting Staff

The Consulting Staff shall consist of physicians, dentists or podiatrists: (a) with recognized expertise in a subspecialty area of practice; (b) who have been individually invited by the Chairman of a Clinical Department; (c) to provide special consulting or assisting services on an occasional basis together with Active or Associate members of the particular Clinical Department; and, (d) who are members in good standing of the Active Professional/AHP Staff of a hospital accredited by Joint Commission on Accreditation of Healthcare Organizations or other accrediting entities on the faculty of an accredited teaching facility. Consulting Staff members may qualify for specialty privileges only, in accordance with Article IV.

Applicants are appointed directly to this staff and shall receive an initial monitoring in accordance with procedures established by the member's Clinical Department. Members of the Consulting Staff may attend but are not required to attend Professional/AHP

Staff, Departmental or Section meetings. Consulting Staff members are not eligible to vote, hold office, or serve as chairmen of committees, but may serve but not vote on all committees with the exception of the Executive, Credentials, Bylaws, and Nominating Committees. They have no vote on any committee.

The clinical privileges and professional membership of a member of the Consulting Staff shall automatically terminate without right to notice, hearing or appeal as provided in Article VI, if the particular Clinical Department votes to withdraw its invitation; provided, however, that the member shall be entitled to the notice hearing and appeal rights of Article VI, if the Clinical Department bases its action on an independent finding of medical disciplinary cause or reason. Prior to withdrawing its invitation, the Clinical Departmental Committee shall inform the Consulting Staff member of the reasons for the proposed action and shall allow the member to discuss the proposed action with the Departmental Committee. Such notice and discussion shall not constitute a formal hearing or review and shall not be subject to the requirements of Article VI.

7.3 Contractual Professional Services

Under circumstances approved by the Medical Executive Committee, it is appropriate for members of the Professional/AHP Staff to have a contract with the Medical Center to render professional and/or administrative services. Those physicians who render contract services within the Medical Center must be members of the Professional/AHP Staff. The performance of their professional services shall be reviewed annually. Their clinical privileges shall be regularly reviewed as with all other members of the Professional/AHP Staff. Termination of the contract need not affect the membership or privileges unless stated in the contract. When a professional service contract is being reviewed for renewal the officers of the Professional/AHP Staff shall make a recommendation to Administration regarding the quality of professional services and contract renewal.

7.4 Dues

The Vice Chief of Staff shall present a detailed budget annually to the Medical Executive Committee and from this budget the annual dues shall be determined. All members of the Staff except the Honorary Staff shall pay dues.

ARTICLE VII-A
PATIENT CARE SERVICES BY NON-MEMBERS OF THE PROFESSIONAL/AHP STAFF

7-A.1 In General The Professional/AHP Staff is responsible to assure that all persons who provide direct patient care services at Providence Saint Joseph Medical Center (other than persons directly employed by the Medical Center) are qualified to exercise the specific clinical privileges which they exercise and that they are subject to appropriate supervision and monitoring. Delineated clinical privileges or practice privileges may be granted to non-members of the Professional/AHP Staff pursuant to the provisions for Allied Health Professionals and Physicians in Training contained in this Article.

7-A.2 Allied Health Professionals

Allied health professionals (AHPs) are practitioners who hold a license, certificate, or such other legal credentials as are required by California law, which authorize the AHPs to provide certain professional services, and who are in a category of AHPs designated by the Governing Board. Such AHPs are eligible for practice privileges in the Medical Center only if they:

A. Hold a license, certificate, or other legal credential in a category of AHPs which the Governing Board has identified as eligible to apply for practice privileges.

B. Document their experience, background, training, demonstrated ability, judgment, and physical and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the professional level of quality and efficiency established by the Medical Center, and that they are qualified to exercise practice privileges within the Medical Center; and

C. Are determined on the basis of documented references, to adhere strictly to the lawful ethics of the Professional/AHP Staff and their respective professionals, to work cooperatively with others in the Medical Center setting; and to be willing to commit and regularly assist in the Medical Center in fulfilling its obligations relating to patient care, within the areas of their professional competence and credentials.

7-A.2.1 Delineation of Categories of AHPs Eligible to Apply for Practice Privileges

The Governing Board shall review and identify the categories of AHPs which shall be eligible to apply for practice privileges in the Medical Center. For each eligible AHP category, the Governing Board shall identify the practice privileges and prerogatives that may be granted to qualified AHPs in that category. The Medical Executive Committee shall offer recommendation to the Governing

Board as to the categories of AHPs which should be eligible to apply for practice privileges and as to the practice privileges, prerogatives, terms and conditions which may be granted and apply to AHPs in each category. The Governing Board and Medical Executive Committee shall delineate the categories of AHPs eligible to apply for practice privileges, together with the terms and conditions applicable to each such category, in Professional/AHP Staff Rules and Regulations. Any licensed or otherwise certified AHP in a category which has not been approved for practice privileges in the Medical Center may submit a written request to the Administrator, asking that the Governing Board consider granting such privileges to his practitioner category. The Governing Board shall consider all such requests by the time of its annual consideration of AHP categories.

7-A.2.2 Responsibilities

A. Meet those responsibilities required by the Bylaws, General Rules and Regulations, Departmental Rules and Regulations of the Professional/AHP Staff, Medical Center and Governing Board, and if not so specified, meet those responsibilities specified in Article III, Section 3 as are generally applicable to the more limited practice of the AHP.

B. Retain appropriate responsibility within his area of professional competence for the care and supervision of each patient in the Medical Center for whom he is providing services.

C. Participate, as appropriate, in patient care audit and other quality review, evaluation, and monitoring activities required of AHPs in supervising initial appointees of his same occupation or profession, and in discharging such other functions as may be required from time to time.

D. Serve on Professional/AHP Staff, Department, and Medical Center Committees to which he is assigned.

E. Attend the meetings of the Department to which he is assigned, as permitted by the Departmental Rules and Regulations, and attend Medical Center education programs in his field of practice.

7-A.2.3 AHP Grievance Process

Nothing contained in these Bylaws shall be interpreted to entitle an AHP to the fair hearing rights set forth in Articles V and VI. However, the AHP shall have the right to challenge any action that would constitute grounds for a hearing under Article VI, Section 2, by filing a written grievance with the Chairman of the Clinical Department too which the AHP has been assigned and in which he has practice privileges or the right to render the services in question, within fifteen (15) days of such action. Within forty-five (45) calendar days of the receipt of such a grievance, the Department Chairman shall initiate a careful investigation and afford the affected AHP an opportunity for an interview before the Departmental Committee. The Department Committee may include, for the purpose of this interview, an AHP or AHPs holding the same or similar license or certificate as the affected AHP. Such AHPs shall be appointed to the committee for this purpose by the Department Chairman. The interview shall not constitute the same type of "hearing," as is established by Article VI, and shall not be conducted according to the procedural rules applicable with respect to hearings. Before the interview, the AHP shall be informed of the general nature of the circumstances giving rise to the proposed action, and at the interview, the AHP may present information relevant thereto. A record of the findings of such interview shall be made. A report of the findings and recommendations shall be made by the Department Chairman to the Medical Executive Committee which shall act thereon at the next regularly scheduled meeting. The action of the Medical Executive Committee shall be final, subject to approval by the Governing Board.

7-A.3 Healthcare Providers Under Medical Direction

The Medical Executive Committee may grant limited clinical privileges, subject to supervision, to physicians or other licensed individuals in the State of California who are participants in an approved residency or fellowship program, and part of a training program approved by the Education Committee and the Medical Executive Committee. They shall be assigned to a clinical department which shall make a recommendation regarding their privileges, shall review their performance, and be responsible for their activities. A letter verifying their participation in a training program must be in their file and can be substitutes for medical references.

Enrollees in qualified medical education programs and permitted to provide medical services to patients pursuant to state law, may be granted delineated clinical privileges as recommended by the Education Committee and shall be subject to such provisions for supervision and review as the Medical Executive Committee may require.

ARTICLE VIII
(EP 12) STRUCTURE OF THE PROFESSIONAL / AHP STAFF: CLINICAL DEPARTMENTS AND THEIR COMMITTEES

8.1 Clinical Departments and Sections

The Clinical Departments of the Professional/AHP Staff shall consist of Medical, Surgical, Obstetrics and Gynecology, Pediatric, General and Family Practice, and Professional Service Departments. The clinical departments may be further organized into specialty sections as defined in Departmental Rules and Regulations. All members of the Professional/AHP Staff shall be assigned to a clinical department by the Credentials Committee according to their primary field of practice. The Professional Service Department will consist of those physicians who provide contract services in the hospital on a full or part-time basis, to include but not limited to pathologists, radiologists, radiation therapists, and physicians in Emergency Medicine.

8.2 Clinical Departmental Committees

Each clinical department shall be supervised by a committee which shall be responsible for all departmental activities including quality and supervision of patient care and administrative functions. Each committee is accountable to the Medical Executive Committee.

8.2.1 Each Committee shall:

A. recommend and review all privileges as outlined in Article IV of these Bylaws;

B. review and recommend staff categories for their members as outlined in Article VII;

C. be responsible for and have authority to formulate, annually review, modify, and enforce committee rules and regulations;

D. be responsible for an ongoing patient care evaluation program, including regular patient care audits for the purpose of analyzing, reviewing, and evaluating the quality of care within that department;

E. be responsible for education programs based in part upon patient care evaluation;

F. confer and cooperate with other departments regarding interdepartmental policies;

G. integrate the patient care provided by the departments' members with nursing, ancillary, and administrative services;

H. hold regular and special meetings to conduct the business of the department;

I. be responsible for regular clinical departmental committee meetings, quarterly departmental meetings, and ensure that specialty section meetings are conducted as needed to transact the business of the sections;

J. be responsible for all other activities as delegated by the Medical Executive Committee.

8.2.2 Departmental Chairs and Vice Chairs

A. Qualifications for Departmental Chairs and Vice Chairs

Candidates for the offices of Chair and Vice Chair of a Clinical Department must:

(1) be members in good standing of the Active Category;

(2) not have been subject to adverse disciplinary action or medical disciplinary cause or reason under these Bylaws during the preceding five (5) years;

(3) be willing to serve;

(4) be willing to disclose current and future perceived conflicts of interest in accordance with the policy on conflicts of interest adopted by the Medical Executive Committee;

(5) satisfy such additional requirements as may be established in the Department's Rules and Regulations; and

(6) (EP 36) be board certified or possess comparable competence confirmed through the credentialing process.

B. Selection of Clinical Department Chairs and Vice Chairs.

In odd years, not less than 90 days before the Annual Business Meeting of the Staff, written notice shall be sent to the Clinical Department Active Category members soliciting nominations for departmental committee chairs for a term of two years.

All such nominations for Chair shall be delivered in the same manner in writing to the Departmental Chair not less than sixty (60) days before the Annual Meeting. Any person so nominated shall promptly furnish the Professional/AHP Staff Office with a written statement describing the nominee's interests, qualifications and current or potential perceived conflicts of interest. The Professional/AHP Staff Office shall send copies of such written statements to all Active Category members of the Department before the Annual Meeting.

Before the Annual Business Meeting of the Staff, the Active Category members of the Department shall elect a Chair for the following two (2) Professional/AHP Staff years by majority vote of the Active members of the Department voting.

The Vice Chair shall be appointed at the first departmental meeting from the Clinical Departmental Committee for one year by the Chair of the Department with concurrence of the Departmental Committee and may be reappointed.

C. Duties and Responsibilities of the Departmental Chair

The Departmental Chair shall be responsible to the Medical Executive Committee for the function and general supervision of all departmental and committee activities. Without limitation, the Chair's responsibilities shall include:

(1) (EP 36) being responsible for the quality of care in his department and quality control programs, as appropriate;

(2) selecting the composition of the departmental committees which may be either members-at-large or subcommittee chairmen when indicated;

(3) (EP 36) chairing departmental committee meetings;

(4) (EP 36) preparing regular and annual reports to the Medical Executive Committee;

(5) (EP 36) serving on the Medical Executive Committee;

(6) (EP 36) recommending to the Professional/AHP Staff the criteria for clinical privileges in the department that are relevant to the care provided in the department;

(7) the determination of the qualifications and competence of Allied Health Professionals;

(8) (EP 36) recommending clinical privileges for each member of the department and temporary privileges where appropriate;

(9) the orientation and continuing education of all persons in the department;

(10) the continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the department;

(11) participation in disciplinary action involving members of his department as outlined in Article V of these Bylaws;

(12) when necessary, shall require and arrange for consultation when appropriate;

(13) annually review the departmental rules and regulations, and review/develop and implement policies and procedures that guide and support the provision of services, care and treatment;

(14) (EP 36) all clinically related activities of the department, and all administratively related activities of the department unless otherwise provided for by the hospital;

(15) (EP 36) the integration of the department into the primary functions of the organization;

(16) (EP 36) the coordination and integration of interdepartmental and intra departmental services;

(17) serve as a member of the Nominating Committee.

(18) (EP 36) the Departmental Chairman assesses and recommends to the relevant hospital authority off-site sources for needed patient care services not provided by the department or the organization;

(19) (EP 36) recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

(20) (EP 36) determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services;

(21) (EP 36) coordination of the continuous assessment and improvement of the quality of care, treatment, and services;

(22) (EP 36) recommending space and other resources needed by the department or service;

(23) (EP 36) oversight of clinical activity.

D. Duties and Responsibilities of the Departmental Vice Chair

The Departmental Vice Chair shall assist the Chair as requested and in the Chair's absence shall discharge the Chair's duties and responsibilities.

E. Removal of Departmental Chair or Vice Chair

A motion to remove the Chair or Vice Chair of a Clinical Department may be made by any member of the Medical Executive Committee or by written petition signed by at least twenty-five percent (25%) of the Active Category members of the Department.

Upon such motion, the Medical Executive Committee shall vote on whether to recommend the removal. If the Medical Executive Committee, by two-thirds (2/3) vote of all members entitled to vote, recommends removal, the individual shall be thereupon removed from office and shall remain removed unless, within sixty (60) days, the Active Category members of the Department, by majority vote, restore the individual to office.

If a Departmental Chair is removed, the Vice Chair shall automatically assume the office of Chair. He shall appoint a new Vice Chair from the Clinical Departmental Committee and with the concurrence of the committee. If the Vice Chair is removed, the Chairman shall appoint a new Vice Chair in accordance with the process specified in Article VIII, Section 2, Subsection 2, item B.

8.2.3 Departmental Committee Membership

In each department, members who are in the Courtesy, Associate, or Active Categories may be appointed to and shall serve on the Departmental Committees. Representatives from Administration, Nursing, Medical Records, Pharmacy, Social Services, and other Medical Center departments may be appointed as ex-officio members where appropriate to the functions of the committee.

A. The MEDICAL COMMITTEE shall be composed of representatives from General Internal Medicine and the Medical Subspecialties, in part proportional to their numbers and clinical importance in the Medical Center. Additional members shall be selected from clinical areas and services, the medical laboratories, and a representative from the General and Family Practice Department with medical privileges.

B. The SURGICAL COMMITTEE shall be composed of representatives of the surgical specialties within the department and other members of the Surgical Department as necessary to achieve appropriate representation. Other members of the Professional/AHP Staff shall be appointed to assure appropriate liaison with other departments, including representatives from the Department of Obstetrics and Gynecology, the Department of General and Family Practice, and a pathologist from the Medical Center Department of Pathology.

C. The PEDIATRIC COMMITTEE shall be composed of at least six (6) Pediatricians and one (1) representative from the General and Family Practice Department with Pediatric privileges.

D. The OBSTETRICS AND GYNECOLOGY COMMITTEE shall be composed of at least five (5) members of the Obstetrics and Gynecology Department and, if feasible at least one (1) representative from the General and Family Practice Department with Obstetrics/Gynecology privileges.

E. The GENERAL AND FAMILY PRACTICE COMMITTEE shall be composed of at least five (5) members of the General and Family Practice Department. The committee members shall also serve as liaison representatives on the Medical, Surgical, Pediatric, and Obstetrics and Gynecology, and Professional Services Clinical Departmental Committees.

F. The PROFESSIONAL SERVICE COMMITTEE shall be composed of eleven (11) members. One (1) representative shall be chosen each from the Clinical Laboratories, Imaging Services, Radiation Therapy, and the Emergency Department. Each member from these departments shall be the Chief of the respective department. Two (2) other members shall be chosen from other contract physicians. Four (4) other members-at-large shall be selected by the chairman, chosen one (1) each from the Medical, Surgical, Obstetrics and Gynecology or Pediatric, and General and Family Practice Departments. The Chairman shall be chosen from the contract physician members on a rotational basis and shall sit on the Medical Executive Committee.

8.2.4 Section Chairs

The qualifications for Section Chair shall be the same as for Department Chairs and Vice Chairs, except that Section Chairs may be members of either the Active or Associate Category. Section Chairs shall be elected by majority vote of the Active and Associate members of the Section present and voting at a regular or special meeting of the Section.
Before the Annual Business Meeting of the Staff, the Active and Associate Category members of the Section shall elect a Chair for the following two (2) Professional/AHP Staff years by majority vote of the Active and Associate members of the Section voting. 03:2018

If any Section fails to elect a Chair before November 30, the Vice Chair of the applicable Clinical Department shall select a Section Chair for the following Professional/AHP Staff year. The Active Category members of the Section may remove the Section Chair upon two-thirds (2/3) vote. If the Section Chair is removed, the Departmental Chair shall appoint an interim Section Chair to serve until a new Section Chair is elected. The Section Chairs shall act as representatives of their respective specialty sections, serve as members of their clinical departmental committees, and perform those tasks assigned to them by the department and/or the Department Chair.

ARTICLE IX
(EP 12) STRUCTURE OF THE PROFESSIONAL / AHP STAFF: OFFICERS

9.1 Officers

(EP 19) The Officers of the Professional/AHP Staff shall be the Chief of Staff and the Vice Chief of Staff.

9.2 Qualifications of Officers

In order to be nominated as an Officer a candidate must:

(a) be member in good standing of the Active Category with no adverse, final disciplinary actions as provided in Article V and VI of these Bylaws within the prior five (5) years;

(b) agree to disclose current and potential future perceived conflicts of interest in accordance with the conflict of interest policy adopted by the Medical Executive Committee. If conflicts of interest exist, these will be disclosed to the members of the Active Category before the election; and

c) have demonstrated ability in leadership, administration, professional relations and decision-making

9.3 Nomination of Officers

To be eligible to run for professional staff office, the candidate, in addition to other rules present within the bylaws, must have at least 50 patient contacts over their 2 year reappointment cycle. A patient contact occurs when a patient is seen or has a procedure during a discrete admission. Regardless of the number of visits or procedures performed during a given admission, each admission counts as 1 contact. 03:2018

Each member of the Nominating Committee may nominate two candidates. The Nominating Committee shall consider all candidates without prejudice by manner of nomination. Each Active Staff member may sign only one petition per election cycle. The Nominating Committee will be responsible for verification that only one signature occurs during any election cycle. Voting by the Nominating Committee will be by secret ballot and overseen by the current Chief and Chief of Staff-Elect. The Committee shall submit the names of the candidates with the two highest votes as nominees to the Professional/AHP Staff. Additionally, an additional nominee may be added if the Chief of Staff receives a petition signed by twenty percent (20%) of the Active Staff members (an Active Staff member shall only sign one (1) post nomination petition) not less than twenty one (21) days prior to the Annual Meeting. To permit time for such a petition, the Nominating Committee shall conclude its deliberations and announce nominee selections at least thirty (30) days prior to the Annual Meeting. The hospital shall have no right to approve the slate of candidates or otherwise participate in the activities of the nominating committee.

9.4 Voting By Secret Ballot

Ballots shall be submitted secretly. These will be available in the Professional/AHP Staff Office fifteen (15) days in advance of the election. Ballots will also be available on the day of the General Election. There will be a confidential master list to confirm that no one has received more than one ballot. Such voting may occur in person, by mail, or by such method of electronic voting approved by the Medical Executive Committee.

9.5 (EP 18) Election of Officers

The names and conflict of interest statements of all individuals nominated as officers shall be made available to the members of the Active Category not less than twenty-five (25) days before the Annual Meeting. Should a nominee fail to submit such a conflict of interest statement by this deadline stated above, that nominee shall be considered to have withdrawn as a candidate and his or her name will not appear on any ballot. The election of officers shall be held at the Annual Meeting of every even-numbered Professional/AHP Staff year. Votes for the election of officers will be counted at the Annual Meeting and results made available thereafter.

Members of the Active Category may vote, either in person or by written ballot signed and delivered to the Chief of Staff before the beginning of the Annual Meeting. Election as an officer shall require a 45% plurality of the votes cast; provided, at least forty percent (40%) of the members of the Active Category are represented in person or by written ballot. If necessary, run-off votes may be taken. If no candidate for an office is elected at the Annual Meeting, the current Chief of Staff shall call one or more special meetings of the Active Category to elect the officer.

9.5.1 Tie Votes for Election of Officers, Department Chairs, or Section Chairs

a. In the event of a tie in an election for Officers, Department Chairs, or Section Chairs and only two candidates were seeking office:
The election will be decided by the Medical Executive Committee. The candidates will be invited to make brief presentations to the committee prior to the decision. In the event of failure to achieve the stated plurality required in an election for Officers, Department Chairs, or Sections Chairs with more than two candidates seeking office:

1. A runoff election will take place between the two candidates with the highest vote totals, as soon as Such can be reasonably arranged.
2. If there is a tie after the runoff election, the election will be decided by a vote of the Medical Executive Committee as delineated in 9.5.1a

9.6 Term of Office

9.6.1 Term of office shall be two (2) years and the Chief of Staff is eligible for re-election as Vice Chief of Staff.

9.6.2 Officers shall take office on the first day of the staff year.

9.7 (EP 18) Removal of Officers

The Medical Executive Committee may consider the removal of a Professional/AHP Staff Officer upon motion by any voting member of the Medical Executive Committee or upon a written petition signed by at least twenty-five percent (25%) of the members of the Active Category and submitted to the Medical Executive Committee. With the affirmative vote of two-thirds (2/3) of the voting members of the Medical Executive Committee, an officer may be removed. The removal shall be effective immediately. If the Chief of Staff is removed the Vice Chief of Staff shall immediately assume the duties of Chief of Staff. If the Vice Chief of Staff is removed, a replacement shall be elected in accordance with the election procedures set forth in these Bylaws; provided, that the election shall occur at the next General Staff Meeting regardless of whether the year is odd-numbered or even-numbered.

Any Professional/AHP Staff officer may be removed from office by the Medical Executive Committee for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude.

Removal of officers by a vote of the Active Staff: A two-thirds majority written vote with a minimum of two-thirds of the Active Staff voting may remove an Officer for any cause. Written petitions requesting such a vote on such removal from greater than twenty five percent (25%) of the Active Staff shall cause such a written vote to be taken.

9.8 Vacancies in Office

Vacancies in office during the staff year, except Chief of Staff, shall be filled by the Medical Executive Committee. If there is a vacancy in the office of the Chief of Staff, the Vice Chief of Staff shall serve the remainder of the term.

9.9 Duties of Officers

9.9.1 The Chief of Staff shall serve as the chief administrative officer of the Staff to:

A. act in coordination and cooperation with the Administration in all matters;

B. represent the views, policies, needs, and grievances of the Professional/AHP Staff to the Administrator;

C. call, preside, and be responsible for the agenda of all Staff meetings as set forth in Article XI;

D. serve as presiding officer and member of the Medical Executive Committee;

E. be responsible for the appointment of committee chairmen and committee members as provided in these Bylaws;

F. serve as ex-officio member of all other Staff committees;

G. have general supervision over all Staff activities;

H. be responsible for the enforcement of Staff Bylaws, rules and regulations;

I. be responsible for the continuing review of the quality of patient care and related Medical Center services;

J. be responsible for assuring that the educational activities of the Professional/AHP Staff are adequately discharged by appropriate members, departments, and committees of the Staff;

K. be the spokesman for the Staff in its external professional and public relations;

L. perform all other duties required of him under these Bylaws and the policies, procedures, rules, and regulations of the Professional/AHP Staff.

9.9.2 The Vice Chief of Staff shall be a member of the Medical Executive Committee and:

A. shall assume all of the duties and have the authority of the Chief of Staff in the absence of the Chief of Staff;

B. shall assume further responsibilities as assigned to him by the Chief of Staff;

C. shall automatically succeed the Chief of Staff when his term is completed or the office becomes vacant;

D. shall have the responsibility for the planning and organizing functions of the Staff through the Standing Committees;

E. shall attend Credentials Committee, Professional Ethics and Advisory Committee, and Bioethics Committee meetings in a non-voting capacity, acting as their liaison to the Medical Executive Committee.

F. be responsible for accurate and complete minutes of all Staff and committee meetings;

G. call Staff Meetings on the order of the Chief of Staff;

H. attend to all correspondence;

I. be accountable for all funds entrusted to him;

J. be responsible for the preparation and presentation of the annual budget to the Medical Executive Committee;

K. attend Bylaws Committee meetings as a member;

L. perform such other duties as pertain to his office.

9.10 Chief of Staff-Elect

The Chief of Staff-Elect shall be that member of the Staff who succeeds to the position of the Chief of Staff at the biennial Staff election. He shall perform the duties of the office of Chief of Staff-Elect until the beginning of the next staff year, at which time he will become the Chief of Staff. The Chief of Staff-Elect also serves as Vice-Chief of staff for the two year term preceding his/her succession to Chief of Staff.

These duties shall consist of:

A. selecting the other members of the Medical Executive Committee, chairmen of other committees, and committee members as set forth in Article X of these Bylaws;

B. perform all other functions to ensure that the new Staff organization shall be prepared for business at the beginning of the staff year.

ARTICLE X
(EP 12) STAFF ORGANIZATION AND COMMITTEES

10.1 Staff Organization

The Chief of Staff has the ultimate responsibility for administration of the Staff organization, with the assistance of other Staff Officers and the Medical Executive Committee. The clinical functions of the Staff shall be the responsibility of the Clinical Departmental Committees and the Patient Care Committee under the direction of the Chief of Staff. The planning and organization functions of the Staff shall be the responsibility of the Standing Committees under the direction of the Chief of Staff. The documentation of staff activities and the budget is the responsibility of the Chief of Staff. Quality Assurance, evaluation and monitoring functions are the responsibility of the Director of Quality Improvement and Accreditation.

10.2 Staff Committees

The Committees of the Staff shall include the Medical Executive Committee, all clinical Departmental Committees and their subcommittees, the Patient Care Committee and its subcommittees, the Quality Assurance/Improvement Committee and its subcommittees, the Standing Committees, and Special Committees.

10.2.1 (EP 20) The Medical Executive Committee

A. (EP 20) Authority is delegated to the Medical Executive Committee by the organized Professional/AHP Staff to act on its behalf.

(EP 23) That the Medical Executive Committee acts on the behalf of the Professional/AHP Staff between meetings of the organized Professional/AHP Staff, within the scope of its responsibilities as defined by the organized Professional/AHP Staff.

(EP 20) Reduction of authority of the Medical Executive Committee requires amendment to these Bylaws.

The Medical Executive Committee shall:

(1) establish the policies and organizational structure by which the Professional/AHP Staff shall function;

(2) have authority over all other committees (except the Nominating and Bylaws Committees), receive and act upon their reports, coordinate their activities, and arbitrate differences;

(3) coordinate the activities and general policies of the Professional/AHP Staff not otherwise the responsibility of the departments;

(4) review the credentials of applicants and re-applicants through Credentials and Departmental Committee reports and to make recommendations to the Governing Board for staff membership, assignments to departments and delineation of clinical privileges;

(5) make final recommendations regarding disciplinary actions;

(6) represent and act on behalf of the Professional/AHP Staff, subject to such limitations as may be imposed by these Bylaws;

(7) take all reasonable steps to maintain ethical conduct and competent clinical performance on the part of all members of the Staff;

(8) provide liaison between Professional/AHP Staff, the Chief of Administration, and the Governing Board;

(9) make recommendations on Medical Center management matters, such as strategic and long-term planning;

(10) make regular reports to the Staff;

(11) be responsible for the budget, establishing dues, and authorizing expenditure of Staff funds;

(12) establish policy for the Staff in its external professional and public relations;

(13) keep the Professional/AHP Staff abreast of the accreditation status of the program and information on the accreditation status of the hospital;

(14) perform such other duties or functions assigned to it by these Bylaws, by the Professional/AHP Staff, or by the Governing Board;

(15) (EP 25) annually review, consider recommendations for revisions of, and propose revisions for the Rules and Regulations of the Professional/AHP Staff.

B. (EP 20) (EP 21) The Medical Executive Committee shall consist of eleven (11) members of the Professional/AHP Staff as follows: the two (2) officers of the Staff (the Chief of Staff, and Vice Chief of Staff), and the Immediate Past Chief of Staff; the Chairs of the General and Family Practice, the Medical, Obstetrics and Gynecology, Pediatric, Professional Service, and Surgical Committees; the Chairman of the Patient Care Committee, and the Chairman of the Quality Assurance/ Improvement Committee. Six (6) members of the Medical Executive Committee shall constitute a quorum. The Administrator will attend all regular and special meetings of the Medical Executive Committee on an ex-officio basis without vote. The Chair of the Bylaws Committee and the Credentials Committee, or their designees, shall be entitled to attend meetings of the Medical Executive Committee as ex-officio, non-voting members, in order to advise the Medical Executive Committee regarding Professional/AHP Staff governance and peer review issues. The Chief of Staff may invite any other person to attend particular meetings or portions of meetings when necessary to assist the Committee as to specific issues; provided that such invitee may be excluded upon majority vote of the Medical Executive Committee; and provided further, that all persons attending any meeting of the Medical Executive Committee must keep all Professional/AHP Staff information confidential. (EP 22) The Professional/AHP Staff determines the composition of the Medical Executive Committee through its Bylaws.

C. Meetings - The Medical Executive Committee shall meet at least once a month and maintain a record of its proceedings and actions. They may meet in specially called meetings, or in "executive session," at the discretion of the Chief of Staff or a majority of the Committee.

D. Removal of appointed Medical Executive Committee members by a vote of the Active Staff:

A two-thirds majority written vote with a minimum of two-thirds of the Active Staff voting may remove a Medical Executive Committee member for any cause. Written petitions requesting such a vote on such removal from greater than twenty five percent (25%) of the Active Staff shall cause such a written vote to be taken.

10.2.2 PROFESSIONAL STAFF FINANCE COMMITTEE (MEC 05:2018)

Composition
The Finance Committee shall be comprised of five (5) Active members of the Professional Staff. These Active members must have greater than fifty (50) patient contacts over a two (2) year period as per current Bylaw requirements for Professional Staff Election of Officers.

Term of Service and Appointment
The committee members shall serve a five (5) year term. The committee membership shall select new incoming members three (3) months prior to termination of current member(s) term. Vacancies which occur during the five (5) year term, shall be filled by a majority vote of the committee. The initial committee members shall be appointed by the Chief of Staff, Immediate Past Chief of Staff and Chief of Staff-Elect.

Committee Responsibility
The committee shall evaluate any request by the Chief of Staff which exceeds $5,000.00 dollars to any one vendor or individual during the calendar year. Disbursement of any amount exceeding $5,000.00 dollars as described above shall require a majority vote from the Finance Committee members. The Professional Staff attorney stipend, legal fees and

Professional Staff Officer stipends shall not require approval of the Finance Committee. Expenses incurred for the Annual Professional Staff Gals are excluded and shall not require approval of the Finance Committee. Any disbursement of Professional Staff funds which exceed $5,000.00 dollars as described above and approved by the Finance Committee shall be reported to the Medical Executive Committee for informational purposes.

10.2.3 Clinical Departmental Committees

Each Clinical Department shall be supervised by a committee and its chairman as set forth in Article VIII.

10.2.4 Patient Care Committee

The Patient Care Committee shall be composed of the chairmen of the Professional/AHP Staff Committees that are interdepartmental and clinical in nature. The Chairman of the Patient Care Committee shall be appointed in January by the Chief of Staff and continue in that role at the discretion of the Chief of Staff. The Chairman shall also serve on the Medical Executive Committee. The Patient Care Committee shall have as subcommittees the Cancer Committee, the Rehabilitation and Physical Therapy Committee, the Interdisciplinary Practice Committee, the Intensive Care Unit Committee, and other committees as established by the Medical Executive Committee. Cancer Committee shall be a multi-disciplinary standing committee of the Professional/AHP Staff. It reports to the Medical Executive Committee through the Patient Care Committee.
The chairman shall be selected by the Patient Care Committee Chairman, with concurrence by the Chief of Staff. Members shall be selected by the Cancer Committee Chairman to include representation of involved disciplines. Each committee shall have approved charges and, where necessary, approved policy manuals.

10.2.5 Quality Assurance/Improvement Committee

The Quality Assurance/Improvement Committee shall include the Chairman or Vice Chairman of Surgery, Medicine, Obstetrics/Gynecology, Bioethics, Family/General Practice, and Professional Services; the Chairman of Pharmacy and Therapeutics Committee, Transfusion Committee, Utilization Review Committee; and other members as defined in the Quality Assurance/Improvement Committee charges. The Chairman shall be the Immediate Past Chief of Staff or a prior Chief of Staff selected by the current Chief of Staff with Medical Executive Committee approval.

10.2.6 Standing Committees

The Standing Committees of the Staff shall include Credentials Committee, Nominating Committee, Bylaws Committee, Professional Ethics and Advisory Committee, Bioethics Committee, Cancer Committee and Joint Conference Committee. The Credentials Committee, Professional Ethics and Advisory Committee, and Bioethics Committee shall report to the Medical Executive Committee through the Vice Chief of Staff. The Bylaws Committee and Nominating Committee shall report directly to the Staff. The Cancer Committee shall report to the Patient Care Committee and have access directly to the Medical Executive Committee. The Joint Conference Committee shall be directly accountable to the Medical Executive Committee and to the Governing Board.

A. **Credentials Committee**

The Credentials Committee shall consist of seven (7) members who shall be appointed from the Active Category by the Chief of Staff. Their terms shall be for three (3) years on a staggered basis. The Chairman of the Committee shall be appointed by the Chief of Staff in January and shall be chosen from one of the senior members of the Credentials Committee. The Committee shall review the qualifications for membership of all applicants as stated in Article III, Section 1 of these Bylaws, and shall recommend membership/privileges on the appropriate staff (Professional/AHP Staff, Honorary Staff, Consulting Staff, or as an Allied Health Professional or Healthcare Provider Under Medical Direction) to the Medical Executive Committee as outlined in Article VII and Article VII-A. The Credentials Committee shall assign the applicant to the appropriate clinical department as outlined in Article VIII, Section 1. It shall also regularly review all practitioners for reappointment as outlined in Article III, Section 5.

B. **Nominating Committee**

The Nominating Committee shall consist of the current Chief of Staff, current Vice Chief of Staff, the two past Chief's of Staff, the Chair of each of the Clinical Departments and one At-Large member, who shall be appointed by the Chief of Staff. Any Active Staff member in good standing, including members of the Professional Services Committee may be eligible for the At-Large position. The meeting will take place in Executive Session.

The Nominating Committee shall offer nominees for Staff Officers as provided in Article IX, Section 3. Whenever the Nominating Committee is actively considering nominating one of the Committee members for any position, that member shall withdraw from the Committee. If the member under consideration is a Chair of a Clinical Department he shall be replaced on the Committee by the Vice Chair of the same Clinical Department. If the member under consideration is a

former Chief of Staff or an at large member, the member shall be replaced by a member of the Active Category appointed by the current Chief of Staff.

C. **Bylaws Committee**

The Bylaws will be reviewed annually by the Bylaws Committee and, when necessary, revisions shall be recommended. They shall also annually review the General Rules and Regulations prior to Medical Executive Committee approval to confirm they are in accord with these Bylaws. Only members of the Active Category are eligible to serve on this committee. The Bylaws Committee shall consist of five (5) members. There shall be three (3) three-year non-current terms of membership, the Chairman, and the Vice Chief of Staff of the Professional/AHP Staff also serving. The Chairman shall be appointed from previous members of the committee by the Chief of Staff in January with the approval of the Medical Executive Committee.
The one open membership each year shall be filled by the Bylaws Committee Chairman with the approval of the Medical Executive Committee. Members can be reappointed to either the Chairmanship or to a rotating term of membership. The Committee shall report to the Professional/AHP Staff.

D. **Professional Ethics and Advisory Committee**

To promote improved quality of care, enhance competence of the Professional/AHP Staff and further the Professional/AHP Staff's role as part of the Providence Saint Medical Center's ethical community, the Professional/AHP Staff shall establish a Professional Ethics & Advisory Committee. The Committee will be a standing Committee of the Professional/AHP Staff.

(1) Composition.

The Chairman shall be appointed by the Chief of Staff. The Chairman with the advice and consent of the Chief of Staff will appoint not less than three (3), nor more than seven (7) Active Category Professional/AHP Staff members who are not part of other review or oversight committees. Except for initial appointment, each member shall serve a term of two (2) years. Members may be reappointed and terms should be staggered as deemed appropriate to achieve continuity.

(2) Duties.

a. The Committee will receive reports of and respond appropriately to: [1] problems related to professional ethical behavior vis a vis patients or co-workers, or which impacts patient care or safety; [2] problems of physician impairment by reason of physical or mental illness, disability or substance abuse, [3] harassment or disruptive behavior.

b. As a minimum the Committee will adhere to standards embodied in the American College of Physicians and American College of Surgeons, manuals of ethics or other standards set by appropriate professional bodies.

c. The Committee may request interviews with the affected member or other members of the Professional/AHP Staff to gather information. These requests shall be honored as a condition of Professional/AHP Staff membership.

d. After appropriate determination of the facts obtained in a confidential manner, the Committee may on a voluntary basis, provide such advice, counseling or referrals as may seem appropriate.

e. In the event factual information received clearly demonstrates an unreasonable risk of harm to hospitalized patients, or egregious unethical conduct, the information may be referred to the Medical Executive Committee, Chief of Staff and appropriate Department Chairmen for action.

(3) Meetings.

The Committee will meet as often as necessary. Only such records as strictly necessary will be maintained. Such records must be kept in secure Professional/AHP Staff files and be available only to Committee members. Reports of activities and recommendations relating to the Committee's functions shall be made to the Medical Executive Committee by the liaison member of the Medical Executive Committee. Such report shall be forwarded to the Governing Board as frequently as necessary and at least quarterly. Strict confidentiality of proceedings will be maintained.

E. **Cancer Committee**

The Cancer Committee shall be a standing committee of the Professional/AHP Staff. It will report to the Patient Care Committee and may have access directly to the Medical Executive Committee. It shall be a multi-disciplinary committee whose composition, duties, and responsibilities shall be delineated in the General Rules and Regulations.

F. **Biomedical Ethics Committee**

The Biomedical Ethics Committee shall consist of representatives from the Professional Staff, Nursing, Pastoral Care, and others. Longevity on the committee will be emphasized. All committee members will be appointed for three (3) years and may be reappointed. The Chairman will be an active Professional Staff member with knowledge in this area and will serve as liaison member of the hospital Medical Morals Committee. The Chairman shall be appointed in January by the Chief of Staff and continue in that role at the discretion of the Chief of Staff. Nursing representatives will include those from Intensive Care, Oncology, Neonatal-Pediatrics, and general Medical-Surgical units. Other representatives will include those from Pastoral Care, Social Services, and Administration. An attorney, medical ethicist, and Advisory Board or community representative may be advisory members to the committee as necessary and/or available. The Vice Chief of Staff will attend these meetings as a non-voting member, acting as the liaison to the Executive Committee. The responsibilities of the committee shall include the following: the exploration of difficult ethical issues related to patient care; promotion of communication between disciplines and individuals; development and annual updating of policies and guidelines including those related to criteria for death, cardiopulmonary resuscitation, withdrawal from life-support systems, and supportive care guidelines for terminal patients; education of the committee, Professional Staff, nursing, hospital staff, patient, family and community about problems and solutions relative to medical ethics; maintaining knowledge and expertise in the area of medical ethics including legislative decisions, current literature, and special issues related to Catholic hospitals; providing consultation and information resources to members of the Professional Staff, nursing, and others in the hospital, patients, and family in specific areas or general problems related to medical ethics; carrying out other functions as determined by the Executive Committee. When performing a consultative role, findings and recommendations may be recorded in the progress notes by a committee member or the attending physician when appropriate."

10.2.7 (EP 21) Removal of Chairpersons of Standing Committees and/or Members of a Standing Committee by a vote of the Active Staff:

A two-thirds majority written vote with a minimum of two-thirds of the Active Staff voting may remove a chairperson or a member of a standing committee for any cause. Written petitions requesting such a vote on such removal from greater than twenty five percent (25%) of the Active Staff shall cause such a written vote to be taken.

10.2.8 Special Committees

Special committees may be established by the Medical Executive Committee as required to carry out the duties of the Staff. Such committees shall confine their work to the purposes for which they were established. A special committee shall not have power of action unless such is specifically granted by the resolution which established the committee. The Chairman of each committee shall be appointed by the Chief of Staff.

10.2.9 Joint Conference Committee

A. **Composition**

The Joint Conference Committee shall be composed of eight members; the Chief of Staff, the Chief of Staff-Elect, the immediate-past Chief of Staff, a member of the Medical Executive Committee and/or Bylaws Committee, three members of the Hospital's Governing Board and the Chief Executive. All members are voting members. The Joint Conference Committee Chair shall alternate annually between the Chief of Staff in even years and in odd years, Governing Board representatives.

B. **Duties and Meeting Frequency**

1. This committee shall serve as a focal point for furthering an understanding of the roles, relationships and responsibilities of the Governing Board, Administration and Professional/AHP Staff. It may also serve as a forum for discussing any Hospital matters regarding the provision of patient care. It shall meet at often as necessary or as required by TJC to fulfill its responsibilities. Any member of the committee shall have the authority to place matters on the agenda for consideration by the committee.

2. The committee shall also serve as the initial forum to initiate the meet and confer provisions contemplated by Article

XII of these Bylaws; provided however, that upon request of at least four committee members (which four must be comprised of at least three Professional/AHP Staff representatives and one Governing Board representative), a neutral mediator, acceptable to both contingents, shall be engaged to assist in dispute resolution.

C. **Accountability**

The Joint Conference Committee is directly accountable to the Medical Executive Committee and to the Governing Board

ARTICLE XI
MEETINGS

11.1 Staff Meetings

11.1.1 General Staff Meetings

General Staff meetings shall be held four times a year at a time and place designated by the Chief of Staff in order to transact the business of the Staff.

11.1.2 Annual Business Meeting

The Annual Business Meeting of the Staff shall be held the first week of November. At this meeting, the officers and committees shall make such reports as may be desirable. Biennially, officers for the ensuing year shall be elected.

11.1.3 Special Staff Meetings

Special Meetings of the Staff may be called at the request of the Chief of Staff, the Medical Executive Committee, or by petition of not less than twenty-five percent (25%) of the members of the Active Category. The Professional/AHP Staff shall be notified of the time, place and the agenda of any special meeting. This notification shall not be less than two (2) days before the date of the meeting. No business shall be transacted at any Special Meeting except that stated in the notice calling the meeting.

11.1.4 Quorum

Forty percent (40%) of the total membership of the Active Category shall constitute a quorum.

11.1.5 Voting

Only the Active Category members are eligible to vote. A majority of those voting, constituting a quorum, shall rule unless specifically stated otherwise in the Bylaws. Such voting may occur in person, by mail, or by such method of electronic voting approved by the Medical Executive Committee.

11.1.6 Attendance at Meetings

All members of the Active, Associate, and Provisional Categories are required to attend at least eight meetings in their two year reappointment cycle. At least two of these meetings shall be a General Staff meeting. The remainder of the meetings may be a combination of General Staff meetings, Departmental, Specialty Section, and Professional/AHP Staff committee meetings. Courtesy Category members are not required to attend eight (8) meetings unless they desire advancement in Staff Category.

Under unusual circumstances the Credentials Committee Chairman may recommend to the Medical Executive Committee to retain a staff member in category who has attended fewer than the required yearly meetings.

All Professional/AHP Staff members when requested by the Departmental Chairman are required to attend Department or Committee meetings when their cases are to be discussed as part of peer review, patient care evaluation, or quality improvement activities. All Professional/AHP Staff members must also attend meetings of any other established Professional/AHP Staff committee when requested by the Chairman and must respond to inquiries from such committees when requested by the Chairman.

Failure to meet the foregoing attendance requirements may be grounds for demotion in category for members of the Active and Associate Categories, and grounds for termination for members of the Provisional Category.

11.2 Clinical Departmental Meetings

Departmental Meetings shall be scheduled by the Chairman of the Department as often as necessary in order to discuss departmental and Staff functions, and to participate in patient care evaluation and educational programs. Combined meetings with other departments may be held; this includes the General Staff meetings. In addition to these meetings, the department may communicate with its departmental members by mail, electronic mail, via the Staff newsletter, educational conferences, or other appropriate means. Minutes shall be kept of these meetings.

11.2.1 Specialty Section Meetings

If a department has a specialty section as defined in its rules and regulations, each section may meet at the discretion of the specialty section chairman in order to transact the business of the section. Minutes shall be kept at these meetings.

11.3 Staff Committee Meetings

All Staff committees that have direct representation on the Medical Executive Committee shall meet regularly. All other committees, at the discretion of the chairman, shall meet as necessary in order to transact the business of the committee. Minutes shall be kept of these meetings.

ARTICLE XII
DISPUTES WITH THE GOVERNING BOARD

12.1 (EP 10) Disputes with the Governing Board

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

12.1.1 Invoking the Dispute Resolution Process

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

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

12.1.2 Dispute Resolution Forum

A. The initial forum for dispute resolution shall be the Joint Conference Committee, which shall meet and confer as further described in Article X, Section 2, Subsection 7 of the Bylaws.

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

C. If the parties are unable to resolve the dispute, the Governing Board shall make its final determination giving great weight to the action and recommendations of the Medical Executive Committee. Further, the Governing Board's determination 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 Professional/AHP Staff, and to ensure the responsible governance of the Hospital.

ARTICLE XIII
AMENDMENTS AND ADOPTIONS

(EP 2) (EP 24) Proposed amendments to these Bylaws in part or in total shall be presented by the Bylaws Committee to the Professional/AHP Staff at any regular or special meeting called for such purpose. The proposed amendment shall be laid on the table for not less than one (1) month until the next regular or special meeting of the Staff. Adoption shall require a two-thirds (2/3) majority of the vote of the Active Category members present and constituting a quorum. Such voting may occur in person, by mail, or by such method of electronic voting approved by the Medical Executive Committee. Amendments so made shall be effective when approved by the Governing Board and equally binding on the Governing Board and the Professional/AHP Staff. Neither the Governing Board nor the Professional/AHP Staff may amend the Professional/AHP Staff Bylaws nor Rules and

Regulations unilaterally.

No Professional/AHP Staff governing document and no Hospital corporate Bylaws or other Hospital governing document shall include any provision purporting to allow unilateral amendment of the Professional/AHP Staff Bylaws or other Professional/AHP Staff governing document.

(EP 9) If the voting members of the Professional/AHP Staff propose to adopt a rule, regulation, or policy, or an amendment thereto, they first communicate the proposal to the Medical Executive Committee. If the Medical Executive proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the Professional/AHP Staff; when it adopts a policy or amendment thereto, it communicates this to the Professional/AHP Staff. This element of performance applies only when the Organized Professional/AHP Staff, with the approval of the Governing Board, has delegated authority over such rules, regulations, or policies to the Medical Executive Committee**.**

(EP 11) In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, there is a process by which the Medical Executive Committee, if delegated to do so by the voting members of the Organized Professional/AHP Staff, may provisionally adopt and the Governing Board may provisionally approve an urgent amendment without prior notification of the Professional/AHP staff. In such cases, the Professional/AHP staff must be immediately notified and an affirmative vote of the General Staff must be sought within 30 days. All ballots shall be submitted within twenty (20) days. Absent such affirmative vote the amendment will be withdrawn.

ARTICLE XIV
(EP 10) CONFLICT RESOLUTION BETWEEN THE PROFESSIONAL/AHP STAFF AND THE MEDICAL EXECUTIVE COMMITTEE

The organized Professional/AHP Staff has a process which is implemented to manage conflict between the Professional/AHP Staff and the Medical Executive Committee on issues including, but not limited to, proposals to adopt a rule, regulation or policy or an amendment thereto. Nothing in the foregoing is intended to prevent Professional/AHP Staff members from communicating with the Governing Board on a rule, regulation, or policy adopted by the Organized Professional/AHP Staff or the Medical Executive Committee. The Governing Board determines the method of communication.

Under the following circumstances, the Medical Executive Committee shall initiate a conflict management process to address a disagreement between members of the Professional/AHP Staff and the Medical Executive Committee about an issue relating to the Professional/AHP Staff's documents or functions, including but not limited to a proposal to adopt or amend the Professional/AHP Staff Bylaws, Rules and Regulations or policies; or a proposal to remove some authority delegated to the Medical Executive Committee by the Professional/AHP Staff under these Bylaws (by amending the Bylaws):

Conflict Management Process:

Upon written petition signed by either:

At least one third (1/3) of the voting members of the Professional/AHP Staff, or

At least two thirds (2/3) of the members of any department of the Professional/AHP Staff; or

Upon the Medical Executive Committee's own initiative at any time; or

As otherwise specified in these bylaws.

Management process must be submitted in writing with an explanation for evoking the process within any deadline specified in these bylaws**.**

A petition to initiate the conflict management process shall designate two active Professional/AHP Staff members to serve as representatives of the petitioners, describe the nature of the conflict, and state the reasons why the conflict management process shall do all of the following**:**

Provide a reasonably timely, efficient, and meaningful opportunity for the parties to express their views**;**

Require good-faith participation by representatives of the parties; and

Provide for a written decision or recommendation by the Medical Executive Committee on the issues within a reasonable time, including an explanation of the Medical Executive Committee's rationale for its decision or recommendation.

At the Medical Executive Committee's discretion, the process for management of a conflict between the Medical Executive

Committee and Professional/AHP Staff members may include the involvement of a third party to facilitate or mediate the conflict management efforts**.**

The conflict management process described in this section shall be a necessary prerequisite to any proposal to the Governing Board by Professional/AHP Staff members for adoption or amendment of a bylaw, rules and regulations provision, or policy not supported by the Medical Executive Committee, including (but not limited to) a proposed bylaws amendment intended to remove from the Medical Executive Committee some authority that has been delegated to it by the Professional/AHP Staff.

Nothing in this Section is intended to prevent Professional/AHP Staff members from communicating with the Governing Board about Professional/AHP Staff bylaws, rules and regulations, or policies; according to such procedures as the Governing Board shall specify.

ARTICLE XV
RULES AND REGULATIONS

(EP 25) 15.1 General Professional/AHP Staff Rules and Regulations and Policies

Subject to approval by the Governing Board, the Medical Executive Committee may supplement these bylaws with rules and regulations and policies that provide associated details, as the Medical Executive Committee deems necessary to implement more specifically the general principles established in these bylaws. Neither the Medical Executive Committee nor the Governing Board may unilaterally amend the Professional/AHP Staff rules and regulations or policies**.**

Proposals for new rules and regulations or policies, or amendments to existing rules and regulations or policies, may be submitted to the Medical Executive Committee by any voting member(s) of the Professional/AHP Staff, or by the Hospital Chief Executive or his/her designee on behalf of Hospital Administration, or proposed by the Medical Executive Committee on its own initiative.

A proposal bearing the signatures of thirty three percent (33%) or more of the voting members of the active Professional/AHP Staff (which will constitute notice of the proposal to the Medical Executive Committee) must identify two active Professional/AHP Staff members who will serve as representatives and act on behalf of the proposal signers in the processes described below (including any conflict management processes):

If the Medical Executive Committee supports the proposal as submitted, the proposal will be disseminated to the Professional/AHP Staff for comment as described below, before the Medical Executive Committee submits the proposal to the Governing Board for approval.

If the Medical Executive Committee does not support the proposal, it will notify the designated representatives in writing, and they will have 30 days from receipt of the notice to invoke the conflict management process described in Article XIV. If the conflict management process is not invoked within 30 days, it will be deemed waived and the proposal will be deemed withdrawn.

If the conflict is not resolved by withdrawal of the proposal, or by Medical Executive Committee support of the proposal as modified in the conflict management process, then the proposal will be submitted (in original form or, if the original proposal has been modified by the conflict management process, then as modified) to the Professional/AHP Staff for comment as described below before the proposal is submitted to the Governing Board for approval.
With respect to any proposal that does not bear the signatures of thirty three percent (33%) or more of the Active Staff members, the Medical Executive Committee has the discretion to do any of the following:

1. Disseminate the proposal, as submitted, to the Professional/AHP Staff for comment;

2. Modify the proposal and disseminate it, as modified, to the Professional/AHP Staff for comment; or

3. Reject the proposal and not disseminate it to the Professional/AHP Staff for consideration.

Except as otherwise provided in this Article, before the Medical Executive Committee submits any proposal for adoption or amendment of rules and regulations to the Governing Board for approval, the Medical Executive Committee shall disseminate the proposal to the Professional/AHP Staff in a reasonably manner, which may include posting it in a newsletter or bulletin, distributing it at a general Professional/AHP Staff meeting, or any other method regularly used by the Professional/AHP Staff office to provide notices to members. Voting members of the Professional/AHP Staff shall be given an opportunity to submit written comments, through the Professional/AHP Staff office for a period of not less than [15] days**.** After considering any comments that have been received within the allotted period, the Medical Executive Committee may modify the proposal in light of the comments. The Medical Executive Committee will disseminate any such modified proposal to the Professional/AHP Staff, and may, in the Medical Executive Committee's discretion, solicit further comments in the manner described above.

If the proposal did not include the signatures of thirty three percent (33%) or more of the voting members of the active

Professional/AHP Staff, but the Medical Executive Committee disseminated the proposal to the Professional/AHP Staff for comment, then after the comment period ends the Medical Executive Committee in its discretion may do either of the following:

Submit the proposal to the Governing Board for approval, in its original form as modified in light of the comments; or Reject the proposal and not submit it to the Governing Board.

Upon approval by the Governing Board, new rules and regulations, policies, or amendments to existing rules and regulations or policies, shall be announced promptly to the Professional/AHP Staff in a reasonable manner, as described above.

Duly adopted rules and regulations and policies shall be binding on all applicants to and members of the Professional/AHP Staff, as well as to any practitioners who are granted temporary privileges.

If a proposal is not approved by the Governing Board, then the Medical Executive Committee (or the designated representatives of the group of Professional/AHP Staff members who submitted a non-Medical Executive Committee-supported proposal that went directly to the Governing Board may invoke the conflict management process set forth in Article XIV of these Bylaws within fifteen (15) days of receiving notice that the proposal was not approved by the Governing Board.

If the Medical Executive Committee receives documentation of an urgent need to amend the Professional/AHP Staff rules and regulations to comply with law or regulation, the Medical Executive Committee may adopt the necessary amendment provisionally and submit to the Governing Board for provisional approval, without prior notification of the Professional/AHP Staff. Immediately following the Medical Executive Committee's adoption and the Governing Board's provisional approval of such an urgent provisional amendment to the rules and regulations, the Medical Executive Committee will notify the Professional/AHP Staff (by an acceptable method of providing such notice as described above), and offer an opportunity for any interested Professional/AHP Staff member to submit written comments to the Medical Executive Committee within fifteen (15) days of the date of the notice. The amendment will become final at the end of the comment period if the comments indicate there is not substantial conflict regarding the provisional amendment. (There is no substantial conflict unless at least thirty three percent (33%) of voting active Professional/AHP Staff members express opposition to the amendment in writing.)

If the comments indicate a substantial conflict over the provisional amendment, then the Medical Executive Committee will implement the conflict management process set forth in Article XIV of these bylaws, and may submit a revised amendment to the Governing Board for approval if necessary.

In the event of a conflict between these bylaws and any provision of the Professional/AHP Staff rules and regulations or policies, as determined by the Medical Executive Committee, the bylaws shall prevail.

15.2 Department Rules and Regulations and Policies

Rules and regulations and policies for Professional/AHP Staff departments shall be established and amended by the same process as general Professional/AHP Staff rules and regulations and policies, except that:

Proposals for establishing or amending department-specific rules and regulations or Policies shall be submitted to the Medical Executive Committee by the relevant department chair following adoption by a majority of the voting members of the department.

Department-initiated proposals that are acceptable to the Medical Executive Committee as submitted may be adopted by the Medical Executive Committee and submitted to the Governing Board for approval.

Each Medical Executive Committee-initiated proposal and department-initiated proposal that the Medical Executive Committee proposes to modify or reject shall be disseminated to the relevant department only (not to the general Professional/AHP Staff) for comment, along with a statement of the Medical Executive Committee's reasons, before the Medical Executive Committee submits any such proposal to the Governing Board for approval. The department will have fifteen (15) days to submit responsive comments to the Medical Executive Committee in writing, and any such department comments will be submitted to the Governing Board along with the Medical Executive Committee's proposal.

If the Medical Executive Committee has rejected a department-initiated proposal, the department chair (or another department representative chosen by the department members, if the chair does not support the proposal) may invoke the conflict management process set forth in Article XIV of these bylaws within fifteen (15) days of receiving notice of the rejection. If the conflict management process is not invoked timely, it will be deemed waived. If the matter is not resolved in the conflict management process, the proposal will be submitted to the Governing Board for approval along with the written comments of the department and the Medical Executive Committee.

If the Governing Board does not approve a department-specific proposal, the Medical Executive Committee, department chair, and/or designated department representative may invoke the conflict management process set forth in Article XII of these Bylaws within thirty (30) days of receiving notice that the Governing Board did not approve the proposal**.**

CONSTRUCTION OF TERMS AND HEADINGS

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

TECHNICAL CORRECTIONS

The Medical Executive Committee shall have authority to adopt non-substantive changes to the rules and regulations, and policies such as reorganization or renumbering, and technical corrections needed due to errors in punctuation, spelling, grammar or syntax, and/or inaccurate or missing cross-references. Such changes shall not affect the interpretation or intent of the sections being changed. The Medical Executive Committee may take action to implement such non-substantive changes by motion, in the same manner as any other motion before the Medical Executive Committee. After approval by the Medical Executive Committee, such technical corrections shall be communicated promptly in writing to the Governing Board. Such corrections are subject to approval by the Governing Board, which approval shall not be withheld unreasonably. Following approval by the Governing Board, technical corrections will be communicated to the Professional/AHP Staff within a time that is reasonable under the circumstances (which may be when the Professional/AHP Staff is notified of the next substantive change to the rules and regulations, or policies affected).

These Bylaws of the Professional/AHP Staff of Providence Saint Joseph Medical Center of Burbank, California, incorporate all amendments approved through **May 21, 2018** by the Professional/AHP Staff and PHS, SFVSA Community Ministry Board of Providence Saint Joseph Medical Center, Burbank, California.

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John K. Conrad, M.D.
Chief of Staff

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Sasan Najibi, M.D.
Chief of Staff-Elect

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Approved by Board: 03/12/14 \ Approved by Board: 10/16/14 \ Approved by Board: 02/19/15
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Revised : 05/2018: Approved by Clinical Services Committee 07/19/2018: Approved by Board 08/17/2018

APPENDIX A

Note: Anything in this standard that is found to be in conflict with the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation, and consequently could threaten The Joint Commission's deeming status, will be changed to align with the CMS requirements.

Please note that two acronyms appear in this Standard: CAH and HAP. CAH stands for Critical Access Hospital Accreditation Program and HAP stands for Hospital Accreditation Program. These acronyms are used to indicate which portions of the Standard apply to each program. Also note that new requirements are underlined. Standard MS.01.01.01 (formerly MS.1.20) Note: This standard goes into effect March 31, 2011. Introduction for Standard MS.01.01.01 (CAH, HAP).

The doctors of medicine and osteopathy and, in accordance with medical staff bylaws, other practitioners are organized into a self-governing medical staff that oversees the quality of care provided by all physicians and by other practitioners who are privileged through a medical staff process. The organized medical staff and the governing body collaborate in a well-functioning relationship, reflecting clearly recognized roles, responsibilities, and accountabilities, to enhance the quality and safety of care, treatment, and services provided to patients. This collaborative relationship is critical to providing safe, high quality care in the hospital. While the governing body is ultimately responsible for the quality and safety of care at the hospital, the governing body, medical staff, and administration collaborate to provide safe, quality care. (Please see the Leadership chapter for more discussion of the relationship among the organized medical staff, administration, and governing body.)

To support its work, and its relationship with and accountability to the governing body, the organized medical staff creates a written set of documents that describes its organizational structure and the rules for its self-governance. These documents are called medical staff bylaws, rules and regulations, and policies. These documents create a system of rights, responsibilities, and accountabilities between the organized medical staff and the governing body, and between the organized medical staff and its members. Because of the significance of these documents, the medical staff leaders should strive to ensure that the medical staff members understand the content and purpose of the medical staff bylaws and relevant rules and regulations and policies, and their adoption and amendment processes.

Of the members of the organized medical staff, only those who are identified in the bylaws as having voting rights can vote to adopt and amend the medical staff bylaws. The voting members of the organized medical staff may include within the scope of responsibilities delegated to the medical executive committee the authority to adopt, on the behalf of the voting members of the organized medical staff, any details associated with Elements of Performance 12 through 36 that are placed in rules and regulations, or policies.

The medical executive committee plays a vital role in the relationship between the medical staff and the governing body. Medical staffs and governing bodies often rely on the medical executive committee to act expeditiously on urgent and other delegated matters that arise within the organization. The medical executive committee serves as a voice for the medical staff to communicate to the governing body, and is, therefore, accountable to the organized medical staff, regardless of how the medical executive committee members are selected. Because it plays this vital role, it is incumbent upon the medical executive committee to convey accurately to the governing body the views of the medical staff on all issues, including those relating to quality and safety. In order to fulfill this role, the medical executive committee seeks out the medical staff's views on all appropriate issues.

If conflict arises within the medical staff regarding medical staff bylaws, rules and regulations, or policies, it implements its process for managing internal conflict (see Element of Performance 10). If conflicts regarding the medical staff bylaws, rules and regulations, or policies arise between the governing body and the organized medical staff, the organization implements its conflict management processes, as set forth in the Leadership chapter.

Standard MS.01.01.01 (CAH, HAP)
Medical staff bylaws address self-governance and accountability to the governing body

Elements of Performance for Standard MS.01.01.01

1. (CAH, HAP) The organized medical staff develops medical staff bylaws, rules and regulations, and policies.

2. (CAH, HAP) The organized medical staff adopts and amends medical staff bylaws. Adoption or amendment of medical staff bylaws cannot be delegated. After adoption or amendment by the organized medical staff, the proposed bylaws are submitted to the governing body for action. Bylaws become effective only upon governing body approval. (See the Leadership chapter for requirements regarding the governing body's authority and conflict management processes. See Element of Performance 17 for information on which medical staff members are eligible to vote.)

3. (CAH, HAP) Every requirement set forth in Elements of Performance 12 through 36 is in the medical staff bylaws. These requirements may have associated details, some of which may be extensive; such details may reside in the medical staff bylaws, rules and regulations, or policies. The organized medical staff adopts what constitutes the associated details, where they reside, and whether their adoption can be delegated. Adoption of associated details that reside in medical staff bylaws cannot be delegated. For those Elements of Performance 12 through 36 that require a process, the medical staff bylaws include at a minimum the basic steps, as determined by the organized medical staff and approved by the governing body, required for implementation of the requirement.

The organized medical staff submits its proposals to the governing body for action. Proposals become effective only upon governing body approval. (See the Leadership chapter for requirements regarding the governing body's authority and conflict management processes.)

Note: If an organization is found to be out of compliance with this Element of Performance, the citation will occur at the appropriate Element(s) of Performance 12 through 36.

4. (HAP) The medical staff bylaws, rules and regulations, and policies, the governing body bylaws, and the hospital policies are compatible with each other and are compliant with law and regulation. (See also Standard MS.01.01.03 regarding unilateral amendment of the medical staff bylaws.)

5. (CAH, HAP) The medical staff complies with the medical staff bylaws, rules and regulations, and policies.

6. (HAP) The organized medical staff enforces the medical staff bylaws, rules and regulations, and policies by recommending action to the governing body in certain circumstances, and taking action in others.

7. (CAH, HAP) The governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body.

8. (HAP) The organized medical staff has the ability to adopt medical staff bylaws, rules and regulations, and policies, and amendments thereto, and to propose them directly to the governing body.

9. (HAP) If the voting members of the organized medical staff propose to adopt a rule, regulation, or policy, or an amendment thereto, they first communicate the proposal to the medical executive committee. If the medical executive committee proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the medical staff; when it adopts a policy or an amendment thereto, it communicates this to the medical staff. This Element of Performance applies only when the organized medical staff, with the approval of the governing body, has delegated authority over such rules, regulations, or policies to the medical executive committee.

10. (HAP) The organized medical staff has a process which is implemented to manage conflict between the medical staff and the medical executive committee on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto. Nothing in the foregoing is intended to prevent medical staff members from communicating with the governing body on a rule, regulation, or policy adopted by the organized medical staff or the medical executive committee. The governing body determines the method of communication.

11. (HAP) In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, there is a process by which the medical executive committee, if delegated to do so by the voting members of the organized medical staff, may provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the medical staff will be immediately notified by the medical executive committee. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the medical executive committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the medical executive committee is implemented. If necessary, a revised amendment is then submitted to the governing body for action.

The medical staff bylaws include the following requirements, in accordance with Element of Performance 3:

12. (CAH, HAP) The structure of the medical staff. (CMS CoP requirement)

13. (CAH, HAP) Qualifications for appointment to the medical staff. (CMS CoP requirement)

14. (CAH, HAP) The process for privileging and re-privileging licensed independent practitioners, which may include the process for privileging and re-privileging other practitioners. (CMS CoP requirement) (See also EM.02.02.13, EP 2)

15. (CAH, HAP) A statement of the duties and privileges related to each category of the medical staff (for example, active, courtesy). (CMS CoP requirement) Note: The word "privileges" can be interpreted in several ways. The Joint Commission interprets it, solely for the purposes of this element of performance, to mean the duties and prerogatives of each category, and not the clinical privileges to provide patient care, treatment, and services related to each category.

16. (CAH, HAP) The requirements for completing and documenting medical histories and physical examinations. The medical history and physical examination are completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy. (CMS CoP requirement) (See also standard MS.03.01.01.) Note: The requirements referred to in this element of performance are, at a minimum, those described in the element of performance and Standard PC.01.02.03, EPs 4 & 5.

17. (HAP) A description of those members of the medical staff who are eligible to vote.

18. (HAP) The process, as determined by the organized medical staff and approved by the governing body, by which the organized medical staff selects and/or elects and removes the medical staff officers.

19. (HAP) A list of all the officer positions for the medical staff.

20. (HAP) The medical executive committee's function, size, and composition, as determined by the organized medical staff and approved by the governing body; the authority delegated to the medical executive committee by the organized medical staff to act on the medical staff's behalf; and how such authority is delegated or removed. (See also Standard MS.02.01.01 regarding the medical executive committee.)

21. (HAP) The process, as determined by the organized medical staff and approved by the governing body, for selecting and/or electing and removing the medical executive committee members.

22. (HAP) That the medical executive committee includes physicians and may include other practitioners and any other individuals as determined by the organized medical staff.

23. (HAP) That the medical executive committee acts on the behalf of the medical staff between meetings of the organized medical staff, within the scope of its responsibilities as defined by the organized medical staff.

24. (HAP) The process for adopting and amending the medical staff bylaws.

25. (HAP) The process for adopting and amending the medical staff rules and regulations, and policies.

26. (CAH, HAP) The process for credentialing and re-credentialing licensed independent practitioners, which may include the process for credentialing and re-credentialing other practitioners.

27. (HAP) The process for appointment and re-appointment to membership on the medical staff.

28. (HAP) Indications for automatic suspension of a practitioner's medical staff membership or clinical privileges.

29. (HAP) Indications for summary suspension of a practitioner's medical staff membership or clinical privileges.

30. (HAP) Indications for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges.

31. (HAP) The process for automatic suspension of a practitioner's medical staff membership or clinical privileges.

32. HAP) The process for summary suspension of a practitioner's medical staff membership or clinical privileges.

33. (HAP) The process for recommending termination or suspension of medical staff membership and/or termination, suspension, or reduction of clinical privileges.

34. (HAP) The fair hearing and appeal process, which at a minimum shall include:
• The process for scheduling hearings and appeals
• The process for conducting hearings and appeals

35. (HAP) The composition of the fair hearing committee.

36. (HAP) If departments of the medical staff exist, the qualifications and roles and responsibilities of the department chair, which are defined by the organized medical staff and include the following:

Qualifications:
• Certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process.

Roles and responsibilities:

• Clinically related activities of the department.

• Administratively related activities of the department, unless otherwise provided by the hospital.

• Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.

• Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department.

• Recommending clinical privileges for each member of the department.
• Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization.

• Integration of the department or service into the primary functions of the organization.

• Coordination and integration of interdepartmental and intradepartmental services.

• Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.

• Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.

• Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.

• Continuous assessment and improvement of the quality of care, treatment, and services.

• Maintenance of quality control programs, as appropriate.

• Orientation and continuing education of all persons in the department or service.

• Recommending space and other resources needed by the department or service.