# BYLAWS

# AND

# GENERAL RULES & REGULATIONS

# OF THE MEDICAL STAFF

# PROVIDENCE LITTLE COMPANY OF MARY MEDICAL CENTER SAN PEDRO

Approved:
Bylaws Committee: 8-8-17
Medical Executive Committee: 10-16-17
General Staff (Bylaws Only): 11-16-17
Board of Directors: 11-28-17

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## PREAMBLE

**WHEREAS**, San Pedro Peninsula Hospital (dba Providence Little Company of Mary Medical Center San Pedro Hospital) is a non-profit corporation organized under the laws of the State of California; and

**WHEREAS**, its purpose is to serve as an acute general hospital providing patient care, education and research; and

**WHEREAS**, it is recognized that the Medical Staff is delegated responsibility by the Board of Directors for the quality of medical care in the Hospital and must accept and discharge this responsibility; and

**WHEREAS**, it is recognized that the cooperative efforts of the Medical Staff, the Hospital administration, and the Board of Directors are necessary to fulfill the foregoing responsibilities of the Medical Staff and the Hospital's obligations to its patients; and

**WHEREAS**, the relationship between the Board of Directors and the Medical Staff is one of mutual responsibility and interdependence with mutual responsibility for the proper performance of respective obligations; and

**WHEREAS**, only duly qualified physicians, dentists, podiatrists, and clinical psychologists are eligible for Medical Staff membership, privileges and prerogatives; and

**THEREFORE**, the physicians, dentists, podiatrists, and clinical psychologists practicing in this Hospital have adopted these Bylaws in order to provide for the organization of the medical staff of Little Company of Mary - San Pedro Hospital and to provide a framework for self-government in order to permit the medical staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of issues and the conduct of medical staff functions supportive of those purposes. These bylaws provide the professional and legal structure for medical staff operations, organized medical staff relations with the Board of Directors, and relations with applicants and members of the medical staff.

## DEFINITIONS

1. **HOSPITALCHIEF EXECUTIVE (Chief Executive)** means the person appointed by the Board of Directors to act on its behalf in the overall management of the Hospital, or his/her authorized representative.
2. **CHIEF OF STAFF** means the chief officer of the Medical Staff elected by the members of the Medical Staff.
3. **CLINICAL PRIVILEGES** or **PRIVILEGES** means the permission granted to a Medical Staff member to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services.
4. **EX OFFICIO** means a position by virtue of or because of an office, with no reference to specific voting power.
5. **BOARD OF DIRECTORS or BOARD** means the Hospital's Board of Directors or any delegate of the Board. Where indicated or not prohibited in these Bylaws, they may delegate certain functions to duly authorized Medical Staff Committee's thereof, following notice to and approval of the Medical Executive Committee of the proposed delegation.
6. **HOSPITAL** means Providence Little Company of Mary - San Pedro Hospital.
7. **MEDICAL EXECUTIVE COMMITTEE** means the executive committee of the medical staff which shall constitute the Board of Directors of the medical staff as described in these Bylaws.
8. **MEDICAL STAFF or STAFF** means the formal organization of all licensed physicians, dentists, podiatrists, and clinical psychologists who are privileged to attend patients in the Hospital.
9. **VOTING MEDICAL STAFF** means those who can vote on proposed amendments to the Bylaws, Rules and Regulations and policies.

10. **MEDICAL STAFF YEAR** means the period from January 1 to December 31.
11. **MEDICO-ADMINISTRATIVE OFFICER** means a practitioner, employed by or otherwise serving the Hospital on a full- or part-time basis, whose duties include certain responsibilities, which are both administrative and clinical in nature. Clinical responsibilities, as used herein, are those responsibilities which require a practitioner to exercise clinical judgment with respect to patient care and it includes the supervision of professional activities of practitioners under his/her direction.
12. **MEMBER** means, unless otherwise expressly limited, any physician (M.D. or D.O.), dentist, podiatrist or clinical psychologist holding a current license to practice within the scope of his/her license who has been appointed to the Medical Staff with clinical privileges to practice in the Hospital.
13. **NOTICE** means any notice required or provided for in these Bylaws. Unless otherwise provided for, such notice shall be given in accordance with the provisions of Section 8.1-4(b) and 15.4. Notices given in accordance with such requirements when sent with proper postage prepaid addressed to the addressee's last known address with request for return receipt, and the production of a returned receipt purporting to be signed by the addressee or on his/her behalf by any person authorized to accept mail on his/her behalf shall create a disputable presumption that such notice was received by the person to whom addressed.
14. **PHYSICIAN** means an individual with a M.D. or D.O. degree who is currently licensed to practice medicine.
15. **PRACTITIONER** means, unless otherwise expressly limited, any physician, dentist, podiatrist, or clinical psychologist who is applying for Medical Staff membership and/or clinical privileges, or who is a Medical Staff member and/or who exercises clinical privileges in this Hospital.
16. **PREROGATIVE** means a participatory right granted, by virtue of Staff category or otherwise, to a Medical Staff member, which is exercisable subject to, and in accordance with, the conditions imposed by these Bylaws and by other Hospital and Medical Staff rules, regulations, or policies.
17. **AFFILIATE HOSPITAL** means a hospital, which is part of the Providence Health System.
18. **LIMITED LICENSE PRACTITIONER** means members who are dentists, clinical psychologists and podiatrists.
19. **PATIENT CONTACTS** means admissions, consults and procedures (includes procedures done as primary surgeon).

## ARTICLE I

## NAME

The name of this organization is the Medical Staff of Providence Little Company of Mary Medical Center - San Pedro.

## ARTICLE II

## PURPOSES

The purposes of this organization are:

1. To assure that all patients admitted to or treated in any of the facilities, departments, or services of the Hospital shall, within the Hospital's means and circumstances receive a high level of care consistent with community standards.

2. To assure a high level of professional performance of all practitioners authorized to practice in the Hospital, through the appropriate delineation of the clinical privileges that each practitioner may exercise in the Hospital, and through an ongoing review and evaluation of each practitioner's performance in the Hospital.
3. To initiate and maintain Bylaws, Rules and Regulations for the Medical Staff to carry out its responsibility to be self-governing with respect to the professional work performed in the Hospital, pursuant to the authority delegated by the Board of Directors.
4. To provide means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Board of Directors and the Hospital Chief Executive Chief Executive
5. To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill.

## ARTICLE III

## MEMBERSHIP

### 3.1 Nature of Membership

Membership in the Medical Staff of Little Company of Mary - San Pedro Hospital and/or clinical privileges shall be extended only to professionally competent physicians, dentists, podiatrists, and clinical psychologists, including those in a medico-administrative position by virtue of a contract with the Hospital, who continuously meet the qualifications, standards and requirements set forth in these Bylaws, Rules and Regulations or departmental rules and regulations. Appointment and membership in the Medical Staff shall confer on the member only such clinical privileges and prerogatives as have been granted by the Board of Directors in accordance with these Bylaws. No practitioner shall admit or provide services to patients in the Hospital unless he/she or she is a member of the Medical Staff or has been granted privileges in accordance with the procedures set forth in these Bylaws.

### 3.2 Qualifications for Membership

#### 3.2-1 General Qualifications

Practitioners shall be qualified for Medical Staff membership only if they:

a. document their licensure, education, 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 generally recognized professional and ethical level of quality and efficiency established by the Medical Staff and Hospital, and that they are qualified (see department rules and regulations) to exercise clinical privileges within the Hospital;
b. are determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective professions, to work cooperatively with others in the Hospital setting, to be willing to participate in and properly discharge Staff responsibilities, maintain confidentiality of all information and recommendations received in the physician-patient relationship, be willing to commit to and regularly assist the Medical Staff and Hospital in fulfilling the Hospital's obligations related to patient care, within the areas of their professional competence and credentials; and agree to abide by the Ethical and Religious Directives for Catholic Health Care Facilities;

c. have never been convicted or pleaded guilty or nolo contendere with respect to any felony or who have never been convicted or pleaded guilty or nolo contendere with respect to any misdemeanor related to (i) controlled substances; (ii) illegal drugs; (iii) MediCare, MediCaid, or insurance fraud or abuse; (iv) violence against another, including sexual assault or abuse, or (v) any other illegal activity involving patients or otherwise substantially related to the practitioner's qualifications, functions, or professional practice. A practitioner who has been indicted, convicted, or pleaded guilty or nolo contendere with respect to any of the above is not eligible to apply for membership and privileges. Upon a showing of good cause satisfactory to the Medical Executive Committee (MEC), the MEC may, in its discretion, permit a practitioner to apply for membership and privileges, notwithstanding such indictment, conviction or plea. Practitioners seeking such consideration must submit a statement of good cause in writing to the Chief of Staff. The decision of the MEC whether to permit an application in such circumstances shall not afford the practitioner hearing rights under these bylaws.

d. have never been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid or any public program or if action related to the above is pending. In addition, such action or pending action may be the basis of suspension or termination of the medical staff membership and/or privileges of a member. The question of rejection of an application or re-application shall be at the sole discretion of the Medical Executive Committee.

e. are located close enough (office and residence) to the Hospital to provide continuous care to their patients and to meet any applicable on call and emergency requirements; and

f. maintain in force professional liability insurance in not less than the minimum amounts as from time to time may be jointly determined by the Board of Directors and the Medical Executive Committee.

g. Must not be excluded from participation in Medicare, Medicaid or any other Federal health care program, as evidenced by being so listed on the Office of the Inspector General's List of Excluded Individuals or Entities.

**3.2-2 Particular Qualifications**

a. **Physicians.** An applicant for physician membership in the Medical Staff must hold a M.D. or D.O. degree issued by a medical or osteopathic school and a current license to practice medicine issued by the Medical Board of California or the California Board of Osteopathic Examiners.

b. **Limited License Practitioners.**
   1. **Dentists.** An applicant for dental membership in the Medical Staff, must hold a D.D.S. or equivalent degree issued by a dental school and a current license to practice dentistry issued by the California Board of Dental Examiners.
   2. **Podiatrists.** An applicant for podiatric membership on the Medical Staff must hold a D.P.M. degree and a current license to practice podiatry issued by the Board of Podiatric Medicine.
   3. **Clinical Psychologists**. An applicant for clinical psychologist membership on the Medical Staff must hold a doctoral degree in clinical psychology and current license to practice clinical psychology issued by the Medical Board of California.

### 3.3 Effect of Other Affiliations

No practitioner shall be automatically entitled to Medical Staff membership, or to exercise any particular clinical privileges, merely because he/she holds a certain degree, is licensed to practice in California or any other state, is a member of any professional organization, is certified by any clinical board, or had, or presently has, Staff membership or privileges at this Hospital or at another health care facility. Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this hospital, or employment relationship with this or any hospital or system or its subsidiaries or affiliates or accountable care organizations. Medical staff membership or clinical privileges shall not be revoked, denied, or otherwise infringed based on the member's professional or business interests. Neither the existence of an actual or potential conflict of interest, nor the disclosure thereof shall affect a member's medical staff membership or clinical privileges.

### 3.4 Nondiscrimination

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, or national origin, or on the basis of any other criterion, unrelated to the delivery of quality patient care in the Hospital setting, to professional qualifications, the Hospital's purposes, needs and capabilities or community needs.

### 3.5 Medico-Administrative Officers

a. When the need for a director of a special unit or service becomes apparent to either the Medical Staff or the Chief Executive, the Chief of Staff, with approval of the Medical Executive Committee, shall appoint an ad hoc committee to conduct the activities necessary to recommend one or more individuals for this position. The ad hoc committee shall include the representative(s) identified by the Hospital Chief Executive of the Hospital. Those Medical Staff members appointed by the Chief of Staff to the ad hoc committee should have particular interest and knowledge in the special unit or service involved.
b. Before interviews for the position are conducted, the Hospital Administration and the ad hoc committee shall jointly develop a job description for the position.
c. The ad hoc committee shall review all applications in light of the job description and qualifications if requesting clinical privileges. Particular attention should be directed toward the individual's qualifications, professional background and demonstrated competence. Whenever advisable, personal interviews with applicants should take place and the ad hoc committee should perform any investigation necessary to make a proper recommendation to the Medical Executive Committee.
d. The Medical Executive Committee shall review the recommendation from the ad hoc committee and, if approved, shall submit this recommendation to the Board of Directors.
e. All directorships shall be subject to a review upon renewal of appointment and at the Medical Executive Committee's discretion. If the Medical Executive Committee and the Board of Directors disagree regarding a director's appointment or renewal of appointment, the matter shall be submitted to the Joint Conference Committee for review and recommendation to the Board of Directors.
f. The director shall be appointed as co-chair of the committee involved with the activities of the special unit or service. A physician appointed by the Medical Executive Committee shall serve as the other co-chair.

g. A practitioner who is engaged as an independent contractor in a medico-administrative position must be a Medical Staff member, achieving his/her status by the procedure provided in Articles V and VI. The Medical Staff membership and clinical privileges of any medico-administrative officer shall also be subject to the terms and conditions of his/her contract or agreement with the Hospital. The contract or agreement shall govern over these Medical Staff Bylaws as to all matters covered by said contract or agreement, provided that any such contract shall be consistent with these Bylaws. Unless a contract or agreement executed after the adoption of this provision provides otherwise, only those privileges made exclusive or semi-exclusive, pursuant to a closed-staff or limited-staff specialty policy, will automatically terminate, without the right of access to the due process and hearing procedure of Articles VII and VIII of these Bylaws, with the termination of the medico-administrative officer's contract or agreement.

It shall further be the responsibility of all medico-administrative officers to provide in the agreements that they have with practitioners or AHP partners, employees, subcontractors and the like (hereinafter referred to as "subcontractors") that privileges made exclusive or semi-exclusive to the holder of a contract or agreement are likewise subject to automatic termination upon termination of the medico-administrative officer's contract or agreement with the Hospital, or upon termination by the medico-administrative officer of his/her employment of, association with, or partnership with the subcontractor. Failure of a medico-administrative officer to include such provision in his/her agreements shall not, however, affect the Hospital's right to deem or determine that the privileges of subcontractors have been automatically terminated in the event of termination of the Hospital's contract with the medico-administrative officer, or of the relationship between the medico-administrative practitioner and a subcontractor, which provided the basis upon which the subcontractor was eligible to enjoy privileges.

### 3.6 Basic Responsibilities of Medical Staff Membership

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

a. Exercising good judgment in providing patients with care within the scope of clinical privileges granted and at the generally recognized professional level of quality and efficiency established by the Medical Staff and the Hospital.
b. Retaining responsibility within his/her area of professional competence for the continuous care and supervision of each patient for whom he/she is providing services, or arrange for a suitable alternative to assure such care and supervision.
c. Complying with all requirements set forth in the Medical Staff Bylaws and Rules and Regulations and by all lawful standards, policies, and rules of the Hospital including those related to patient’s rights. A copy of the Bylaws shall be supplied to each practitioner with the initial application and each member shall be notified of amendments upon their adoption.
d. Discharging such personal, Medical Staff, Department, Committee and Hospital functions including, but not limited to, peer review, monitoring and evaluation activities including performance improvement, the protection of patient privacy and confidentiality, proctoring review, utilization review, emergency service and back-up functions for which he/she is responsible by virtue of his/her Staff category assignment, appointment, election, utilization of AHPs, or exercise of privileges, prerogatives, or other rights in the Hospital.

Subject to exceptions as approved by the Medical Executive Committee under Section 3.7, all members of the Active, Courtesy and Provisional staffs shall be subject to service on the emergency backup list unless such member has fewer than twelve (12) patient contacts per year at the Hospital. In addition to admissions, patient contacts shall include consultations, and procedures but shall not count patient contacts resulting from service on the emergency backup list or those where the member is the assistant surgeon. Any disputes concerning patient contacts shall be resolved by vote of the Medical Executive Committee.

e. Preparing and completing in timely fashion the medical and other required records for all patients he/she admits or in any way provides care to in the Hospital.
f. Abiding by the lawful ethical principles of his/her profession.
g. Assisting the Hospital in fulfilling its uncompensated or partially compensated patient care obligations within the areas of his/her professional competence and credentials.
h. Treating each other and Hospital staff with respect, dignity and fairness.
i. Providing information to and/or testifying on behalf of the Medical Staff or an accused practitioner regarding any matter under an investigation pursuant to paragraph 7.1-3, and those which are the subject of a hearing pursuant to Article VIII.
j. Refraining from the practice of the division of professional fees under any guise whatsoever.
k. Refraining from unlawful discrimination or harassment of any sort of patients, employees, other members, and other persons.
l. Refraining from practicing in the hospital and other hospital related facilities while under the influence of any mind altering chemical (see rules and regulations for policy).

### 3.7 Emergency Backup Call

Notwithstanding any other provision of these bylaws,

a. Only members who themselves are currently serving on the emergency backup list shall be eligible to vote on issues pertaining to the list, except that any member of the Medical Executive Committee may vote on such issues when they are before that Committee regardless of whether they serve on the emergency backup list.
b. Members with personal situations that make participation on the emergency backup list an undue hardship may request exemption from their clinical department (subject to review and approval of the Medical Executive Committee) from the obligation to participate on the emergency backup list.

### 3.8 Board Certification

a. As used herein, “Board Certified” refers to certification by a board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Podiatric Surgery, the American Board of Orthopedic Podiatric Medicine, the American Board of General Dentistry, the American Board of Oral and Maxillofacial Surgery, National Board of Physicians and Surgeons, or any other specialty board or association with equivalent requirements approved by the Medical Board of California, the Osteopathic Medical Board of California, the Dental Board of California, or the California Board of Podiatric Medicine.

b. Beginning 01/01/2016, all Practitioners applying as initial applicants must be Board Certified in the primary specialty that they will practice at PLCMMC San Pedro. Practitioners who have completed their post-graduate training within the prior six (6) years may fulfill this requirement by demonstrating that they are in the process of obtaining such Certification.

~~c.~~ Furthermore, those practitioners who have been appointed to the professional staff after 1/1/2016 must remain Board Certified in order to be eligible for reappointment, or they will be deemed to have resigned their Membership and Clinical Privileges. Such automatic resignation shall not give rise to any procedural rights under these Bylaws.

d. Those Members who were in the process of obtaining Board Certification at the time of their initial appointment must remain in good standing in that process, and must obtain such Certification within six (6) years of the completion of their post-graduate training, in order to be eligible for reappointment.

e. The Board Certification requirement does not apply to any professional staff member who was appointed to staff prior to 1/1/2016.

f. The Medical Executive Committee may grant exceptions to the Board Certification requirement, for certain medical specialties, based upon community need, at its sole discretion.

g. Failure to Meet Specific Minimum Requirements Those members who were in the process of obtaining Board Certification at the time of their initial appointment, and who fail to remain in good standing in that process, or to obtain Board Certification within six (6) years of the completion of their postgraduate training, will be deemed to have resigned their Membership and Clinical Privileges. Such automatic resignation shall not give rise to any procedural rights under these Bylaws.

## ARTICLE IV

## CATEGORIES OF MEMBERSHIP

### 4.1 Categories

The categories of the Medical Staff shall include the following: Active, Associate, Provisional, Courtesy, Limited, Honorary, and Telemedicine Professional Staff.

### 4.2 Active Staff

### 4.2-1 Qualifications

The Active Staff shall consist of members who:

a. Meet the qualifications set forth in Section 3.2.
b. Regularly admit or are otherwise regularly involved in the care of, more than twelve (12) patients per year in this Hospital.
c. Have satisfactorily completed their proctoring requirements.

### 4.2-2 Prerogatives

The prerogatives of an Active Medical Staff member shall be to:

a. Admit patients consistent with his/her privileges, unless otherwise provided in the Medical Staff Bylaws or Rules and Regulations.
b. Exercise such clinical privileges as are granted to him/her pursuant to Article VI.
c. Hold office in the Medical Staff and in the Department and committees of which he/she is a member, and serve on committees, hold staff, division, or department office and serve as a voting member of committees to which he/she is duly appointed or elected by the Medical Staff or duly authorized representative thereof.
d. Vote for Medical Staff officers, on proposed amendments to the Medical Staff Bylaws, Rules and Regulations, policies, and on all matters presented at general and special meetings of the Medical Staff and of the Department and committees of which he/she is a member, unless otherwise provided in the Medical Staff Bylaws.

### 4.2-3 Responsibilities

Each Active Medical Staff member shall:

a. Meet the basic responsibilities set forth in Section 3.6.

### 4.2-4 Transfer of Active Staff Member

If an Active Medical Staff member fails to regularly care for 12 patients per year in this hospital or be regularly involved in Medical Staff functions, that member shall be transferred to the appropriate category, if any, for which the member is qualified.

## 4.3 Provisional Staff

### 4.3-1 Qualifications

a. All new applicants for membership shall initially be appointed to the Provisional Staff and shall be subject to proctoring requirements. Appointments to the Provisional Staff shall be for a period of not less than six (6) months nor more than two (2) years, provided that the Medical Executive Committee may extend the period of Provisional Staff membership in such cases as the Medical Executive Committee deems appropriate. If the proctored member has reached the two (2) year time period and has not satisfied the proctoring requirements of the department and there is nothing derogatory related to his/her or her clinical practice, in the opinion of the department, the Medical Executive Committee may, upon a showing of good cause, extend the Provisional period for one (1) year to allow the member time to complete the proctoring requirements.
b. Each Provisional Staff member shall undergo a period of observation by proctors as described in the department rules and regulations and privilege delineation forms. The observation shall be to evaluate the member's (1) proficiency in the exercise of clinical privileges initially granted and (2) overall eligibility for continued membership and advancement within Medical Staff categories. Observation of Provisional Staff members shall follow whatever frequency and format each department deems appropriate in order to evaluate adequately the member. This review will include but not be limited to concurrent or retrospective chart review, mandatory consultation and/or direct observation.

Appropriate records shall be maintained in the member's file in the Medical Staff Services Department. Proctoring shall be in effect until the department chair or designee has determined that proctoring requirements have been satisfactorily met.

c. The failure to complete the proctoring requirements without good cause and to advance shall result in automatic termination of membership and privileges.

### 4.3-2 Prerogatives

The prerogatives of a Provisional Staff member shall be to:

a. Admit patients consistent with his/her privileges, unless otherwise provided in the Medical Staff Bylaws or Rules and Regulations.
b. Exercise such clinical privileges as are granted to him/her pursuant to Article VI.
c. Serve on committees, unless provided otherwise in these Bylaws. A Provisional member may not hold office in the Medical Staff or in the Department and committees of which he/she is a member.
d. Vote on all matters presented at meetings of the department and committees of which he/she is a member. A Provisional member may not vote for Medical Staff officers, on Bylaws amendments, or on any matters presented at general and special meetings of the Medical Staff.

### 4.3-3 Responsibilities

Each Provisional Staff member shall be required to discharge the responsibilities, which are specified in Section 3.6. Failure to fulfill those responsibilities shall be grounds for denial of advancement from the Provisional Staff.

### 4.3-4 Action at Conclusion of Provisional Staff Status

a. If the Provisional Staff member has demonstrated to the satisfaction of the department chair, and the Medical Executive Committee his/her ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued Medical Staff membership, the member shall be eligible for advancement from the Provisional Staff as appropriate.
b. In all other cases, the appropriate department shall advise the Medical Executive Committee which, in turn, shall make its recommendation to the Board of Directors regarding a modification or termination of clinical privileges. In such cases, the provisions of Section 4.3-1 shall be applicable.

## 4.4 Courtesy Staff

### 4.4-1 Qualifications

The Courtesy Staff shall consist of members who:

a. Meet the qualifications set forth in Section 3.2.
b. Admit, or otherwise provide professional services for, not more than twelve (12) patients in the Hospital during each Medical Staff year. Members whose activity exceeds this limit shall be transferred to the appropriate category.
c. Have satisfactorily completed their proctoring requirements.

### 4.4-2 Prerogatives

The prerogatives of a Courtesy Staff member shall be to:

a. Admit, or provide professional services for, not more than twelve (12) patients in the Hospital during each Medical Staff year.
b. Exercise such clinical privileges as are granted to him/her pursuant to Article VI.
c. Attend meetings of the Medical Staff and the Department of which he/she is a member. A Courtesy Staff member may not hold office in the Medical Staff or in the Department of which he/she is a member, or serve on committees.

d. A Courtesy Staff member may vote on departmental matters, however, may not vote on any General Medical Staff matter.

### 4.4-3 Responsibilities

Each Courtesy Staff member shall meet the basic responsibilities set forth in Section 3.6.

## 4.5 Limited Staff

### 4.5-1 Qualifications

a. The Limited Staff is a special category and shall consist of members who may require certain limited privileges to provide specific services. They do not include admitting or consulting privileges in the acute setting. Practitioners shall submit an application for membership and privileges and the application shall be processed and considered in the same manner as initial applicants. Proctoring requirements shall also apply as outlined in the department rules and regulations or privilege delineation form.

b. The Limited Staff shall consist of: (1) members who wish to only provide care at post-acute care sites affiliated with Little Company of Mary – San Pedro Hospital; (2) members who practice at urgent care centers or industrial medical clinics; and (3) members who provide less than full-time professional care in contracted departments, pursuant to the contract with the hospital. The contracted department will have the responsibility to professionally staff the departments with qualified practitioners who shall meet the qualifications for membership outlined in Section 3.2 and those found in the applicable departmental rules and regulations.

### 4.5-2 Prerogatives

Members of the Limited Staff shall have no voting privileges and may not hold elective office, but may attend Medical Staff meetings (department, committee and general staff).

### 4.5-3 Responsibilities

Each Limited Staff member shall meet the basic responsibilities set forth in Section 3.6.

### 4.5-4 Transfer of a Limited Staff Member

In the event that a member desires an appointment to another Staff category, the member shall request privilege revision along with the new staff category. The member shall be required to provide any necessary documentation as requested to support his/her request.

## 4.6 Honorary Staff

### 4.6-1 Qualifications

The Honorary Staff shall consist of members who do not actively practice at the Hospital and are recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous long-standing service to the Hospital and community, and who exemplify high standards of professional and ethical conduct.

### 4.6-2 Prerogatives

Honorary Staff members are not eligible to admit patients to the Hospital or to exercise clinical privileges in the Hospital. They may, however, attend Staff and Department meetings and any Staff or Hospital education meetings. Honorary member may be excused from any medical staff meeting at the discretion of the chair for executive sessions or for peer review discussions. An Honorary Staff member may not vote on any Medical Staff matter, hold office in the Medical Staff or in the Department of which he/she is a member, or serve on committees.

### 4.6-3 Responsibilities

Each Honorary Staff member shall abide by the applicable sections of the Medical Staff Bylaws and Rules and Regulations, all other lawful standards, policies, and rules of the Hospital and by the lawful ethical principles of the profession.

## 4.7 Associate Staff (Academic Appointment)

### 4.7-1 Qualifications

Members may qualify for this category who:

a. Meet the qualifications set forth in Section 3.2;
b. Hold a full time academic position at a level of assistant professor or above in an AMA approved school of medicine under terms and conditions as defined by the Medical Executive Committee;
c. Maintain active staff status at a medical school affiliated acute care hospital acceptable to the Medical Executive Committee, although exceptions to this requirement may be made by the Medical Executive Committee for good cause;
d. Are willing and able to come to the hospital on schedule or promptly respond when called to consult or render clinical services within their area of expertise; and
e. Have satisfactorily completed appointment in the Provisional category, subject to such proctoring requirements as the Medical Executive Committee may establish.

### 4.7-2 Prerogatives

Members in this staff category may:

a. Have up to five (5) patient encounters per calendar year, consistent with the clinical privileges granted, subject to modification on a case by case basis by the member's Department Chair or the Chief of Staff;
b. Exercise such clinical privileges as are granted pursuant to Article VI; and
c. Attend meetings of the Medical Staff and the department of which that person is a member, including open committee meetings and educational programs, except that regular meeting attendance shall not be required.

Members of this staff category shall not be eligible to vote on any Medical Staff matter or to hold office in the Medical Staff, but may serve on committees.

### 4.7-3 Responsibilities

Each member in this staff category shall:

a. Meet the basic responsibilities set forth in Section 3.6; and
b. Be willing to conduct at least one (1) medical education program per year for Medical Staff and Hospital personnel in the practitioner's area of expertise.

### 4.8 Telemedicine Professional Staff

The Telemedicine Professional Staff shall consist of members who act at Providence Little Company of Mary Medical Center San Pedro only as consultants within their fields of special clinical competency by exercising only those clinical privileges that have been granted by the Board of Directors. They shall be considered for appointment or reappointment only by written invitation of the Medical Executive Committee and upon a determination by the Medical Executive Committee of a special need for their services to be available to patients of the Medical Center.

The Telemedicine Professional Staff status may be administratively terminated by the Medical Executive Committee based upon a determination that such special need no longer exists. Upon such a termination or denial of reappointment, a Telemedicine Professional Staff Member may be invited to apply for Provisional Staff Status on the Medical Staff if the member has the appropriate qualifications. Such termination or denial of reappointment shall not provide the member with any rights pursuant to Article VII of these Bylaws.

The Telemedicine Professional Staff shall be appointed to a specific department. They shall not admit patients or serve as attending physicians for patients in Providence Little Company of Mary Medical Center.

Telemedicine Professional Staff members shall not be eligible to vote or hold office in this Medical Staff organization, but they shall be eligible to serve on committees, and to vote on matters before committees to which they have been appointed. They shall not be required to attend Medical Staff meetings or pay medical staff dues.

### 4.9 Limitation of Prerogatives

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other Sections of these Bylaws, by the Medical Staff Rules and Regulations, or by other policies of the Hospital. The prerogatives of dental, clinical psychologist and podiatric members of the Medical Staff shall be limited to those for which they can demonstrate the possession of the requisite licensure, education, training, and experience.

### 4.10 Exceptions to Prerogatives

Regardless of the category of membership in the Medical Staff, and unless otherwise required by law, limited license members:

a. shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, the chair of the meeting, shall determine that issue, subject to final decision by the Medical Executive Committee.
b. shall exercise clinical privileges only within the scope of their licensure and as set forth in Section 6.4.
c. May only admit and treat patients by co-admitting each patient with a physician member of the Medical Staff who has privileges to admit patients and who assumes, as required by Section 6.4 hereof, responsibility for the care of the patient's medical problems.

### 4.11 Modification of Membership

On its own, upon recommendation of the Credentials Committee, or pursuant to a request by a member under Section 5.5, or upon direction of the Board of Directors, the Medical Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of the Bylaws.

## ARTICLE V

## PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

### 5.1 Duration of Appointment

Initial appointments to the Medical Staff shall be for a maximum of two (2) years. Reappointments shall be for a period not to exceed two (2) years.

### 5.2 General Procedure

The Medical Staff, through its designated departments, committees, and officers shall consider each application for appointment or reappointment to the Staff, and for clinical privileges, and each request for modification of Staff membership status or clinical privileges, utilizing the resources of the Hospital Chief Executive and his/her staff to investigate and validate the contents of each application, before adopting and transmitting its recommendations to the Board of Directors. The Medical Staff shall also perform the same function in connection with any individual who has applied only for Special Privileges, or who otherwise seeks to exercise privileges or to provide specified services in any Hospital Department or service.

## 5.3 Appointment Authority

Initial appointments, reappointments, denials and revocations of appointment to the Medical Staff shall be made as set forth in these Bylaws, but only after there has been a recommendation from the Medical Staff provided, however, that in the event that the Medical Staff has failed to act on the appointment/ reappointment or privileges of an applicant/member within the time periods specified in Section 5.7-9, the matter shall be referred to the Joint Conference Committee upon the written request of the Hospital Chief Executive.

## 5.4 Application for Appointment and Reappointment

### 5.4-1 Content

All applications for appointment and reappointment to the Medical Staff shall be in writing, signed by the applicant (refers to either an applicant for initial appointment or a member applying for reappointment unless other indicated) and submitted on a form prescribed by the Medical Executive Committee. All provisions of the form shall be completed or an explanation given for any unavailable information.

Applicants (initial appointment) shall be given a copy of these Bylaws, the Medical Staff Rules and Regulations, and summaries or other relevant policies (if any) relating to clinical practice which may affect the processing of the application or the applicant's practice in the Hospital and he/she shall acknowledge that he/she has received and reviewed the documents and that he/she agrees to be bound by the terms thereof, as they may be amended from time to time, if he/she is granted membership or clinical privileges, and to be bound by the terms thereof, without regard to whether or not he/she is granted membership and/or clinical privileges in all matters relating to consideration of the application.

The application or application for reappointment shall require the applicant or member (reapplicant) to provide:

a. Detailed information concerning professional qualifications, competency, licensure, and other certifications related to the clinical privileges to be exercised as outlined in the respective department rules and regulations.
b. Information as to whether any action, including any investigation, has ever been undertaken, whether it is still pending or completed, which involves denial, revocation, suspension, reduction, limitation, probation, non-renewal, or voluntary relinquishment by resignation or expiration (including relinquishment that was requested or bargained for) of membership status and/or clinical privileges and/or prerogatives at any other Hospital or institution; membership or fellowship in any local, state, regional, national, or international professional organization; license to practice any profession in any jurisdiction; Drug Enforcement Administration or other controlled substances registration; specialty board certification; and/or professional school faculty position or membership.
c. Information pertaining to professional liability insurance coverage, any professional liability claims, complaints, or causes of action that have been lodged and the status or outcome of such matters including final judgments or settlements, and any filed cases pending.
d. Information as to any pending administrative agency or court cases, or administrative agency decisions or court judgments in which the applicant is alleged to have violated, or was found guilty of violating, any criminal law (excluding minor traffic violations) or is alleged to be liable, or was found liable, for any injury caused by the applicant’s negligent or willful act or omission in rendering services.

e. Information as to details of any prior or pending government agency or third party payer proceeding or litigation challenging or sanctioning patient admission, treatment, discharge, charging, collection, or utilization practices, including, but not limited to, Medicare and Medi-Cal fraud and abuse proceedings and convictions.
f. Information pertaining to physical and mental health.
g. Certification of agreement to the terms and conditions set forth in Section 5.6 regarding the effect of the application.
h. An acknowledgment responsibility to inform the Medical Staff of any changes in the information provided during the application and reappointment period and at any subsequent time.

**5.4-2 Application for Appointment of Telemedicine Practitioners:**

Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care by a practitioner at a distant site to patients located at an originating site (San Pedro). All practitioners who are responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the Hospital through one of the following mechanisms:

1. The hospital may choose to fully privilege and credential the practitioner according to the Medical Staff credentialing and privilege process as outlined in these Bylaws.
2. The originating site (San Pedro) may choose to use the credentialing and privileging decision from the distant site (the Providence Health and Services site where the practitioner providing the professional service is located) to make a final privileging decision if:
    A. The distant site is a Joint Commission accredited facility
    B. The practitioner is privileged at the distant site for those services to be provided at the originating site.
    C. The distant site provides the originating site with a current list of licensed independent practitioners' privileges
    D. The originating site has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement.

**5.5 Effect of Application**

By applying for appointment to the Medical Staff, reappointment, advancement or transfer, each applicant thereby:

a. signifies his/her willingness to appear for interviews in regard to his/her application;
b. authorizes the Hospital's Medical Staff or its designee to consult with members of medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on his/her competence, character and ethical qualifications, and authorizes such persons to provide all such information;
c. consents to the Hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications, personality, ability to cooperate with others, moral and ethical qualifications for membership, and physical, mental, and professional competence to carry out the clinical privileges he/she requests, and directs individuals who have custody of such records and documents to permit inspection and/or copying;

d. certifies that he/she will report any changes in the information submitted on the application or application for reappointment form, which may subsequently occur;
e. releases from any liability, to the fullest extent permitted by law, all individuals and organizations providing information to the Hospital concerning the applicant and all Hospital representatives for their acts performed in connection with evaluating the applicant and his/her credentials ; so long as such actions are carried out in good faith. In addition to the general consent to disclose information contained in the application or reappointment application, the applicant or member shall, upon request, execute a specific consent and release of liability directed to any person or institution to the Medical Staff deems it necessary to secure information concerning the applicant.
f. consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the hospital or medical staff may have, and releases the medical staff and hospital from liability for so doing to the fullest extent permitted by law;
g. pledges to provide for continuous quality care for patients;
h. pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing continuous care of his/her patients, seeking consultation whenever necessary, refraining from providing "ghost" surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners.

## 5.6 Processing the Application

### 5.6-1 Applicant's Burden

Each applicant for appointment, reappointment, advancement, or transfer shall have the burden of producing accurate and adequate information for a proper evaluation of his/her competence, character, ethics, experience, background, training, demonstrated ability, physical and mental health status, and all other qualifications specified in the Medical Staff Bylaws, Rules and Regulations (general staff and departmental), and departmental privilege delineation forms, as appropriate to evaluate his/her qualifications and suitability for the clinical privileges and staff category requested, and of his/her compliance with standards and criteria set forth in the Medical Staff Bylaws and Rules and Regulations, and for resolving any doubts about these matters, and for satisfying requests for information.

In order for the Medical Executive Committee to make a recommendation to the Board of Directors concerning an applicant for appointment or reappointment to the Medical Staff (or for clinical privileges), the Medical Staff must have in its possession adequate information for a conscientious evaluation of the applicant's training, experience and background as measured against the unique professional standards of this Hospital. Accordingly, the Medical Staff will not take action on an application that is not "complete."

An application for appointment, reappointment or new clinical privileges shall be deemed "incomplete," for purposes of sub-paragraph (3) below, unless and until:

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

b. The applicant responds to all further requests from the Medical Staff, through its authorized representatives, for clarifying information or the submission of supplementary materials. This may include, but not necessarily be limited to, submission to a medical or psychiatric evaluation, at the applicant's expense, if deemed appropriate by the Medical Executive Committee to resolve questions about the applicant's fitness to perform the physical and/or mental functions associated with requested clinical privileges or to determine reasonable accommodations. If the practice of the applicant or member at another hospital or practice location is deemed relevant, the applicant or member shall have the burden of providing copies of patient records from such other hospital or location as requested. If the requested items or information or materials, such as reports or memoranda, are in the exclusive possession of another person or entity, the applicant shall take such measures as are necessary to obtain them or to arrange for them to be submitted to the Medical Staff directly by the source; and

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

An application for new or additional privileges by a member of the Medical Staff, whether or not there is a prescribed form, shall not be complete unless and until:

a. The applicant submits a written request for the privileges, supported by a complete description of the applicant's training, experience and other relevant qualifications, with documentation as appropriate.

b. The applicant responds to any requests for additional information and materials as described above.

An application that is determined to be incomplete shall not qualify for a credentialing recommendation by any official or committee of the Medical Staff or by the Board of Directors, regardless of any assessment or determination that may have been made as to its completeness at an earlier stage in the process. Should the applicant fail to make the application complete after being given a reasonable opportunity to do so, the credentialing process will be terminated at the discretion of the Medical Executive Committee, after giving the applicant an opportunity to be heard, either in writing or at a meeting, as determined by the Medical Executive Committee. Termination of the credentialing process under this provision shall not constitute grounds for a hearing under Article VIII.

Until notice is received from the Board of Directors regarding final action on an application for appointment, reappointment or new clinical privileges, the applicant and reapplicant shall be responsible for keeping the application current and complete by informing the Medical Staff, in writing in the event that any information becomes available to the applicant that is at variance in any way with the information supplied by the applicant or member in the application or reappointment application. Failure to meet this responsibility will be grounds for denial of the application, nullification of an approval if granted, and/or immediate termination of Medical Staff membership and/or clinical privileges.

### 5.6-2 Verification of Information

The applicant shall deliver an application that contains all required information to the Medical Staff Services Department, which shall, in timely fashion, seek to collect or verify the references, licensure, and other qualification evidence submitted. The Medical Staff shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information. An applicant whose application is not completed within six months after it was received by the Medical Staff Services Department shall be automatically removed from consideration for staff membership. Such an applicant's application may, thereafter, be reconsidered only if all information therein which may change over time, including, but not limited to, hospital reports and personal references, have been resubmitted.

When collection and verification is accomplished and completed, the application and all supporting materials shall be transmitted to the Chair of the Department in which the applicant seeks privileges for a recommendation which shall then be transmitted to the Credentials Committee.

Applications that are deemed “complete” should be acted upon by the Medical Executive Committee within one hundred and eighty (180) days. This time period requirement excludes applications where the burden to produce information has been placed on the applicant.

### 5.6-3 Department Action

Upon receipt, the Chair of the department shall review the application, and supporting documentation and may conduct a personal interview with the applicant at his/her discretion. The Chair and/or appropriate committee designated by him/her, shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges granted, and shall transmit to the Credentials Committee a recommendation as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached. The chair may also request that the Credentials Committee defer action on the application, in which case the basis for such request shall accompany the recommendation.

### 5.6-4 Credentials Committee Action

The Credentials Committee shall review the application, evaluate and verify the supporting documentation, the department chair's recommendations, and other relevant information. The Credentials Committee shall interview the applicant and may elect to seek additional information. In the event that an applicant needs to be interviewed for consideration of Special Privileges (see Section 6.5) prior to the regularly scheduled Credentials Committee, said applicant may be interviewed by the Credentials Committee Chair and at least one other member of the Credentials Committee. As soon as practicable, the Credentials Committee shall transmit to the Medical Executive Committee and Board of Directors its recommendations as to appointment and if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment.

### 5.6-5 Effect of Medical Executive Committee Action

a. Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, it shall be promptly forward its recommendation to the Board of Directors.
b. Adverse Recommendation: When a final recommendation of the Medical Executive Committee is adverse to the applicant, the Board of Directors and the applicant shall be promptly informed by written notice. The applicant shall then be entitled to the procedural rights as provided in Article VIII.

### 5.6-6 Action by the Board of Directors

Upon receipt of the Medical Executive Committee's recommendation the Board of Directors may accept the recommendation of the Medical Executive Committee or may refer the matter back to the Medical Executive Committee for further consideration, stating the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. The Board shall, in reaching its decision, give great weight to the recommendation of the Medical Executive Committee, except that when a decision has been rendered in the matter by a Judicial Review Committee, it shall give great weight to the decision of the Judicial Review Committee. In no event shall the Board of Directors act in an arbitrary or capricious manner. The following procedures shall apply with respect to action on the application:

a. If the Medical Executive Committee issues a favorable recommendation, and
    1. the Board of Directors affirms that recommendation, the decision of the Board shall be deemed final action.
    2. If the tentative final action of the Board of Directors is unfavorable, the Hospital Chief Executive shall give the applicant and the Medical Executive Committee written notice of the tentative adverse recommendation and the applicant shall be entitled to the procedural rights set forth in Article VIII. If the applicant waives his/her procedural rights, the decision of the Board of Directors shall be deemed final action.
b. In the event the recommendation of the Medical Executive Committee, or any significant part of it, is unfavorable to the applicant the procedural rights set forth in Article VIII shall apply.
    1. If the applicant waives his/her procedural rights, the recommendations of the Medical Executive Committee shall be forwarded to the Board of Directors for final action.
    2. If the applicant requests a hearing following the adverse Medical Executive Committee recommendation pursuant to Section 5.7-6(b) or an adverse Board of Directors tentative final action pursuant to 5.7-6(a) (2), the Board of Directors shall take final action only after the applicant has exhausted his/her procedural rights as established by Article VIII. After exhaustion of the procedures set forth in Article VIII, the Board shall make a final decision, which shall be in writing and shall specify the reasons for the action taken.

### 5.6-7 Notice of Final Decision

a. Notice of the Board of Director's final decision shall be given, through the Hospital Chief Executive, to the Medical Executive Committee and the applicant.
b. A decision and notice to appoint shall include at least: (1) the Staff category to which the applicant is appointed; (2) the Department to which he/she is assigned; (3) the clinical privileges he/she may exercise; and (4) any special conditions attached to the appointment.

### 5.6-8 Reapplication After Adverse Decision Denying Application, Adverse Corrective Action Decision, or Resignation in Lieu of Medical Disciplinary Action

a. An applicant who:
   1. has received a final adverse decision regarding appointment; or
   2. withdrew his/her application or request for membership or privileges following an adverse recommendation by the Medical Executive Committee; or

b. A former Medical Staff member who has:
   1. received a final adverse decision resulting in termination of Medical Staff membership and clinical privileges; or
   2. resigned from the Medical Staff following the issuance of a Medical Staff or recommendation adverse to the Member's Medical Staff membership or clinical privileges; or

c. A Medical Staff member who has received a final adverse decision resulting in:
   1. termination or restriction of his/her clinical privileges; or
   2. denial of his/her request for additional clinical privileges.

Action taken as noted above shall result in a practitioner not being eligible to reapply for Medical Staff membership and/or clinical privileges affected by the previous action for a period of at least thirty-six (36) months from the date the adverse decision became final, the date the application or request was withdrawn, or the date the former Medical Staff member's resignation became effective, whichever is applicable.

For the purpose of this Section, a decision shall be considered to be adverse only if it is based on the type of occurrences which might give rise to corrective action and not if it is based upon reasons that do not directly pertain to medical or ethical conduct, or to pay dues, which can be cured by paying dues, or to maintaining professional liability insurance, which can be cured by securing such insurance. Further, for the purpose of this Section, an adverse decision shall be considered final at the time of completion of: (1) all hearing, appellate review, and other quasi-judicial proceedings conducted by the Hospital bearing on the decision and (2) all judicial proceedings bearing upon the decision which are filed and served within thirty-six (36) months after the completion of the Hospital proceedings described in (1) above.

After the thirty-six (36) month period, the former applicant or former member may submit an application for Medical Staff membership and/or clinical privileges, which shall be processed as an initial application. The former applicant, or former member shall also furnish evidence that the basis for the earlier adverse recommendation or action no longer exists and/or of rehabilitation in those areas which formed the basis for the previous adverse recommendation or action. In addition, the former applicant or member shall furnish satisfactory evidence of compliance with all of the specific requirements any such adverse decision may have included, such as completion of training or proctoring conditions.

### 5.6-9 Time Periods for Processing

Applications shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and, except for good cause.

## 5.7 Reappointments

### 5.7-1 Application for Reappointments, Schedule for Review

At least 120 days prior to the expiration date of the current staff appointment, a reapplication packet developed by the Medical Executive Committee shall be mailed or delivered to each member eligible for reappointment. Such form shall require detailed information concerning any changes in the member's qualifications since his/her last review, including all of the information and certifications requested in the reappointment application form, as provided for in Section 5.4-1, which is subject to change over time, as well as information obtained during the performance improvement activities and from peer references.

The form shall also provide the member with the option to request a change in his/her clinical privileges, including reductions and deletions as well as additional privileges. Requests for additional privileges must be supported by the type and nature of evidence, which would be necessary for such privileges to be granted in an initial application for it.

A third and final notice shall be sent via Certified Mail at least 60 days prior to appointment expiration. If an application for reappointment is not received at least 30 days prior to the expiration date the member shall be deemed to have resigned his/her membership.

### 5.7-2 Verification of Information

The Medical Staff Services Department shall, in timely fashion, seek to collect or verify the additional information made available on each reappointment application form and to collect any other materials or information deemed pertinent. The completed reappointment application packet and supporting materials shall be transmitted to the chair of each department, in which the Staff member has or requests privileges.

### 5.7-3 Basis for Reappointment

Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon whether such member has met the qualifications specified in Section 3.2, carried out the responsibilities specified in Section 3.6, and met all of the standards and requirements set forth in all sections of these Bylaws and in the Medical Staff Rules and Regulations. Specifically, recommendations shall also be based upon the member's compliance with legal requirements applicable to the practice of his/her profession, with the Medical Staff Bylaws and Rules and Regulations and Hospital policies, rendition of services to his/her patients, any physical or mental impairment which might interfere with the applicant's ability to practice medicine with reasonable skill and safety, and his/her provision of accurate and adequate information to allow the Medical Staff to evaluate his/her competency and qualifications.

### 5.7-4 Department Chair’s Action

The department chair shall review the reappointment application and other available information as appropriate, and shall transmit to the Credentials Committee his/her written recommendations, which are prepared in accordance with Section 5.8-7.

### 5.7-5 Credentials Committee Action

Following receipt of the department chair's recommendations concerning the application for reappointment, the Credentials Committee shall review the department chair's report and reappointment packet if necessary, and all other pertinent information available on the member who is being considered for reappointment and shall transmit to the Medical Executive Committee its recommendations prepared in accordance with Section 5.8-7.

### 5.7-6 Medical Executive Committee Action

The Medical Executive Committee shall review the department chair and Credentials Committee's reports, all other relevant information available to it, and shall forward to the Board of Directors, through the Hospital Chief Executive, its favorable reports and recommendations, prepared in accordance with Section 5.8-7.

When the Medical Executive Committee recommends adverse action, as defined in Section 8.2, either in respect to reappointment or clinical privileges, the Chief of Staff shall give the applicant written notice of the adverse recommendation and of the applicant's right to request a hearing in the matter specified in Section 8.3-2, and the member shall be entitled to the procedural rights as provided in Article VIII.

The Board of Directors shall be informed of, but not take action on, the pending adverse recommendation until the applicant has exhausted or waived his/her procedural rights.

Thereafter, the procedures specified in Sections 5.7-5 (Effect of Medical Executive Committee Action), 5.7-7 (Notice of Final Decision) and 5.7-8 (Reapplication After Adverse Decision Denying Application, Adverse Corrective Action Decision, or Resignation in Lieu of Medical Disciplinary Action) shall be followed, except that whenever the Board of Director's decision regarding a reappointment application is contrary to a favorable recommendation of the Medical Executive Committee, the Board shall submit the matter to the Joint Conference Committee for review and recommendation and shall consider such recommendation before making its decision final.

In making its decision, the Board of Directors shall give great weight to the recommendation of the Medical Executive Committee and in no event shall act in an arbitrary or capricious manner. The Medical Executive Committee may also defer action; however, any such deferral must be followed up within 70 days with a subsequent recommendation.

### 5.7-7 Reappointment Reports

The department chair, Credentials Committee, and Medical Executive Committee recommendations including peer recommendations shall be written and shall be submitted in the form prescribed by the Medical Executive Committee. Each report and recommendation shall specify the term of reappointment (two (2) years or less), whether the applicant's appointment should be renewed, renewed with modified membership category, and/or clinical privileges, or terminated. Where non-reappointment, denial of requested privileges, a reduction in status, or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

### 5.7-8 Failure to File Reappointment Application

If the member fails to submit an application for reappointment completed as required at least 30 days prior to the expiration of the reappointment, he/she shall be deemed to have resigned his/her membership in the Medical Staff. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article VIII shall not apply, and the appointment shall terminate following appropriate and adequate notification.

## 5.8 Leave of Absence

### 5.8-1 Leave Status

A Medical Staff member may apply for a voluntary leave of absence from the Medical Staff by submitting written notice to the Chief of Staff and/or the Medical Executive Committee stating the approximate period of time of the leave, which may not exceed two years. During the period of the leave, the member may not exercise clinical privileges or prerogatives, and shall not be subject to the normal Medical Staff responsibilities.

### 5.8-2 Termination of Leave

At least 30 days prior to the termination of the leave, or at any earlier time, the Medical Staff member must request reinstatement of his/her privileges and prerogatives by submitting a written request to that effect to the Medical Staff. The Staff member shall submit a written summary of his/her relevant activities during the leave and provide such other information as the Medical Staff may request. The Medical Executive Committee shall recommend whether to approve the member's request for reinstatement of his/her privileges and prerogatives.

Failure to request reinstatement or to provide a requested summary of activities shall be deemed to be a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

### 5.8-3 Health Status

It is the responsibility of all medical staff members to notify the Chief of Staff and department chair of any major or prolonged illness that might be considered to affect cognitive or motor skills required in the performance of any privileges. Such illnesses which may disable a medical staff member include, but are not limited to the following: cerebral vascular accident, cardiovascular surgery with bypass, cardiac arrest with resuscitation, syncope, and seizure. Upon return to practice following such an illness, the medical staff member will be required to provide an attestation that he/she is capable of performing the privileges that he/she has been granted. Prior to exercising any privileges, the medical staff member will be evaluated by the respective department chair and/or the Chief of Staff to determine if monitoring is required to verify ability to perform his/her privileges.

# ARTICLE VI

# CLINICAL PRIVILEGES

## 6.1 Exercise of Privileges

A member providing direct clinical services at this Hospital, in connection with such practice and except as otherwise provided in Section 6.6, shall be entitled to exercise only those clinical privileges specifically granted to him/her by the Board of Directors. Said privileges must be hospital specific, within the scope of any license, certificate, or other legal credential authorizing him/her to practice in this State and consistent with any restrictions thereon and shall be subject to the rules and regulations or privilege delineation form of the clinical department and the authority of the chair of the department and the Medical Staff.

## 6.2 Delineation of Privileges in General

### 6.2-1 Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant/member. Requests from an applicant for privileges, or from members for modification of privileges, must be supported by documentation of the requisite training, experience, qualifications and competency to exercise such privileges.

The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence, references and other relevant information. The applicant shall have the burden of establishing such qualifications and competence for the clinical privileges requested. The requirements for completeness, as described in Section 5.7, shall apply to all applications for clinical privileges.

### 6.2-2 Basis for Privileges Determination

Requests for clinical privileges shall be evaluated on the basis of the applicant/member's compliance with any credentialing guidelines, education, training, experience, demonstrated professional competence and judgment, clinical performance, and the documented results of patient care, peer review and other performance improvement and monitoring (relevant practitioner specific data and when available, compared to aggregate data) which the medical staff deems appropriate, challenges to any licensure or registration, voluntary and involuntary relinquishment of any license or registration, voluntary or involuntary termination of medical staff membership, voluntary and involuntary limitation, reduction or loss of clinical privileges, involvement in a professional liability action, including final judgments and settlements, and documentation as to the member’s health status. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges.

### 6.2-3 Procedure

All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article VI.

### 6.3 Focused Professional Practice Evaluation (Proctoring Requirement)

#### 6.3-1 For Initial Appointments

All new applicants for membership shall initially be appointed to the Provisional Staff and shall be subject to a period of focused review (proctoring requirements). Appointments to the Provisional Staff shall be for a period of not less than six (6) months nor more than two (2) years, provided that the Medical Executive Committee may extend the period of Provisional Staff membership in such cases as the Medical Executive Committee deems appropriate. If the proctored member has reached the two (2) year time period and has not satisfied the proctoring requirements of the department and there is nothing derogatory related to his/her or her clinical practice, in the opinion of the department, the Medical Executive Committee may, upon a showing of good cause, extend the Provisional period for one (1) year to allow the member time to complete the proctoring requirements.

Each Provisional Staff member shall undergo a period of observation by proctors as described in the department rules and regulations and privilege delineation forms. The observation shall be to evaluate the member's (1) proficiency in the exercise of clinical privileges initially granted and (2) overall eligibility for continued membership and advancement within Medical Staff categories. Observation of Provisional Staff members shall follow whatever frequency and format each department deems appropriate in order to evaluate adequately the member. This review will include but not be limited to concurrent or retrospective chart review, mandatory consultation and/or direct observation. Appropriate records shall be maintained in the member's file in the Medical Staff Services Department. Proctoring shall be in effect until the department chair has determined that proctoring requirements have been satisfactorily met.

The failure to complete the proctoring requirements without good cause and to advance shall result in automatic termination of membership and privileges.

Reference: Focused Professional Practice Evaluation Policy/Procedure.

#### 6.3-2 For Modification of Membership Status or Privileges

Additional proctoring may be required for members requesting new privileges, or for members whose clinical department determines that additional or continued proctoring is necessary or desirable. Continued proctoring shall not constitute grounds for a hearing unless action is taken for medical disciplinary cause or reason.

### 6.4 Conditions for Privileges of Limited License Practitioners

#### 6.4-1 Admissions

When dentists and oral surgeons, podiatrists, and clinical psychologists who are members of the Medical Staff admit patients, a physician member of the Medical Staff must conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry, oral surgery, podiatry, or clinical psychology) and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice.

### 6.4-2 Surgery

Surgical procedures performed by dentists, oral surgeons and podiatrists shall be under the overall supervision of the Chair of the Department of Surgery, and Orthopedic Surgery, or the Chair's designee.

### 6.4-3 Medical Appraisal

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

## 6.5 Temporary Membership and Privileges

Temporary membership and privileges are allowed under two circumstances only: to address a patient care need or to finalize a pending application (application complete, raises no concerns and is awaiting review and approval by the Medical Executive Committee and Board of Directors).

Temporary membership and privileges shall be granted by the Chief Executive, upon the basis of information then available which may be reasonably be relied upon as to the competence and ethical standing of the practitioner, and with the written concurrence of the department chair concerned and of the Chief of Staff.

### 6.5-1 Patient Care Needs

#### a. Care of Specific Patient

Temporary membership and clinical privileges may be granted where good cause exists to allow a practitioner to provide care to a specific patient provided that the practitioner either has special expertise or an emergent need exists. The procedures described in Section 6.4-3 must be satisfied.

### 6.5-2 Pending Application for Permanent Membership

Temporary membership clinical privileges may be granted to applicants while the application for permanent membership and privileges is pending, provided that the application has been completely verified, has been reviewed by the Credentials committee, raises no concerns and is awaiting approval by the Medical Executive Committee and Board of Directors. Such practitioners may only attend patients for a period not to exceed one hundred and twenty (120) days.

### 6.5-3 General Conditions

a. For practitioners who are not applying for permanent membership and privileges, completion of a temporary privilege application is required.

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

c. Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended under Articles VII and/or VIII of these Bylaws or unless affirmatively renewed. As necessary, the appropriate department chair or designee shall assign a member of the medical staff to assume responsibility for the care of such practitioner's patient(s). The wishes of the patient shall be considered in the choice of a replacement medical staff member.

d. Requirements for proctoring and monitoring, including but not limited to those outlined in Section 6.3, shall be imposed on such terms as may be appropriate under the circumstances upon any practitioner granted temporary privileges after consultation with the departmental chair or the chair's designee.

e. All practitioners requesting or receiving temporary privileges shall be bound by the Bylaws and Rules and Regulations of the Medical Staff.

### 6.6 Disaster Privileges

For the purposes of this Section, an "emergency" is defined as a condition in which a patient is in imminent danger of serious or permanent harm or death and any delay in administering treatment would add to that danger.

In the case of an emergency/disaster when the emergency plan has been activated and there are insufficient Medical Staff members to meet patient needs, the Hospital Chief Executive or his/her designee, Chief of Staff and the designated emergency medical care director (EMCD) have the authority to grant disaster privileges on a case by case basis to any volunteer practitioner (physicians, dentists, podiatrists and allied health professionals), to the degree permitted by his/her license and regardless of Department, Medical Staff status, or clinical privileges or lack of it, to do everything possible to save a patient from such danger, and said volunteer practitioner shall be assisted by Hospital personnel. To the extent possible, disaster privileges should be specialty specific to the volunteer practitioner and these may be assigned in any manner deemed appropriate by the granting authority

See Medical Staff Policy/Procedure: Disaster Privileges for additional details.

### 6.7 History and Physical Privileges

Histories and physicals can be conducted or updated and documented only pursuant to specific privileges granted upon request to qualified physicians (as defined by Centers for Medicare and Medicaid Services, CMS) who are members of the medical staff, acting within their scope of practice.

A medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after inpatient admission, but prior to surgery or a procedure requiring anesthesia services. For a medical history and physical examination that was completed within 30 days prior to inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours of inpatient admission, but prior to surgery or a procedure requiring anesthesia. Additional information regarding history and physical documentation requirements is delineated in the Medical Staff Rules and Regulations.

### Section 6.8 Exclusive Privileges

Whenever the Hospital plans to issue a contract, exclusive or otherwise, to provide services delivered under clinical privileges, it informs the Medical Executive Committee as to which specialties and services will be affected. The Medical Executive Committee (or an ad hoc committee formed for this purpose) collects information from the members that would be affected, from the hospital administration, and from other interested parties, to make an informed recommendation as to whether those services should be closed or discontinued, or provided through a contract, and, should a contract arrangement be recommended, what contract sources should be utilized. The actual terms of any contract and any financial information related to the contract, including but not limited to the remuneration to be paid to medical staff members under contract, are not relevant and therefore are neither disclosed to the Medical Executive Committee nor discussed as part of this contracting evaluation process. Unless the recommendation is arbitrary or capricious, the board's action regarding the contract is consistent with the recommendation of the Medical Executive Committee.

## ARTICLE VII

## CORRECTIVE ACTION

### 7.1 Routine Corrective Action

### 7.1-1 Criteria for Initiation

Whenever a practitioner with clinical privileges shall engage in, make, or exhibit acts, statements, demeanor, or professional conduct, either within or outside of the Hospital, and the same is, or is reasonably likely to be, detrimental to patient safety or to the delivery of quality patient care within the Hospital, to be disruptive to Hospital operations, or to constitute fraud or abuse, or be contrary to the Medical Staff Bylaws, Rules and Regulations, or the same results in the imposition of sanctions by any governmental authority, an investigation or corrective action against such person may be requested by any Medical Staff officer, by the chair of any department in which the practitioner is a member or exercises clinical privileges, by the chair of any standing Medical Staff committee, by the Board of Directors, or by the Hospital Chief Executive, upon the complaint, request or suggestion of any person.

### 7.1-2 Initiation

Proposed corrective action, including a request for an investigation, must be initiated by the Medical Executive Committee on its own initiative or by a written request which is submitted to the Medical Executive Committee and identifies the specific activities or conduct which are alleged to constitute the grounds for proposing an investigation or specific corrective action. The Chief of Staff shall promptly notify the Hospital Chief Executive and the Board of Directors of all proposals for corrective action so initiated.

### 7.1-3 Investigation

Upon receipt, the Medical Executive Committee may act on the proposal or direct that an investigation be undertaken. The Medical Executive Committee may conduct that investigation itself or may assign this task to an appropriately charged officer, or standing or ad hoc Medical Staff committee. The Medical Executive Committee in its discretion may appoint practitioners who are not members of the Medical Staff for the sole purpose of serving on a standing or ad hoc committee, and not for the purpose of granting these practitioners special clinical privileges under Section 6.5, should circumstances warrant. Such process shall include an interview with the affected practitioner, advising him/her of the reasons for the investigation and giving him/her an opportunity to comment thereon. No such investigative process shall be deemed to be a "hearing" as described in Article VIII.

If the investigation is delegated to an officer or Committee other than the Medical Executive Committee, such officer or Committee shall forward a written report of the investigation to the Medical Executive Committee, which may include recommendations for appropriate corrective action, as soon as is practicable after the assignment to investigate has been made.

The Medical Executive Committee may at any time within its discretion, and shall at the request of the Board of Directors, terminate the investigative process with action as provided in Section 7.1-4 below.

### 7.1-4 Executive Committee Action

As soon as is practicable after the conclusion of the investigative process, if any, but in any event within 60 days after the initiation of proposed corrective action, unless deferred pursuant to Section 7.1-5, the Medical Executive Committee shall act thereon. Such action may include, without limitation, recommending:

a. If corrective action as set forth in Section 7.1-4 (b)-(k) is recommended by the Medical Executive Committee. If so recommended by the Medical Executive Committee, that recommendation shall be transmitted to the Board of Directors.
b. No corrective action. If the Medical Executive Committee determines that no credible evidence existed for the complaint, it may recommend no corrective action and place the information with the recommendation for no corrective action concerning the complaint in the Member's file.
c. Rejection or modification of the proposed corrective action.
d. Letter of admonition, letter or reprimand, or warning or such other actions as are permitted under Section 7.1-7(b).
e. Terms of probation or individual requirements of co-admission, mandatory consultation, or monitoring.
f. Reduction or revocation of clinical privileges.

g. Suspension of clinical privileges until completion of specific conditions or requirements.
h. Reduction of membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care.
i. Suspension of Medical Staff membership until completion of specific conditions or requirements.
j. Revocation of Medical Staff membership.
k. Other actions appropriate to the facts which prompted the investigation.

Nothing set forth herein shall inhibit the Medical Executive Committee from implementing summary suspension at any time, in the exercise of its discretion pursuant to Section 7.2.

### 7.1-5 Deferral

If additional time is needed to complete the investigative process, the Medical Executive Committee may defer action on the request, and it shall so notify the affected practitioner. A subsequent recommendation for any one or more of the actions provided in Section 7.1-4, Paragraphs (a) through (k) above must be made within the time specified by the Medical Executive Committee, and if no such time is specified, then within 30 days of the deferral.

### 7.1-6 Procedural Rights

Any recommendation by the Medical Executive Committee pursuant to Section 7.1-4 which constitutes grounds for a hearing as set forth in Section 8.2 shall entitle the practitioner to the procedural rights as provided in Article VIII. In such cases, the Chief of Staff shall give the practitioner written notice of the adverse recommendation and of his/her right to request a hearing in the manner specified in Article VIII.

### 7.1-7 Other Action

a. If the Medical Executive Committee's recommended action is to recommend no corrective action, such recommendation, together with such supporting documentation as may be required by the Board of Directors, shall be transmitted to the Board of Directors. Thereafter, the procedure to be followed shall be the same as that provided for applicants in Sections 5.7-6 (Action by the Board of Directors) and 5.7-7(a) Notice of Final Decision), as applicable.
b. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude department heads from issuing informal written or oral warnings outside of the mechanism for corrective action. If the Medical Executive Committee's recommended action is an admonition, reprimand, or warning to a practitioner, it shall, at the practitioner's request, grant him/her an interview as provided in Section 7.4. Following the interview, if one is requested, if the Medical Executive Committee's final recommendation to the Board is an admonition, reprimand, or warning this shall conclude the matter when approved by the Board without substantial modification, and notice of the final decision shall be given to the Hospital Chief Executive, Medical Executive Committee, the chair of each Committee concerned, and the practitioner.
c. If any proposed corrective action by the Board will substantially modify the Medical Executive Committee's recommendation, the Board may submit the matter back to the Medical Executive Committee for review and recommendation before making its decision final. Any recommendation of the Board which constitutes grounds for a hearing as set forth in Section 8.2, shall entitle the practitioner to the procedural rights as provided in Article VIII. In such cases, the Board of Directors shall give the practitioner written notice of the tentative adverse recommendation and of his/her right to request a hearing in the manner specified in Section 8.3-2.

d. If the Medical Executive Committee fails to investigate or take disciplinary action contrary to the weight of the evidence in a timely fashion, the Board may direct the Medical Executive Committee to initiate investigation or disciplinary action, but only after consultation with the Medical Executive Committee. If the Medical Executive Committee fails to take action in response to that direction, the Board of Directors may initiate corrective action, but this corrective action must comply with Articles VII and VIII of these Medical Staff bylaws.

## 7.2 Summary Suspension or Summary Restriction

### 7.2-1 Criteria for Initiation

Whenever a practitioner's conduct requires immediate action to be taken to reduce a substantial likelihood of imminent impairment of the health or safety of any patient, prospective patient, employee or other person present in the Hospital, any person or body authorized to request corrective action or a corrective action investigation pursuant to Section 7.1-1 hereof shall have the authority to summarily suspend or restrict the Medical Staff membership status or all or any portion of the clinical privileges of such practitioner. Summary suspensions or restrictions initiated by the Board of Directors are subject to ratification requirements described in Section 7.2-4.

Such summary suspensions shall become effective immediately upon imposition, and the person or body responsible therefore shall promptly give oral or written notice of the suspension to the practitioner, Board of Directors, Medical Executive Committee, and Hospital Chief Executive. The notice of the suspension given to the Medical Executive Committee shall constitute a request for corrective action and the procedures set forth in Section 7.1 shall be followed. In the event of any such suspension, the practitioner's patients whose treatment by such practitioner is terminated by the summary suspension shall be assigned to another practitioner by the department chair or by the Chief of Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

### 7.2-2 Executive Committee Action

After such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee shall be convened within seven (7) days to review and consider the action. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose (which such attendance shall be considered an "Interview" as defined in Section 7.4), and in no event shall any meeting of the Medical Executive Committee, with or without the member, constitute a "hearing" within the meaning of Article VIII, nor shall any procedural rules apply. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the member with notice of its decision.

### 7.2-3 Procedural Rights

Unless the Medical Executive Committee terminates the suspension, it shall remain in effect during the pendency of and the completion of the corrective action process and of the hearing and appellate review process, unless the summary suspension is terminated by the Judicial Hearing Committee. The practitioner shall not be entitled to the procedural rights afforded by Article VIII until such time as the Medical Executive Committee has taken action pursuant to Sections 7.1-4 through 7.1-7, except that the judicial review must be held within 45 days as set forth in section 8.3-3, and then only if the action taken constitutes grounds for a hearing as set forth in Section 8.2.

### 7.2-4 Initiation by Board of Directors

If the Chief of Staff, members of the Medical Executive Committee and the chair of the department (or designee) in which the member holds privileges are not available to summarily restrict or suspend the member's membership or clinical privileges, the Board of Directors (or designee) may immediately suspend a member's privileges if a failure to summarily suspend those privileges is likely to result in an imminent danger to the health of any patient, prospective patient, or other person, provided that the Board of Directors (or designee) made reasonable attempts to contact the Chief of Staff, members of the Medical Executive Committee and the chair of the department (or his/her designee) before the suspension.

Such a suspension is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two working days, excluding weekends and holidays, the summary suspension shall terminate automatically.

## 7.3 Automatic Suspension

In the following instances, the member's privileges or membership or privileges as noted below may be automatically suspended or limited as described below:

### 7.3-1 License

a. **Revocation or Expiration:** Whenever a practitioner's license or other legal credential authorizing him/her to practice in this State is revoked or has expired, his/her Medical Staff membership, prerogatives, and clinical privileges shall be immediately and automatically suspended until documentation of current licensure is received by the Medical Staff Services Department.
b. **Restriction:** Whenever a practitioner's license or other legal credential authorizing him/her to practice in this State is limited or restricted by the applicable licensing or certifying authority, those clinical privileges which he/she has been granted rights to perform that are within the scope of said limitation or restriction shall be immediately and automatically suspended.
c. **Suspension:** Whenever a practitioner license or other legal credential authorizing him/her to practice in this State is suspended, his/her Staff membership and clinical privileges shall be automatically suspended effective upon, and for at least the term of, the suspension.
d. **Probation:** Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, his/her applicable membership status, prerogatives, privileges and responsibilities, if any, shall automatically become subject to the terms and conditions of the probation effective upon, and for at least the term of the probation.

### 7.3-2 Drug Enforcement Administration

a. **Revocation, Suspension, or Expiration:** Whenever a practitioner's DEA certificate is revoked, limited, suspended or expired, he/she shall immediately and automatically be divested of his/her right to prescribe medications covered by the certificate.
b. **Probation:** Whenever a practitioner's DEA certificate is subject to an order of probation, his/her right to prescribe medications covered by the certificate shall automatically become subject to the terms and conditions of the probation effective upon, and for at least the term of, the probation.

### 7.3-3 Failure to Satisfy Special Appearance Requirement

A practitioner who fails, without good cause, to appear and satisfy the requirements of Section 13.7-2, shall automatically be suspended from exercising all, or such portion of his/her clinical privileges as may be suspended, in accordance with the provisions of said Section 13.7-2.

### 7.3-4 Malpractice Insurance

Practitioners shall give immediate written notice to the Medical Staff Services Department of any cancellation, termination, or other change in the amount or scope of the professional liability coverage required under Section 15.2. Regardless of whether such notice is given, in the event that a practitioner, fails to maintain the required amount of professional liability insurance his/her membership and clinical privileges shall automatically be suspended. Membership and privileges shall remain so suspended until the practitioner provides evidence acceptable to the Medical Executive Committee that he/she has secured professional liability coverage in the amount required under Section 15.2. Unless excused by the Medical Executive Committee for good cause, such coverage shall include "prior acts" coverage for any period of time during which the member had allowed his/her coverage to lapse. A failure to provide such evidence within one (1) month after the date the automatic suspension became effective shall be deemed to be a voluntary resignation of the practitioner's Medical Staff membership. The failure to give notice of cancellation, termination or other change in coverage shall be independent grounds for corrective action under 7.1-1.

### 7.3-5 Conviction of a Felony or Misdemeanor

A member who has been convicted of any felony or misdemeanor as described in Section 3.2-1(c) (including a member who pleads guilty or nolo contendere) shall be suspended/terminated unless the Medical Executive Committee, for good cause, shall determine otherwise.

### 7.3-6 Membership Criteria – Medicare/Medicaid or Public Program Action (Past or Pending)

Notwithstanding any other provision of these Bylaws, an application or re-application for membership may be rejected on a showing that the applicant or member has ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid or any public program or if action related to the above is pending. In addition, such action or pending action may be the basis of suspension or termination of the medical staff membership and/or privileges of a member. The question of suspension shall be at the sole discretion of the Medical Executive Committee.

### 7.3-7 Medical Executive Committee Deliberations

As soon as practicable after action is taken as described above, 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 Section 7.1-3. The procedure to be followed shall be as provided in Sections 7.1-6 and 7.1-7, as applicable, if the Medical Executive Committee takes action, or as described in Section 7.1-3 through 7.1-7 if the Medical Executive Committee directs a further investigation.

### 7.3-8 Procedural Rights

Members whose clinical privileges are automatically suspended and/or who have resigned their Medical Staff membership pursuant to the above provisions shall be entitled to notice and an opportunity to respond, limited to the question of whether the grounds for automatic suspension or resignation have occurred (see Challenges to Rules under Article VIII).

### 7.3-9 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 Hospital Chief Executive, and the Board of Directors. 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 by such practitioner is terminated by the automatic suspension, shall be assigned to another practitioner by the department chair or Chief of Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

### 7.4 Interviews

Interviews shall neither constitute, nor be deemed, a "hearing", as described in Article VIII, 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/her an interview only when so specified in this Article VII. In all other cases and when the Medical Executive Committee or the Board of Directors has before it an adverse recommendation, as defined in Section 8.2, 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 VIII

## HEARINGS AND APPELLATE REVIEWS

### 8.1 Preamble and Definitions

### 8.1-1 Intra-Organizational Remedies

The intra-organizational remedies and the hearing and appellate review bodies provided for in this Article VIII are strictly quasi-judicial in structure and function and said bodies shall have no power or authority to hold legislative, notice and comment type hearings or to make legislative determinations, or determinations as to the substantive validity of bylaws, rules, regulations or other intra-organizational legislation. Notwithstanding the foregoing, the Board of Directors may entertain challenges to the substantive validity of intra-organizational legislation and in all proper cases shall hear and decide those questions. Where the substantive validity question is the sole issue, the petitioner shall be permitted a direct appeal and hearing in the first instance, before the Board of Directors or its Appeal Board. The final determination by the body conducting such hearing shall be a condition precedent to petitioner's right to seek judicial review in a court of law.

### 8.1-2 Exhaustion of Remedies

If an adverse ruling is made with respect to a practitioner's Staff membership, Staff status, or clinical privileges at any time, regardless of whether he/she is an applicant or a Medical Staff member, he/she must exhaust the intra-organizational remedies afforded by these Bylaws before resorting to formal legal action challenging the decision, the procedures used to arrive at it, or asserting any claim against the Hospital or participants in the decision process; and the exclusive procedure for obtaining judicial review shall be by Petition for Writ of Mandate pursuant to the California Code of Civil Procedure.

### 8.1-3 Challenges to Rules

The hearings provided for in this Article shall not be utilized to make determinations as to the substantive validity of a Bylaw, rule, regulation or policy. Where the substantive validity of such Bylaw, rule, regulation or policy is the only issue and no report to the Medical Board of California under Business and Professions Code Section 805 can be made, the petitioner shall have a direct appeal and hearing, in the first instance before the Medical Executive Committee with an appeal to the Board of Directors.

The hearing and appeal procedures shall be determined by the Medical Executive Committee and Board of Directors, respectively, and need not comply with the procedures for hearings contained in this Article VIII. Such hearing and appeal procedures must be utilized prior to resorting to legal action.

### 8.1-4 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 officers, members or committees of the Medical Staff took the action or rendered the decision which resulted in a hearing being requested, and refers to the Board of Directors in all cases where the Board of Directors or authorized officers, directors or committees of the Board of Directors took the action or rendered the decision which resulted in a hearing being requested.
b. **"Notice"** refers to a written communication delivered personally to the required addressee or sent by United States Postal Service, first-class postage prepaid, certified or registered mail, return receipt requested addressed to the required addressee at his/her office or its address as it appears in the records of the Hospital.
c. **"Petitioner"** refers to the practitioner who has requested a hearing pursuant to Section 8.3 of these Bylaws.
d. **"Date of Receipt"** of any notice or other communication shall be deemed to be the date such notice or communication was delivered personally to the required addressee or, if delivered by mail, such notice or communication shall be deemed received 48 hours after being deposited, postage prepaid, in the United States mail in compliance with paragraph (b) of this Section 8.1-4.
e. **"Member"** may include "applicant," as it may be applicable under the circumstances, unless otherwise stated.

### 8.1-5 Timely Completion of Process

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

### 8.1-6 Final Action

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

## 8.2 Grounds for Hearing

Except as otherwise specified in applicable bylaws, rules, regulations or policies, any one of the following adverse actions or recommended actions shall be deemed grounds for a hearing:

a. Denial of Medical Staff membership, reappointment and/or clinical privileges, based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients;
b. Revocation of Medical Staff membership, based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients;
c. Revocation or reduction of clinical privileges, based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients;
d. Significant restriction of clinical privileges (except for proctoring incidental to Provisional Status, new privileges, insufficient activity, or return from leave of absence) for more than fourteen (14) days based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients;
e. Suspension of Medical Staff membership and/or clinical privileges for more than fourteen (14) days based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients; and,
f. Any other disciplinary action or recommendation that must be reported, by law, to the Medical Board of California.

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

## 8.3 Requests for a Hearing

### 8.3-1 Notice of Action or Proposed Action

In all cases where the body which, under these Bylaws, has the authority to, and pursuant to that authority, has recommended or taken any of the actions constituting grounds for hearing as set forth in Section 8.2 of this Article, said body shall give the affected practitioner notice of its recommendation, or final action and that such action, if adopted, shall be taken and reported to the Medical Board of California pursuant to Section 805 of the California Business and Professions Code and/or to other agencies as required by state or federal law and notice of his/her right to request a hearing pursuant to Section 8.3-2 below, and that such hearing must be requested within thirty (30) days.

### 8.3-2 Request for Hearing

The petitioner shall have thirty (30) days following the date of receipt of notice of such action to request a hearing by a Judicial Hearing Committee. Said request shall be effected by notice to the Chief of Staff with a copy to the Hospital Chief Executive. In the event the petitioner does not request a hearing within the time and in the manner herein above set forth, he/she shall be deemed to have accepted the recommendation, decision, or action involved and it shall thereupon become the final action of the Medical Staff. Such final recommendation shall be considered by the Board of Directors within forty-five (45) days, but shall not be binding on the Board of Directors.

### 8.3-3 Time and Place for Hearing

Upon receiving a request for hearing, the Medical Executive Committee shall schedule and arrange for a hearing, and within 30 days give notice to the member of the time, place and date of the hearing. The date of the commencement of the hearing shall be not less than thirty (30) days, nor more than sixty (60) days from the date of receipt of the request for a hearing by the Chief of Staff. However, if the affected petitioner is under a suspension which is then in effect, the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed forty-five (45) days from the date of receipt of the request for hearing by the Chief of Staff.

### 8.3-4 Notice of Hearing

Together with the notice stating the place, time and date of the hearing, which date shall not be less than 30 days after the date of notice unless waived by a member under summary suspension, the Medical Executive Committee shall state clearly and concisely in writing the reasons for the adverse action taken or recommended, including the acts or omission with which the member is charged and provide a list of the charts in question, where applicable, and a list of the witnesses (if any) expected to testify at the hearing on behalf of the Medical Executive Committee. The content of this list is subject to update pursuant to Section 8.4-1.

### 8.3-5 Judicial Hearing Committee

When a hearing is requested, the Medical Executive Committee shall recommend a Judicial Hearing Committee to the Board of Directors for appointment. The Board of Directors shall be deemed to approve the selection unless it provides written notice to the Medical Executive Committee stating the reasons for its objections within 5 days. The Judicial Hearing Committee shall be composed of not less than three (3) Active members of the Medical Staff. The Judicial Hearing Committee members shall gain no direct financial benefit from the outcome, and shall not have acted as accuser, investigator, fact finder, or initial decision maker. The Chief of Staff shall designate a chair who shall preside in the manner described in Sections 8.4-1 and 8.4-3, and handle all prehearing matters and preside until a hearing officer, as described in Section 8.4-4 below, is appointed.

In the event that it is not feasible to appoint a Judicial Hearing Committee from the Active Medical Staff, the Medical Executive Committee may appoint members from other Staff categories or practitioners who are not members of the Medical Staff. Such appointment shall include designation of the chair. Membership on the Judicial Hearing Committee shall consist of one member who shall have the same healing arts licensure as the accused, and where feasible, include an individual practicing the same specialty as the practitioner. All other members shall have M.D. or D.O. degrees.

### 8.3-6 Failure to Appear

Failure, without good cause, of the petitioner to appear and proceed at such a hearing shall be deemed to constitute a voluntary acceptance of the recommendations or actions involved, and it shall thereupon become the final recommendation of the Medical Staff. Such final recommendation shall be considered by the Board of Directors within forty-five (45) days, but shall not be binding on the Board of Directors.

### 8.3-7 Postponements and Extensions

Postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by either party and shall be permitted by the Judicial Hearing Committee or the Hearing Officer acting upon its behalf on a showing of good cause.

## 8.4 Hearing Procedure

### 8.4-1 Prehearing Procedure

a. If either side to the hearing requests in writing a list of witnesses, within fifteen (15) days of such request, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is reasonably known or anticipated to give testimony or evidence in support of that party at the hearing. The member shall have the right to inspect and, at his/her expense, copy documents or other evidence upon which the charges are based, and shall also have the right to receive at least thirty (30) days prior to the hearing a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the member to prepare a defense including all evidence which was considered by the Medical Executive Committee in determining whether to proceed with the adverse action, and any exculpatory evidence in the possession of the hospital or Medical Staff. The member and the Medical Executive Committee shall have the right to receive all evidence, which will be made available to the Judicial Hearing Committee.

b. The Medical Executive Committee shall have the right to inspect and copy at its expense any documents or other evidence relevant to the charges which the member has in his/her possession or control at least thirty (30) days prior to the hearing.

c. The failure by either party to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the member under review.

d. The Hearing Officer shall consider and rule upon any request for access to information and may impose any safeguards for the protection of the peer review process and justice requirements. In so doing, the Hearing Officer shall consider:
    1. whether the information sought may be introduced to support or defend the charges;
    2. the exculpatory or inculpatory nature of the information sought, if any;
    3. the burden imposed on the party in possession of the information sought, if access is granted; and
    4. any previous requests for access to information submitted or resisted by the parties to the same proceeding.

e. The member shall be entitled to a reasonable opportunity to question and challenge the impartiality of Judicial Hearing Committee members and the Hearing Officer. Challenges to the impartiality of any Judicial Hearing Committee member or the Hearing Officer shall be ruled on by the Hearing Officer.

f. It shall be the duty of the member and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the chair of the Judicial Hearing Committee and Hearing Officer if one is appointed of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

### 8.4-2 Representation

The petitioner, the Medical Executive Committee and the Board of Directors may be represented by legal counsel at the judicial hearing or the appellate hearing if the party desiring to be so represented gives written notice thereof to the other party and the Judicial Hearing Committee or the Board of Directors, as appropriate, at least 15 days prior to the commencement of the hearing. If such notice is given the other party shall automatically be entitled to representation by legal counsel and need not provide any notice regarding such representation. In any case in which less than 30 days notice of the hearing has been given to the petitioner, either party shall be entitled to reduce the required notice period regarding legal representation to 10 days; providing that if such reduction is effected, the other party shall be entitled by request made within 3 days of its receipt of such notice to a postponement of the hearing date to a date not less than 15 days after the date it received the other party's notice of its intention to be represented by legal counsel. If the petitioner does not provide timely notice of a request to be represented by legal counsel he/she shall only be entitled to be accompanied and represented at such hearings by a physician, dentist or podiatrist licensed to practice in the State of California who is not also an attorney at law, and who is preferably a member of the Medical Staff who is not currently subject to any restriction of privileges or recommendation for corrective action. In any case in which the body whose decision prompted the hearing declines to exercise its right to be represented by legal counsel, such body shall appoint a representative from the Medical Staff or from the Board of Directors (whichever body's decision prompted the hearing) who shall present its recommendation, decision, or action taken and the materials in support thereof and examine witnesses.

### 8.4-3 The Presiding Officer

The presiding officer at the hearing shall be a hearing officer as described in Section 8.4-4 or, if no such hearing officer has been appointed, the chair 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/she shall be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing. He/she shall have the authority and discretion, in accordance with these Bylaws, to make all rulings on questions which, with reasonable diligence, could not have been raised prior to the hearing and which pertain to matters of law, procedure, or the admissibility of evidence.

### 8.4-4 The Hearing Officer

The Medical Executive Committee shall recommend a hearing officer to the Board of Directors to preside at the hearing. The Board of Directors shall be deemed to approve the selection unless it provides written notice to the Medical Executive Committee stating the reasons for its objections within 5 days. The hearing officer shall be an attorney at law qualified to preside over a quasi-judicial hearing and, preferably with experience in Medical Staff matters. A person who has financial interest in the outcome of the hearing shall be disqualified from serving as a hearing officer. The hearing officer must not act as a prosecuting officer, as an advocate for the Hospital, Medical Executive Committee, the body whose action prompted the hearing, or the petitioner. If requested by the Judicial Hearing Committee, he/she may participate in the deliberations of such body and be a legal advisor to it, but he/she shall not be entitled to vote.

### 8.4-5 Record of the Hearing

The Judicial Hearing Committee shall maintain a record of the hearing by one of the following methods: a certified shorthand reporter present to make a record of the hearing, or a record of the proceedings. The cost of the transcript and any certified shorthand reporter shall be borne by the party requesting it. The Judicial Hearing Committee may, but shall not be 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.

### 8.4-6 Rights of the Parties

Prior to commencement of the hearing both sides shall have the right to ask members of the Judicial Hearing Committee and the hearing officer, if one is appointed, questions which are directly related to determining whether they are impermissibly biased and to challenge such members or the hearing officer. Any challenge directed at one or more of the members of the Committee shall be subject to the provisions of Section 8.4-1 (e) and shall be resolved by the hearing officer prior to the continuation of the proceedings. Challenges regarding the impartiality of members or the hearing officer may also be made at such time, if any, during the course of the hearing, at which new information regarding possible bias is presented if such information was not reasonably available to the challenging party in accordance with the provisions of Section 8.4-1. During the hearing each party shall have the right to call and examine witnesses, to introduce exhibits or other documents, to cross-examine or otherwise attempt to impeach any witness who shall have testified orally on any matter relevant to the issues, and otherwise to rebut any evidence. The petitioner may be called by the body whose decision prompted the hearing and examined as if under cross-examination.

### 8.4-7 Miscellaneous Rules

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. Each party shall have the right to submit a written statement in support of his/her position and the Judicial Hearing Committee may request such a statement to be filed following the conclusion of the presentation of oral testimony. The Judicial Hearing Committee may interrogate the witness or call additional witnesses if it deems such action appropriate.

### 8.4-8 Basis of Decision

If the Judicial Hearing Committee should find the charge(s) or any of them to be true, it shall impose such form of discipline as it shall find warranted, provided, however, that such form of discipline shall not be more stringent than that recommended by the body whose decision prompted the hearing. The decision of the Judicial Hearing Committee shall be based on the arguments and evidence produced at the hearing. Such material may consist of the following:

a. Oral testimony of witness.
b. Briefs or written statements presented in connection with the hearing.
c. Any material contained in the Hospital or Medical Staff personnel files regarding the petitioner, which shall have been made a part of the hearing record.
c. Any and all applications, references, medical records, exhibits and other documents and records which shall have been made a part of the hearing record.
d. Any other evidence admissible hereunder.

### 8.4-9 Burdens of Presenting Evidence and Proof

a. At the hearing, the Medical Executive Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The member shall be obligated to present evidence in response.
b. An applicant shall bear the burden of persuading the Judicial Hearing Committee, by a preponderance of the evidence, of his/her qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning his/her current qualifications for membership and privileges. An applicant shall not be permitted to introduce information requested by the Medical Staff but not produced during the application process unless the applicant establishes the information could not have been produced previously in the exercise of reasonable diligence.
c. Except as provided above for applicants, throughout the hearing, the Medical Executive Committee shall bear the burden of persuading the Judicial Hearing Committee, by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.

### 8.4-10 Adjournment and Conclusion

The presiding officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Both the Medical Executive Committee and the member may submit a written statement at the close of the hearing. Upon conclusion of the presentation or oral and written evidence and argument, the hearing shall be closed. The Judicial Hearing Committee, in the presence of the Hearing Officer, shall conduct its deliberations and render a decision and accompanying report.

### 8.4-11 Basis for Decision

The decision of the Judicial Hearing Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony.

### 8.4-12 Decision of the Judicial Hearing Committee

Within thirty (30) days after final adjournment of the hearing, the Judicial Hearing Committee shall render a decision which shall be accompanied by a report in writing and shall be delivered to the Medical Executive Committee. If the member is currently under suspension, however, the time for the decision and report shall be fifteen (15) days. A copy of said decision also shall be forwarded to the Hospital Chief Executive, the Board of Directors and to the member. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. Both the member and the Medical Executive Committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the Judicial Hearing Committee shall become the final recommendation of the Medical Staff to the Board of Directors, unless appealed in accordance with Section 8.5. If neither party appeals the decision of the Judicial Hearing Committee in accordance with Section 8.5, the Board of Directors shall take action on the decision in accordance with Section 8.5-6.

## 8.5 Appeals to the Board of Directors

### 8.5-1 Time for Appeal

Within fifteen (15) days after receipt of the decision of the Judicial Review Committee, either the member or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the Chief of Staff, the Hospital Chief Executive, and the other party in the hearing. If a request for appellate review is not requested within such period, that action or recommendation shall be affirmed by the Board of Directors as the final action if, in their opinion, it is supported by substantial evidence, following a fair procedure.

### 8.5-2 Grounds for Appeal

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be: (a) substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice; and/or (b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 8.5-5.

### 8.5-3 Time, Place, and Notice

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

### 8.5-4 Appeal Board

The Board of Directors may sit as the Appeal Board, or it may appoint an appeal board which shall be composed of not less than three (3) members of the Board of Directors. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person did not take part in a prior hearing on the same matter. The Appeal Board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal. The attorney selected by the Board of Directors shall not be the attorney that represented either party at the hearing before the Judicial Review Committee.

### 8.5-5 Appeal 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 Review Committee, provided that the Appeal Board may accept additional oral or written evidence, subject to a foundational showing that such evidence is relevant to the appeal and could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence. Introduction of such evidence is subject to the same rights of cross-examination or confrontation provided at the Judicial Review hearing or the Appeal Board may remand the matter to the Judicial Review Committee for the taking of further evidence and for decision.

Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of his or her position on appeal, and to personally appear and make oral argument. The Appeal Board and/or its attorney shall determine the specific details for the appeal, including length of written submissions, oral arguments, and other appeal processes not specified in these Bylaws. After the conclusion of the appellate hearing, the Appeal Board may conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives.

The Appeal Board shall present to the Board of Directors its written recommendations as to whether the Board of Directors should affirm, modify, or reverse the Judicial Review Committee decision, or remand the matter to the Judicial Review Committee for further review and decision.

### 8.5-6 Decision

a. Except as provided in Section 8.5-6(b), within thirty (30) days after the conclusion of the appellate review proceedings, the Board of Directors shall render a final decision and shall affirm the decision of the Judicial Review Committee if the Judicial Review Committee's decision in their opinion is supported by substantial evidence, following a fair procedure.

b. Should the Board of Directors determine that the Judicial Review Committee decision is not supported by substantial evidence or did not involve a fair procedure, the Board may modify or reverse the decision of the Judicial Review Committee and may instead, or shall, where a fair procedure has not been afforded, remand the matter to the Judicial Review Committee for reconsideration, stating the purpose for the referral. If the matter is remanded to the Judicial Review Committee for further review and recommendation, the Committee shall promptly, as directed by the Board of Directors, conduct its review and make its recommendations to the Board of Directors.

c. The final decision of the Board of Directors shall be in writing and shall specify the reasons for the action taken.

### 8.5-7 Right to One Hearing

No member shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

## 8.6 Exceptions to Hearing Rights

### 8.6-1 Closed Staff or Exclusive Use Departments and Medico-Administrative Officers

a. **Closed Staff or Exclusive Use Departments.** The fair hearing rights of Articles VII and VIII do not apply to a practitioner whose application for Medical Staff membership and privileges was denied on the basis the privileges he/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 Board of Directors review the denial, and the Board of Directors 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/her position to the Board of Directors.

b. **Medico-Administrative Officer.** The fair hearing rights of Articles VII and VIII do not apply to those persons serving the Hospital in a medico-administrative capacity when the action relates to their removal from office. Removal from office of such persons shall instead be governed by the terms of their individual contracts and agreements with the Hospital.

However, the hearing rights of the preceding sections of this Article VIII and of Article VII shall apply to the extent that Medical Staff membership status or clinical privileges, which are independent of the practitioner's contract, are also removed or suspended, unless the contract includes a specific provision establishing alternative procedural rights applicable to such decisions.

### 8.6-2 Automatic Suspension or Limitation of Practice Privileges

No hearing is required when a member's license or legal credential to practice has been revoked or suspended as set forth in Section 7.3-1(a). In other cases described in Section 7.3-1 and 7.3-2, the issues which may be considered at a hearing, if requested, shall include evidence concerning whether the member may continue to practice in the Hospital with those limitations imposed, not whether the determination by the licensing or credentialing authority, or the DEA was unwarranted.

## 8.7 National Practitioner Data Bank and/or Medical Board of California Reporting

### 8.7-1 Adverse Actions

The authorized representative shall report an adverse action to the National Practitioner Data Bank and/or the Medical Board of California on the prescribed form only upon its adoption as final action and using at least the description set forth in the final action as adopted by the Board of Directors. The authorized representative shall report any and all revisions of an adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

### 8.7-2 Dispute Process

If no hearing was requested, a member who was the subject of an adverse action report may request an informal meeting to dispute the report filed. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report filed is consistent with the final action issued. The meeting shall be attended by the subject of the report, the Chief of Staff, the chair of the subject's department, and the Hospital's authorized representative, or their respective designees. If a hearing was held, the dispute process shall be deemed to have been completed.

# ARTICLE IX

# CLINICAL DEPARTMENTS AND DIVISIONS

## 9.1 Organization of Departments and Divisions

Each Department shall be organized as a separate part of the Medical Staff, shall have a chair and a vice chair who are elected and have the authority, duties, and responsibilities specified in Article X and shall develop rules and regulations consistent with these Bylaws for the operation of the department. In the Department of Medicine/Family Medicine, each specialty shall be represented on the Medical Executive Committee. If the current chair is a family practitioner, a Medicine representative shall be elected for MEC representation and likewise if the Chair is a specialist in Medicine.. When appropriate, the Medical Executive Committee and the Board of Directors, by their joint action, may create or combine Departments. The Medical Executive Committee may recommend to the Board of Directors that a department or division be eliminated.

## 9.2 Designation

The current departments are:

Anesthesia
Medicine/Family Medicine
Orthopedic Surgery
Pediatrics
Surgery
Emergency Medicine
Obstetrics-Gynecology (OBGY)
Pathology
Radiology
Psychiatry

Departments of Anesthesia, Surgery and Orthopedic Surgery may meet together as one department. Chair of the meeting shall be shared on a rotational basis between the three clinical departments. Departments of Internal Medicine and Emergency Medicine may meet together as one department. Chair of the meeting shall be shared on a rotational basis between the two clinical departments.

## 9.3 Assignment to Departments and Divisions

Each member shall be assigned membership in one Department, and one Division, if any, within such Department, but may be granted clinical privileges in one or more of the other Departments or Divisions. The exercise of privileges within each department shall be subject to the rules and regulations thereof and to the authority of the department chair.

## 9.4 Functions of Departments

The primary responsibility delegated to each Department is to implement and conduct specific review and continuous evaluation of activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the Department.

Following Board of Directors approval and subject to review and approval by the Medical Executive Committee, each department shall establish its own criteria, consistent with the policies of the Medical Staff and of the Board of Directors, for the granting of clinical privileges.

Each department shall establish its own rules and regulations subject to approval by the Medical Executive Committee and shall have a maximum degree of autonomy over the affairs of the department including coordination and integration of interdepartmental services and into the primary functions of the organization provided, however, that the Medical Executive Committee shall have ultimate authority over departmental and interdepartmental affairs.

Each department shall be responsible for the evaluation of the professional performance of its members by generally monitoring the quality of patient care and professional performance rendered by members with clinical privileges in the department through a planned and systematic process and by overseeing the effective conduct of patient care, evaluation, and monitoring functions of the department to include transmission to the Medical Executive Committee the department's recommendations concerning corrective action with respect to practitioners with clinical privileges in his or her department and be responsible for implementation within the department of actions taken by the Medical Executive Committee;

Each department shall assess and recommend to Administration off-site sources for needed patient care, treatment and services not provided by the department/service or the organization;

Each department shall recommend space and other resources needed by the department or service;

Each clinical department shall develop and implement departmental programs for retrospective patient care review, ongoing monitoring of practice, credentials review and privileges delineation, orientation and continuing medical education, utilization review, and performance improvement;

Each department shall develop and implement policies and procedures that guide and support the provision of care, treatment and services;

Each department shall recommend sufficient number of qualified and competent persons to provide care, treatment and services and shall determine the qualifications and competence of department or service personnel, i.e., nurses, respiratory therapists, physical therapists, etc. who are not licensed independent practitioners and who provide patient care, treatment and services;

Each department shall encourage the participation of all Medical Staff members in department continuing education programs and required meetings.

## ARTICLE X

## OFFICERS

### 10.1 General Officers of the Medical Staff

#### 10.1-1 Identification

The general officers of the Medical Staff shall be a Chief of Staff, a Chief of Staff-Elect, Immediate Past Chief of Staff and a Secretary-Treasurer.

### 10.1-2 Qualifications

General officers must be members of the Active Medical Staff at the time of nomination and election and must remain members who are not currently subject to any restriction of privileges or recommendation for corrective action during the term of their office. Failure to maintain such status shall immediately create a vacancy in the office involved.

### 10.1-3 Nominations and Elections

Nominations for officers of the Medical Staff shall be made by the Nominating Committee at the Medical Staff meeting preceding the annual meeting. Nominations may also be made from the floor at such meeting subject to the consent of the nominee. Further nominations may be made for any office by any voting member of the Medical Staff. The name of the candidate must be submitted in writing to the Chair of the Nominating Committee, be endorsed by the signature of at least 15 percent of other members eligible to vote and bear the candidate's written consent. These nominations shall be delivered to the Chair of the Nominating Committee as soon as reasonably practicable, but at least twenty (20) days prior to the date of election. For nominations made in this manner, the voting members of the Medical Staff shall be advised by notices delivered or mailed as soon as practicable, but at least ten (10) days prior to the annual meeting.

### 10.1-4 Election

Except as provided in Section 10.1-5, officers shall be elected by written ballot. Ballots shall be sent to the Active Medical Staff by U.S. mail or electronic ballot at least ten (10) days before the annual meeting of the Medical Staff and ballots shall be returned prior to the day of the annual meeting to the Medical Staff Services Department.

All nominees for election or appointment to Medical Staff offices, department chairships, or the Medical Executive Committee shall, at least 20 days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee, in accordance with Article XII, those personal, professional or financial affiliations or relationships that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

All ballots shall be counted by the Chief of Staff and Secretary-Treasurer of the Medical Staff.

A nominee receiving a plurality of votes cast shall be elected. In the case of a tie, the majority vote of the Medical Executive Committee at its next meeting or at a special meeting called for that purpose shall decide the election. This vote shall be conducted by secret written ballot.

Uncontested Election
If there is only a single candidate for an office, that name shall be declared elected by acclamation and the results announced at the annual meeting of the Medical Staff.

### 10.1-5 Chief of Staff and Immediate Past Chief of Staff Provisions

The Chief of Staff-Elect shall, upon completion of his/her term of office in that position, immediately succeed to the office of Chief of Staff and then to the office of Immediate Past Chief of Staff.

### 10.1-6 Term of Elected Officer

Each officer shall serve a two-year term commencing on the first day of the Medical Staff year following his/her election. Each officer shall serve until the end of his/her term and until a successor is elected, unless he/she shall sooner resign or is removed from office. General officers may be re-elected to serve consecutive terms.

### 10.1-7 Removal of Elected Officers

Any officer whose election is subject to these bylaws may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. Recall of a medical staff officer may be initiated by the Medical Executive Committee or shall be initiated by a petition signed by at least 1/3 (one-third) of the members of the Medical Staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a 2/3 (two-thirds) vote of the Medical Staff members eligible to vote for Medical Staff officers who actually cast votes at the special meeting in person or by mail ballot.

### 10.1-8 Vacancies in Elected Office

Vacancies occur on the death or disability, resignation, or removal of the officer, or that officer's loss of membership in the Medical Staff. Vacancies in office, other than that of Chief of Staff, shall be filled by the Medical Executive Committee. If there is a vacancy in the office of Chief of Staff, the Chief of Staff-Elect shall serve out the remaining term and shall then serve as Chief of Staff for the following term. He/she shall immediately appoint an ad hoc nominating committee to decide promptly upon nominees for the office of Chief of Staff-Elect. Those nominees shall be reported to the Medical Executive Committee and to the Medical Staff. A special election to fill the position shall occur at the next regular staff meeting.

If there is a vacancy in the office of Chief of Staff-Elect, that office need not be filled by election, but the Medical Executive Committee shall appoint an interim officer to fill this office until the next regular election, at which time the election shall also include the office of Chief of Staff. A vacancy in the office of Immediate Past Chief of Staff need not be filled, except that the Medical Executive Committee may appoint qualified successors to serve as the chair of, or as a member of, any committee that the Immediate Past Chief of Staff is automatically appointed to pursuant to these Bylaws.

## 10.2 Duties of General Officers

### 10.2-1 Chief of Staff

The Chief of Staff shall serve as the chief executive officer of the Medical Staff. He/she shall:

a. Act in coordination and cooperation with the Hospital Chief Executive and the Board of Directors in all matters of mutual concern within the Hospital.
b. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.
c. Serve as Chair of the Medical Staff Executive Committee.
d. Serve as an ex officio member of all other Medical Staff committees without vote, unless his/her membership in a particular Committee is required by these Bylaws.

e. Be responsible for the enforcement of Medical Staff Bylaws and Rules and Regulations, for the implementation of sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.
f. Appoint, with Medical Executive Committee approval, Committee chairs to all standing, special, and multi-disciplinary Medical Staff committees, except where otherwise provided by these Bylaws or by Medical Staff Rules and Regulations
g. Serve as a member of the Board of Directors in such capacity as may be permitted or required by the Hospital's corporate Bylaws.
h. Represent the views, policies, needs, and grievances of the Medical Staff to the Board of Directors and to the Hospital Chief Executive.
i. Receive and interpret the policies of the Board of Directors to the Medical Staff and report to the Board of Directors on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care.
j. Be the spokesman for the Medical Staff in its external professional and public relations.
k. Perform such other functions as may be assigned to him/her by these Bylaws, by the membership, by the Executive Committee or by the Board of Directors.

### 10.2-2 Chief of Staff Elect

The Chief of Staff-Elect, in the absence of the Chief of Staff, shall assume all duties and authority of the Chief of Staff; be the Performance Improvement Physician Advisor and a member of the Medical Executive Committee; perform such other supervisory duties as the Chief of Staff may assign to him/her; and carry out such other functions as may be delegated to him/her by these Bylaws, by the membership, by the Medical Executive Committee, or by the Board of Directors. He/she shall automatically succeed the Chief of Staff when the latter fails to serve for any reason.

### 10.2-3 Immediate Past Chief of Staff

The Immediate Past Chief of Staff shall be the Chair of the Bylaws Committee and a member of the Medical Executive Committee, perform such other supervisory duties as the Chief of Staff may assign him/her, and carry out such other functions as may be delegated to him/her by these Bylaws, by the membership, by the Medical Executive Committee, or by the Board of Directors.

### 10.2-4 Secretary-Treasurer

The Secretary-Treasurer shall be a member of the Medical Executive Committee, call meetings on the order of the Chief of Staff, attend to all correspondence, receive, safeguard, and be accountable for all funds of the Medical Staff, and perform such other duties as ordinarily pertain to his/her office or as may be assigned to him/her.

## 10.3 Department Officers

### 10.3-1 Qualifications

Each Department Chair and Vice Chair shall be a member of the Active Medical Staff, be Board Certified in his/her specialty and/or qualified by training and experience and possess comparable competence in at least one of the clinical areas covered by the department, and be willing and able to faithfully discharge the function of his/her office.

### 10.3-2 Selection/Election/Conflict of Interest

All nominees for election or appointment to Medical Staff offices, department chairships, or the Medical Executive Committee shall in accordance with Article XII, at least 20 days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional or financial affiliations or relationships that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

The department chairs and vice chairs shall be elected by the members of the Department who are eligible to vote for officers. Each department chair and vice chair will be elected at the department meeting prior to the annual meeting of the Medical Staff. In the Department of Medicine/Family Practice, each specialty shall be represented on the Medical Executive Committee. If the current chair is a family practitioner, a Medicine representative shall be elected for MEC representation and likewise if the Chair is a specialist in Medicine.

### 10.3-3 Term of Office

Each department chair and vice chair shall serve a two-year term commencing on the first day of the medical staff year. They shall serve until the end of the Medical Staff year or until the successors are chosen, unless either shall sooner resign or be removed from office. A department officer shall be eligible to succeed him/herself.

### 10.3-4 Removal

Any department officer whose election is subject to these Bylaws may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude.

Removal of a department chair or vice chair from office may be initiated by the Medical Executive Committee or by written request from twenty percent (20%) of the members of the chair's or vice chair's department who are eligible to vote. Such removal may be effected by a majority vote of the Medical Executive Committee members or by a majority vote of the Department members eligible to vote on departmental matters. All voting shall be conducted by written secret mail ballot as defined in Article XV, Section 15.5, which shall be sent to those eligible to vote within forty-five (45) days after the initiation of removal pursuant to this section. The ballots must be received no later than twenty-one (21) days after they are mailed and shall be counted by the Chief of Staff and the Secretary-Treasurer. No removal shall be effective unless and until it is ratified by the Medical Executive Committee.

### 10.3-5 Duties

Each department chair shall act as presiding officer at departmental meetings and shall have the following authority, duties, and responsibilities, and the vice chair, in the absence of the chair, shall assume all of them and shall otherwise perform such duties as may be assigned to him/her:

a. Be accountable to the Medical Executive Committee and to the Chief of Staff for all professional and administrative activities within his/her department unless otherwise provided by the hospital, and particularly for the quality of patient care rendered by members of his/her department and for the effective conduct of the monitoring and evaluation activities including performance improvement and other performance improvement, evaluation, and monitoring functions delegated to his/her department.

b. Develop and implement departmental programs in cooperation with the Chief of Staff, monitoring of patient care, credentials review, privileges delineation, medical education, and utilization review.
c. Be a member of the Medical Executive Committee, give guidance on the overall medical policies of the Hospital, and make specific recommendations and suggestions regarding his/her own department in order to assure quality patient care.
d. Maintain continuing review of the professional performance of all practitioners with clinical privileges in his/her department and report regularly thereon to the Medical Executive Committee when problems are identified.
e. Transmit to the appropriate authorities his/her department's recommendations concerning appointment and classification, completion of proctoring requirements, reappointment, delineation of clinical privileges, and corrective action with respect to practitioners in his/her department.
f. Enforce the Hospital and Medical Staff Bylaws, rules, regulations, and policies within his/her department, including initiation of corrective action and investigation of clinical performance and ordering of consultations to be provided or sought when necessary.
g. Implement within his/her department actions taken by the Medical Executive Committee and by the Board of Directors.
h. Participate in every phase of administration of his/her department through cooperation with the Patient Care Services Department and the Hospital administration in matters affecting patient care, including personnel, supplies, special regulations, pre-printed orders, and techniques.
i. Assist in the preparation of such annual reports, including budgeting and planning, pertaining to his/her department as may be required by the Medical Executive Committee or the Board of Directors.
j. Be responsible for the orientation and education program in his/her department.
k. Continuous assessment and improvement of the quality of care, treatment, and services.
l. Maintenance of quality control programs, as appropriate.
m. Assist with recommending space or other resources needed by the department or service.
n. Perform such other duties commensurate with his/her office as may from time to time be reasonably requested of him/her by the Chief of Staff, the Medical Executive Committee, or the Board of Directors.

## ARTICLE XI

## COMMITTEES

### 11.1 General

#### 11.1-1 Designation and Substitution

The committees described in this Article shall be the standing committees of the Medical Staff. Unless otherwise specified, the chair of such committees shall be appointed by the Chief of Staff, subject to the Medical Executive Committee's approval, and such committees shall be responsible to the Medical Executive Committee. The Committee chairs shall appoint the members subject to the membership requirements specified in these Bylaws.

In addition, special committees may be created by the Medical Executive Committee on an ad hoc basis to perform specified tasks. Such committees shall terminate at the conclusion of the special committee’s appointed function. The members of special committees shall be appointed by the Chief of Staff, subject to the Medical Executive Committee's approval.

Whenever these Bylaws require that a function be performed by, or that a report or recommendation be submitted to:

a. A named Committee, but no such Committee shall exist, the Medical Executive Committee shall perform such function or receive such report or recommendation or shall assign the functions of such Committee to a new or existing Committee of the Medical Staff or to the Staff as a whole.
b. The Medical Executive Committee, but a standing or special Committee has been formed to perform the function, the Committee so formed shall act in accordance with the authority delegated to it.

### 11.1-2 Terms and Removal of Committee Members

Unless otherwise specified, a Committee member shall be appointed for a term of two (2) years or the term of office of the current chief of staff which ever is less and shall serve until the end of this period or until his/her successor is appointed unless he/she shall sooner resign or be removed from the Committee. Any committee chair or member may be removed by a majority vote of the Medical Executive Committee. The removal of any Committee member who is automatically assigned to a Committee because he/she is a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official.

### 11.1-3 Vacancies

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

### 11.1-4 Conduct and Records of Meetings

Committee meetings shall be conducted and documented in the manner specified for such meetings in Article XIII.

### 11.1-5 Voting

Unless otherwise indicated, only Committee members who are members of the Medical Staff shall have voting rights.

Officers of the Medical Staff will be ex officio non-voting members of all committees except that they shall be voting members of the Medical Executive Committee.

Committee Chairs shall have the vote only in case of a tie, including the Chair of the Medical Executive Committee.

## 11.2 Bylaws Committee

### 11.2-1 Composition

The Committee shall consist of at least 5 members of the Active Staff representative of each clinical department. The Chair of the Bylaws Committee shall be the Immediate Past Chief of Staff.

### 11.2-2 Duties

a. Conduct an annual review of the Bylaws and the rules, regulations, procedures, and forms promulgated in connection therewith.
b. Submit recommendations to the Medical Executive Committee for changes in these documents.
c. Receive and consider all matters specified in subparagraph (a) as may be referred by the Medical Executive Committee, Board of Directors, the Departments, the Chief of Staff, and the Hospital Chief Executive.

### 11.2-3 Meetings

The Committee shall meet as often as necessary at the call of its chair but at least once each year, shall maintain a record of its proceedings and report to the Medical Executive Committee.

## 11.3 Credentials Committee

### 11.3-1 Composition

The Committee shall consist of a chair appointed by the Chief of Staff and five (5) Active Staff members.

### 11.3-2 Duties

Review and evaluate the qualifications of each practitioner applying for initial appointment, reappointment, or modification of appointment, and for clinical privileges and, in connection therewith, obtain and consider the recommendations of the appropriate departments and submit the report as required by Article V and VI on the qualifications of each practitioner applying or reapplying for membership or particular clinical privileges.

### 11.3-3 Meetings

The Committee shall meet as needed and shall maintain a permanent record of its proceedings and actions.

## 11.4 Infection Control/Transfusion Committee

### 11.4-1 Composition

The Committee shall be multi-disciplinary consisting of a chair selected by the Chief of Staff and at least six (6) members of the Active Medical Staff, with representation from the Departments of Medicine, Surgery, OBGY, Pediatrics, and Pathology. It shall also include consultants in microbiology and epidemiology if so nominated by the pathologist, and representatives from Administration, patient care services, pharmacy, infection control, central service, environmental services and operating room. The voting members of the committee shall include those members of the Medical Staff as well as the Infection Control Practitioner.

### 11.4-2 Duties

a. Develop a hospital-wide infection program and maintain surveillance over the program.
c. Develop a system for reporting, identifying, and analyzing the incidence and cause of all nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, as well as for required follow-up action.
d. Develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing, and evaluating aseptic, isolation, and sanitation techniques. Such techniques shall be defined in written policies and procedures.
e. Develop written policies defining special indications for isolation requirements in relation to the medical condition involved and for monitoring the implementation of the policies and quality of care administered.
f. Develop, evaluate and revise preventive, surveillance, and control policies and procedures relating to all phases of the Hospital's activities, including: operating rooms, delivery rooms, special care units, central service, dietetic service, housekeeping, maintenance, and laundry, sterilization and disinfection procedures by heat, chemicals, or otherwise, isolation procedures, prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment, testing of Hospital personnel for carrier status, disposal of infectious material, food sanitation, waste management and other situations as required
g. Coordinate action on findings from the Medical Staff's review of the clinical use of antibiotics.
h. Act upon recommendations related to infection control from the Chief of Staff, the Medical Executive Committee, the Departments, and other Medical Staff and Hospital Committees.
i. Review sensitivities of organisms specific to the facility.
j. Develop proposed policies and procedures for the screening, distribution, handling and administration of blood and blood components.
k. Evaluate the appropriateness of blood transfusions.

### 11.4-3 Meetings

The Committee shall meet at least quarterly, shall maintain a record of its proceedings and activities and shall report regularly thereon to the Medical Executive Committee.

## 11.5 Interdisciplinary Practice Committee

### 11.5-1 Composition

The Committee shall be multi-disciplinary consisting of at least six (6) members, including, as the minimum, the Director of Nursing, the Hospital Chief Executive or his/her designee, and an equal number of physicians appointed by the Chair and of registered nurses appointed by the Director of Nursing. Licensed or certified health professionals other than registered nurses who perform functions requiring standardized procedures shall be included in Committee deliberations regarding such functions and standardized procedures.

**11.5-2 Duties**

a. **Policies and Procedures:** The Committee shall establish written policies and procedures for the conduct of its business. Policies and procedures shall include but not be limited to:

1. Provision for securing recommendations from Medical Staff members in the medical specialty or clinical field of practice under review, and from persons in the appropriate non-medical category who practice in the clinical field or specialty under review.
2. Methodology for the approval of procedures in accordance with the Business and Professions Code, which requires affirmative approval of the procedures by the Director of Nursing or his/her designee, a majority of the physician members, and a majority of the registered nurse members after consultation has been obtained from Medical and Nursing Staff members practicing in the medical and nursing specialties under review.
3. Provision for maintaining clear lines of responsibility of the Patient Care Services Department for nursing care of patients and of the Medical Staff for medical services in the Hospital.
4. Provision for securing approval for each recommendation of the Committee from the Medical Executive Committee and, if so approved, the Board of Directors.

c. **Registered Nurses:** The Committee shall be responsible for recommending policies and procedures for the granting of expanded role privileges to registered nurses, whether or not employed by the facility, to provide for the assessment, planning, and direction of the diagnostic and therapeutic care of a patient in the Hospital. These policies and procedures will be administered by the Committee, which shall be responsible for reviewing credentials and making recommendations for the granting and/or rescinding of such privileges.

c. **Protocols/Procedures For Registered Nurses:** The Committee shall be responsible for:

1. Identifying the functions and/or procedures which require the formulation and adoption of procedures under the Nurse Practice Act and hospital licensing regulations in order for them to be performed by registered nurses in the Hospital, and initiating the preparations of such procedures in accordance with this section.
2. The review and approval of such standardized procedures covering practice by registered nurses in the Hospital.
3. Recommending policies and procedures for the authorization of employed staff registered nurses to perform the identified functions and/or procedures.

These policies and procedures may be administered by the Committee or by delegation to the Director of Nursing.

d. Each procedure approved by the Committee shall:

1. Be in writing and set forth the date it was approved by the Committee.
2. Specify the procedures which registered nurses are authorized to perform and under what circumstances.
3. State any specific requirements, which are to be followed by registered nurses in performing all or part of the functions, covered by the particular procedure.
4. Specify any experience, training or special education requirements for performance of the procedures.
5. Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform the procedures.
6. Provide for a method of maintaining a written record of those persons authorized to perform the procedures.

7. Specify the nature and scope of review and/or supervision required for the performance of the procedures; for example, if the procedure is to be performed only under the immediate supervision of a physician, that limitation must be clearly stated. If physician supervision is not required, that fact should be clearly stated.
8. Set forth any specialized circumstances under which the registered nurse is to communicate immediately with a patient's physician concerning the patient's condition.
9. State any limitation on settings or departments within the Hospital where the procedure may be performed.
10. Specify any special requirements for procedures relating to patient record keeping.
11. Provide for periodic review of the procedure.
12. To establish a mechanism to discuss and resolve patient care issues that affect quality of care.
13. Enhance and improve communications between patient care services and medical staff.

### 11.5-3 Meetings

The Committee shall meet regularly, but at least annually, and shall maintain a record of its proceedings, and report to the Medical Executive Committee.

## 11.6 Joint Conference Committee

The committee shall act as a liaison between the Board of Directors and the Medical Staff on all matters of mutual interest or concern, and shall make recommendations to the Medical Executive Committee or Board of Directors on such matters that are referred to it by the Medical Executive Committee or the Board of Directors, and report back to the appropriate originating body.
The Medical Staff members of the committee shall be the Chief of Staff and the past three Chiefs of Staff who do not have a contractual or salaried relationship with the Hospital. The Board of Directors representatives will be the Chair of the Board of Directors, two members of the Board of Directors and the Hospital Chief Executive.

The committee shall meet at the call of either the Chief of Staff or the Chair of the Board of Directors, who shall act as co-chairs of the committee. The Chief of Staff and the Hospital Chief Executive shall be non-voting members of this committee.

The Committee shall meet as often as necessary. It shall maintain a record of its proceedings and provide reports as appropriate to the Medical Executive Committee and/or the Board of Directors.

## 11.7 Medical Education & Library Committee

### 11.7-1 Composition

The Committee shall be composed of representatives from Medical Staff departments, from the Library and other hospital departments as deemed necessary. AHPs may be included when appropriate.

### 11.7-2 Duties

The Committee shall organize continuing education programs and coordinate them with the hospital-wide performance improvement program, and supervise the Hospital's professional library services. In particular, the Committee shall:

a. Develop and plan, or participate in, programs of continuing education that are designed to keep the Medical Staff informed of significant new developments and new skills in medicine and that are responsive to audit findings.
b. Evaluate, through the hospital-wide patient care audit and performance improvement function, the effectiveness of the educational programs so developed and implemented, and annually reappraise their effectiveness.
c. Analyze, on a continuing basis, the Hospital's and Staff's needs for professional library services.
d. Act upon continuing education recommendations from the Medical Executive Committee, the departments, or other committees responsible for peer review, and other monitoring, evaluation and performance improvement functions.
e. Maintain a record of education activities and submit periodic reports to the Medical Executive Committee concerning these activities, specifically including their relationship to the findings of performance improvement, evaluation and monitoring functions.

### 11.7-3 Meetings

The Committee shall meet at least quarterly, shall maintain a record of its proceedings, and report to the Medical Executive Committee.

## 11.8 Medical Executive Committee (MEC)

### 11.8-1 Composition

The Committee shall be composed of the Chief of Staff, Chief of Staff Elect, Secretary Treasurer, Immediate past Chief of Staff, the chair of each clinical department (the Department of Medicine representation shall include a representative from Medicine/ Family Practice) and the chair of each standing committee. A majority of the voting Medical Executive Committee members must be fully licensed physicians of the Active Medical Staff who actively practice at Providence LCMMC San Pedro. The Hospital Chief Executive, Chief Nursing Officer, Board of Directors Representative, Bioethics Committee Chair and Medical Staff Committee Chairs shall serve in a non-voting capacity, with the exception of the Credentials Committee chair who shall serve in a voting capacity. Other members may also serve in a non-voting capacity as appointed by the Chief of Staff upon approval of the Medical Executive Committee.

### 11.8-2 Duties

a. Represent and act on behalf of the Medical Staff in the intervals between medical staff meetings, within the scope of its responsibilities as defined by the organized medical staff. Such authority may be removed pursuant to the conflict management process set forth in Article XVI, Section 15.2**.**
b. Coordinate the activities and general policies of the Medical Staff not otherwise established as the responsibility of the departments.
c. Receive and act upon department, division, and committee reports and recommendations.
d. Implement policies of the Medical Staff not otherwise the responsibility of the departments.

e. Provide liaison between the Medical Staff and the Hospital Chief Executive and the Board of Directors.
f. Recommend action to the Hospital Chief Executive on matters of a medico-administrative nature.
g. Make recommendations on Hospital management matters, such as long range planning, to the Board of Directors through the Hospital Chief Executive.
h. Fulfill the Medical Staff's responsibility of accountability and evaluation to the Board of Directors for the medical care rendered to patients in the Hospital.
i. Establish the structure of the Medical Staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of performance improvement activities and mechanisms of the Medical Staff, termination of Medical Staff membership and fair hearing procedures, as well as other matters relevant to the operation of an organized medical staff;
j. Assure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital as well as assist in obtaining and maintaining accreditation;
k. Review the qualifications, credentials, performance and professional competence, and character of applicants and Staff members, and make recommendations for Staff appointment and reappointment, assignments to departments, delineation of clinical privileges (in instances where there is doubt about any applicant's ability to perform privileges requested, the MEC shall request evaluations of staff members, and corrective action;
l. Take all reasonable steps to assure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff and AHPs, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted.
m. Report to the Medical Staff at each General Medical Staff meeting.
n. Provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent.
o. Develop and maintain methods for the protection and care of patients and others in the event of internal or external disaster.
p. Designate such committees as may seem necessary or appropriate to assist in carrying out its functions and those of the Medical Staff, and approve or reject appointments made by the Chief of Staff to those committees.
q. Review the quality and appropriateness of services provided by contract physicians.
r. Perform such other functions as may be assigned to it by these Bylaws, by the Medical Staff, or by the Board of Directors.
s. Take reasonable steps to develop continuing education activities and programs for the Medical Staff.
t. When a new, or replacement, designated representative to the Board of Directors from the Medical Staff is to be appointed to one of the designated Board of Directors seats, the following procedure shall be utilized: The Board of Directors shall send to the Medical Executive Committee a list of five (5) candidates who are members of the Active Medical Staff. The Medical Executive Committee shall discuss each candidate and each member of the Medical Executive Committee shall select three (3) candidates. This vote shall be by secret ballot. The three candidates receiving the highest number of votes shall be submitted to the Board of Directors. The Board of Directors shall select one candidate from the list of three, and that candidate shall be appointed to the Board of Directors.
u. Set the amount of annual dues, if any, for each category of the Medical Staff and the amount of the processing fee for initial applications, and to determine the manner of expenditure of funds received.
v. Take a leadership role in the performance improvement activities as outlined in the Organizational Plan for Performance Improvement.

w. Receive and act on reports from the Core Event Response Team (CERT) (the body responsible for review of sentinel events) which shall function as a performance improvement task force of the Medical Executive Committee.
x. Make recommendations directly to the Board of Directors.

### 11.8-3 Authority to Act

Action of the Medical Staff in relation to any person other than the members thereof shall be expressed only through the Chief of Staff or the Medical Executive Committee, or his/her or its designee, and they shall first confer with the Hospital Chief Executive. Any member or members who act in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee or Board of Directors may deem necessary. However, this provision shall not apply if the action involves the Hospital Chief Executive. In such circumstance, the Chief of Staff or Medical Executive Committee may confer directly with the Board of Directors.

### 11.8-4 Meetings

The Medical Executive Committee shall meet at least ten (10) times per year and maintain a permanent record of its proceedings and actions.

## 11.9 Medical Staff Aid Committee

### 11.9-1 Composition

The Committee shall be comprised of no less than 3 Active members of the Medical Staff, a majority of which, including the Chair, shall be physicians. Except for initial appointments, each member shall serve a term of three (3) years and the term shall be staggered as deemed appropriate by the Medical Executive Committee to achieve continuity. Insofar as possible, members of this Committee shall not serve as active participants on other peer review or performance improvement committees while serving on the Committee.

### 11.9-2 Duties

The Committee may receive reports relative to the health, well-being or impairment of Medical Staff members and, as it deems appropriate, may investigate such reports. For matters involving individual Medical Staff members, the Committee may, on a voluntary basis, provide such advice, counseling, or referrals as may seem appropriate. These activities shall be confidential; however, if information received by the Committee clearly documents that the health or known impairment of a Medical Staff member poses an unreasonable risk of harm to hospitalized patients, that information may be referred for corrective action. The Committee shall also consider general matters related to the health and well-being of the Medical Staff and, with the approval of the Medical Executive Committee, develop educational programs or related activities in coordination with the Medical Education & Library Committee.

### 11.9-3 Meetings

The Committee shall meet as often as necessary, but at least quarterly. It shall maintain only such record of its proceedings as it deems advisable, but shall report on its activities on a routine basis to the Medical Executive Committee.

## 11.10 Nominating Committee

### 11.10-1 Composition

The Committee shall be made up of the officers of the Medical Staff, including the Immediate Past Chief of Staff and one (1) representative from each clinical department selected by that department chair. The Chief of Staff shall act as the Committee Chair.

### 11.10-2 Duties

The Committee shall meet as necessary to nominate candidates for Medical Staff Officers.
The Committee shall, when requested by the Chief of Staff, nominate candidates for Medical Staff representative to other hospital-affiliated organizations.

### 11.10-3 Meetings

The Committee shall meet as needed.

## 11.11 Pharmacy and Therapeutics Committee

### 11.11-1 Composition

The Committee shall consist of a chair appointed by the Chief of Staff and at least five (5) representatives from the Medical Staff and one each from the Pharmaceutical Service, the Patient Care Services, and the Hospital Administration. The Hospital Pharmacist shall be an ex officio member of the Committee without voting privileges. The Chair may appoint advisory members without vote to the Committee.

### 11.11-2 Meetings

The Committee shall meet as often as necessary at the call of its Chair, but at least quarterly. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

### 11.11-3 Duties

The Committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital in order to assure optimum clinical results and minimum potential for hazard. It shall also perform the following specific functions:

a. Assist in the formulation of broad professional policies regarding the, storage, distribution, use, safety procedures, administration and all other matters relating to drugs in the Hospital, including antibiotic usage.
b. Review all significant untoward drug reactions and medication errors.
c. Delegates authority for formulary decision making to the Centralized PH&S formulary process, led by a representative PH&S formulary committee of experts in medicine, pharmacy, and nursing throughout the system and continuum of care, that ensures patients of Providence and its affiliates are provided with safe, high-quality, and affordable medications throughout the continuum of care.
d. The Committee accepts and adheres to the outcomes of the centralized PH&S formulary process.

e. The Committee meetings will include and document decisions of the PH&S formulary committee, which is comprised of representatives from medicine, pharmacy, and nursing throughout the system and continuum of care.
f. The Committee or an individual provider in coordination with a P&T led pharmacist, may petition a PH&S formulary decision through the centralized PH&S formulary appeal process with the understanding the burden of proof of value (safety, efficacy, cost) is on those who advocate the alternative.
g. Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients.
h. Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.
i. Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.
j. Perform such other duties as assigned by the Chief of Staff or the Medical Executive Committee.

## 11.12 Physician Performance Committee

### 11.12-1 Composition

The committee shall consist of representatives of each clinical department and the Officers of the medical Staff. The PPC shall also include representatives from the Hospital's administrative and management staff to include the Hospital Chief Executive, Chief Nursing Officer, Director of Performance Improvement, and other members of the administrative and management staff as deemed necessary.

### 11.12-2 Duties

The PPC shall take a leadership role in the following:

a. Active involvement in the process to improve quality, treatment, services, and patient safety.
b. Active involvement in the organization's quality and performance improvement plan.
c. Active in the measuring, assessing, educating, and improving processes of the licensed practitioners who are credentialed and privileged through the medical staff process.
d. The PPC shall make recommendations to the Medical Executive Committee regarding the ongoing professional practice and reappointment of members including privileges. (See Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation policy/procedure).

### 11.12-3 Meetings

The Committee shall meet as often as necessary, but at least quarterly. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

## 11.13 Utilization Review/Medical Records Committee

### 11.13-1 Composition

The Committee shall consist of sufficient members to afford, insofar as feasible, representation from the major specialty departments. Subcommittees may be appointed by the committee for departments or divisions as the committee may deem appropriate. Representatives from administration will include Utilization Review/Discharge Planning, Health Information Management (AKA Medical Records) and others as deemed necessary by the Chair.

### 11.13-2 Duties

The duties of the Committee shall include:

a. conducting utilization review studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and related factors which may contribute to the effective utilization of services. The committee shall make recommendations for the utilization of resources and facilities commensurate with quality patient care and safety;
b. establishing a utilization review plan which shall be approved by the Medical Executive Committee;
c. obtaining, reviewing, and evaluation information and raw statistical data obtained or generated by the hospital's case management system;
d. reviewing and evaluating medical records to determine whether they:
    1. clearly, completely and accurately describe the condition and progress of the patient, the therapy provided, the results thereof, in hospital progress of the patient, condition at time of discharge, and provide adequate identification and records of individual responsibility for all actions taken;
    2. are sufficiently complete at all times to facilitate continuity of care and communications between all individuals providing patient care services in the Hospital; and
    3. for psychiatric or substance abuse services provided in the hospital, that medical records include documentation for the use of restraint or seclusion, electroconvulsive shock therapy, other forms of convulsive therapy, psychosurgery, behavior modification procedures that use aversive condition and other special treatment procedures for children and adolescents as required by California law and The Joint Commission standards.
e. reviewing and making recommendations on Medical Staff and Hospital policies and Rules and Regulations relating to medical records, including medical records completion, forms, formats, filing, indexing, storage, destruction and availability, and recommend methods of enforcement thereof and changes therein;
f. approving all forms, which relate to medical care prior to their inclusion in the medical record.
g. acting upon recommendations from the Medical Executive Committee, the Departments, and other Committees responsible for patient care audit and other performance improvement, evaluation and monitoring functions; and

### 11.13-3 Meetings

The Committee shall meet at least quarterly. It shall maintain a permanent record of its findings, proceedings and actions, and shall make a report of its activities and recommendations to the Medical Executive Committee.

### 11.14 Conflicts Resolution Committee

Within 15 days after the receipt of the petition described in Article XVI, Section 16.2, the Medical Executive Committee will appoint a Conflicts Resolution Committee to address the issues identified in the petition. Including but not limited to meeting with members of the medical staff who may have necessary input and gathering information regarding the conflict, working with the parties to manage and, when possible, to resolve conflict; and protect the safety and quality of patient care.

The Conflicts Resolution Committee voting members include an equal number of members of the Medical Executive Committee and members who were nominated in the Petition, and a non-voting Chair. The Conflicts Resolution Committee will discuss and attempt to resolve the conflict described in the petition. The Conflicts Resolution Committee Chair will report the results of the committee's efforts back to the Medical Executive Committee not more than 30 days after the Conflicts Resolution Committee was appointed. Unless a majority of the Conflicts Resolution Committee's voting members requests continuation of the Conflict Resolution Committee's deliberations and the request is approved by the Medical Executive Committee, the Conflicts Resolution Committee will dissolve thirty (30) days after its Chair reported the results of the committee's efforts to the Medical Executive Committee. Under no circumstances will deliberations continue beyond sixty (60) days after the Conflicts Resolution Committee members are appointed.

## ARTICLE XII

## CONFLICT OF INTEREST STATEMENT

### Section 12.1 Conflict of Interest

All Medical Staff Officers (general officers and department and committee chairs) are in a representative capacity or fiduciary responsibility and their relationship calls for a standard of loyalty to the Medical Staff and to the extent that these members may owe a similar duty of loyalty to other organizations, these members have a duty to disclose conflicts which may arise and to act only in the best interest of the Medical Staff in the exercise of their office.

While it is impossible to list every circumstance giving rise to possible conflicts of interest, the following listing will serve as a guide to the types of activities which might cause conflicts and which need to be fully disclosed to the Medical Staff:

a. Outside business activities. Outside business activities or financial interests which may affect objectivity in representing the Medical Staff must be reported.
b. Outside organizations. This would include obligations by an individual, including responsibilities as an officer or director of another organization, hospital, or enterprise dedicated to the furtherance of any policy which may be in conflict with a specific policy of this Medical Staff.
c. Providence Little Company of Mary Medical Center San Pedro and related organizations. Written or unwritten agreements in a paid or unpaid capacity to provide clinical and/or non-clinical services as a director, manager, or consultant to Providence Little Company of Mary Medical Center San Pedro Corporation or any related entities or ventures. Any financial arrangement or obligation to any outside concern including the Providence Little Company of Mary Medical center Corporation.
d. Inside information. Disclosure or use of confidential Medical Staff information for the personal profit or advantage of the individual or anyone else.

### Section 12.2 Medical Staff Who Shall Execute the Conflict of Interest Statement Annually

a. All candidates for the position of Medical Staff officer or department chair shall execute the Medical Staff Conflict of Interest Statement at least 30 days prior to the election. This includes nominees from the floor at a nominating meeting.
b. All candidates for Medical Staff committee chairs shall execute the Medical Staff Conflict of Interest Statement upon consideration of their selection by the Chief of Staff. Their statement will be examined by a special session of the Medical Executive Committee prior to confirmation of their appointment. This special session will take place prior to the January Medical Executive Committee meeting and will consist of the new officers and departmental chairs excluding Medical Staff committee chairs.
c. Medical Staff officers, Department chairs, and Medical Staff committee chairs shall execute such additional Medical Staff Conflict of Interest Statements as become necessary in the event a potential conflict arises during their term of office. These additional Medical Staff Conflict of Interest Statements shall be submitted to the Medical Executive Committee within 30 days after the possible conflict occurs.

### Section 12.3 Disclosure of Conflicts of Interest

Ballots for candidates for Medical Staff officers and departmental chairs shall be accompanied by a list of possible conflicts of interest as noted in the Medical Staff Conflict of Interest Statement.

Candidates for Medical Executive Committee chairs shall list any possible conflict of interest on the Medical Staff Conflict of Interest Statement which will be presented to the Medical Executive Committee prior to approval of appointments.

All Medical Staff Conflict of Interest Statements for the current year shall be kept on file in the Medical Staff Services Department available for review by all Active Medical Staff members.

### Section 12.4 Failure to Properly Execute the Medical Staff Conflict of Interest Statement

Candidates for any office requiring a Medical Staff Conflict of Interest Statement who fail to provide such a statement or who falsify their statement, may be disqualified from their Medical Staff office. This determination will be made by the Medical Executive Committee.

## ARTICLE XIII

## MEETINGS

### 13.1 Meetings

### 13.1-1 Annual Meeting

There shall be an annual meeting of the Medical Staff members in December. The Chief of Staff shall present a report on actions taken by the Medical Executive committee during the preceding year and on other matters believed to be of interest and value to the membership. Notice of this meeting shall be given to the membership at least twenty (20) days prior to the meeting

### 13.1-2 Regular Meetings

Regular meetings of the membership shall be held at least each quarter, except that the annual meeting may constitute the meeting for one of the quarters. The date, place, and time of the regular meetings shall be determined by the Medical Executive Committee.

### 13.1-3 Agenda

The order of business at a regular meeting shall be determined by the Chief of Staff. The agenda shall include at least:

a. Reading and acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting.
b. Administrative reports from the Hospital Chief Executive, Chief of Staff, the departments, and committees.
c. The election of officers when required by these Bylaws.
d. Reports by responsible officers, committees, and departments on the overall results of monitoring and evaluation activities including performance improvement of the Staff and on the fulfillment of the other required Staff functions.
e. Recommendations for improving patient care within the Hospital.
f. New business.

### 13.1-4 Special Meetings

Special meetings of the Medical Staff may be called at any time by the Chief of Staff, at the request of the Board of Directors, the Medical Executive Committee or ten percent (10%) of the Active Medical Staff members. The meeting must be called within thirty (30) days after receipt of such request. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

## 13.2 Committee and Department Meetings

### 13.2-1 Regular Meetings

Committees and departments, by resolution, may provide the time for holding regular meetings.

### 13.2-2 Special Meetings

A special meeting of any committee or department may be called by, or at the request of, the chair thereof, the Medical Executive Committee, the Chief of Staff or by one-third of the group's current members, but not less than two members.

## 13.3 Notice of Meetings

Written notice stating the place, day, and hour of any regular or special Medical Staff meeting or of any regular or special committee or department meeting not held pursuant to resolution shall be delivered either personally or by mail to each person entitled to be present thereat not less than seventy-two (72) hours nor more than twenty (20) days before the date of such meeting, in the manner specified in Section 15.4, hereof. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

### 13.4 Quorum

#### 13.4-1 Staff Meetings

The presence of fifty percent (50%) of the total membership of the Active Medical Staff at any regular or special meeting shall constitute a quorum for the purpose of amending these Bylaws. The presence of thirty-three and one third percent (33-1/3%) of such membership shall constitute a quorum for all other actions.

#### 13.4-2 Committee Meetings

A quorum shall consist of at least two (2) voting members of a Committee, with the exception of the Medical Executive Committee where the quorum shall be 50% of the voting members.

#### 13.4-3 Department Meetings

Quorums for department meetings shall be specified in the departmental rules and regulations.

### 13.5 Manner of Action

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be required by these Bylaws.

Committee action may be conducted by telephone conference, which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Action may be taken without a meeting by a department, committee, or the Medical Executive Committee by a writing setting forth the action so taken signed by at least two-thirds of the members entitled to vote thereat.

### 13.6 Minutes

Minutes of all meetings shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the recording secretary and a synopsis of action items forwarded to the Medical Executive Committee. Each committee and department shall maintain a permanent file of the minutes of each meeting.

### 13.7 Special Appearance at a Meeting

A practitioner whose patient's clinical course of treatment is scheduled for discussion at a regular department or committee meeting shall be so notified.

Whenever an apparent or suspected deviation from standard clinical practice is involved, notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting, a statement of the issue involved and notification to the practitioner that his/her appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to which he/she was given such notice, unless excused by the Medical Executive Committee upon a showing of good cause, shall result in a automatic suspension of all or such portion of the practitioner's clinical privileges as the Medical Executive Committee may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Medical Executive Committee, as provided in Section 7.3-6.

### 13.8 Conduct of Meetings

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order, however, technical failures to follow such rules shall not invalidate action taken at such a meeting.

### 13.9 Executive Session

### 13.9-1 General Staff Meeting

At the call of its Chief of Staff, the General medical staff may meet in executive session, with attendance restricted to medical staff members, a recording secretary, and such advisors or other attendees as the Chief of Staff may specifically request to attend.

### 13.9-2 Committee and or Department Meeting

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

## ARTICLE XIV

## CONFIDENTIALITY, IMMUNITY, AND RELEASES

### 14.1 Special Definitions

For the purposes of this Article, the following definitions shall apply:

a. **Information** means all acts, communications, records of proceedings, minutes, other records, reports, memoranda, statements, recommendations, data, and other disclosures, whether in written, recorded, computerized or oral form, relating to professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.
b. **Health Practitioner** means a practitioner or an allied health professional.
c. **Representative** means a board, any director, a committee, a chief executive officer or Hospital Chief Executive or other health care institution or their designee; a Medical Staff entity, an organization of health practitioners, a professional review organization, a state or local board of medical or professional licensing agency (i.e. Medical Board of California), and any members, officer, department or committee thereof, and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.
d. **Third Parties** means both individuals and organizations providing information to any representative.

### 14.2 Authorizations and Conditions

By applying for or exercising clinical or practice privileges within this Hospital, a health practitioner:

a. Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing on his/her professional ability and qualifications.
b. Authorizes third parties and their representatives to provide information, including otherwise privileged or confidential information, concerning such health practitioner to the Hospital and its Medical Staff.
c. Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article.
d. Acknowledges that the provisions of this Article are express conditions to his/her application for or acceptance of Medical Staff membership and the continuation of such membership, or to his/her exercise of clinical privileges at this Hospital, or to his/her application for or acceptance of approval and exercise of practice privileges at this Hospital.

### 14.3 Confidentiality of Information

Information with respect to any health practitioner submitted, collected or prepared by any representative for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality or contributing to clinical research shall be confidential, to the fullest extent permitted by law, and shall not be disseminated to anyone other than representative, nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the Medical Staff committee files and shall not become part of any particular patient's file or of the general Hospital records.

Any breach of confidentiality of the discussions or deliberations of Medical Staff departments, divisions, or committees, except in conjunction with other Hospital, society or licensing authority, is outside the appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the hospital. If it is determined that a breach has occurred, the Medical Executive Committee shall undertake corrective action as deemed appropriate.

### 14.4 Immunity from Liability

#### 14.4-1 For Action Taken

Each representative of this Hospital, including its Medical Staff members, shall be exempt, to the fullest extent permitted by law, from liability to a health practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of his/her duties as a representative.

#### 14.4-2 For Providing Information

Each representative of this Hospital, including its Medical Staff members, and all third parties shall be exempt, to the fullest extent permitted by law, from liability to a health practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative concerning a health practitioner.

### 14.5 Activities and Information Covered

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

a. Applications for appointment, reappointment, clinical privileges, practice privileges, and prerogatives and periodic reappraisals of a health practitioner's membership, privileges, and/or prerogatives.
b. Corrective action.
c. Hearings and appellate reviews.
d. Hospital, department, committee, or other Medical Staff activities related to monitoring, maintaining, and improving the quality of patient care, appropriate utilization, and appropriate professional conduct.
e. National Practitioner Data Bank queries and reports, PRO, other peer review organizations, Medical Board of California and like reports.

### 14.6 Releases

Each health practitioner, upon request of the Hospital, shall execute general and specific releases in accordance with the provisions, tenor, and import of this Article. Execution of such releases shall not however, be deemed a prerequisite to the effectiveness of this Article.

## ARTICLE XV

## GENERAL PROVISIONS

### 15.1 Rules, Regulations and Policies

#### 15.1-1 Medical Staff Rules, Regulations and Policies

Subject to the approval of the Board of Directors, which approval shall not unreasonably be withheld, the Medical Executive Committee shall adopt such Rules and Regulations and Policies as may be necessary to implement more specifically the general principles stated in these Bylaws. Such Rules and Regulations shall be considered of equal dignity with these Bylaws. Amendments shall become effective only after approval by the Board of Directors.

#### 15.1-2 Departmental Rules and Regulations

Subject to the approval of the Medical Executive Committee and the Board of Directors, each department shall formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these Bylaws, the general Rules and Regulations of the Medical Staff, or other policies of the Hospital.

### 15.2 Conflict Management Process

Under the following circumstances the Medical Executive Committee will initiate a conflict management process to address disagreement between members of the medical staff and the Medical Executive Committee about an issue relating to the medical staff's documents or functions, including but not limited to a proposal to adopt or amend the medical staff bylaws, rules and regulations or policies; or a proposal to remove some authority delegated to the Medical Executive Committee by the medical staff under these bylaws (by amending the bylaws):

Upon written petition signed by either:
a) At least 25% of the voting members of the medical staff, or
b) At least 2/3 of the members of any clinical department of the medical staff
c) Upon the Medical Executive Committee's own initiative at any time; or
d) As otherwise specified in these bylaws

A request to invoke the conflict management process must be submitted within any deadline specified in these bylaws.

A petition to initiate the conflict management process will designate two active medical staff members to serve as representatives of the petitioners, describe the nature of the conflict, and state the reasons why the conflict management process will do all of the following:

a) Provide a reasonably timely, efficient, and meaningful opportunity for the parties to express their views;
b) Require good-faith participation by representatives of the parties, and
c) 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 the medical 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 will be a necessary prerequisite to any proposal to the Board of Directors by medical 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 medical staff.

Nothing in this Section is intended to prevent medical staff members from communicating with the Board of Directors about medical staff bylaws, rules and regulations, or policies; according to such procedures as the Board of Directors will specify.

Within 15 days after the receipt of the petition described in Article XVI, Section 16.2, the Medical Executive Committee will appoint a Conflicts Resolution Committee to address the issues identified in the petition. Including but not limited to meeting with members of the medical staff who may have necessary input and gathering information regarding the conflict, working with the parties to manage and, when possible, to resolve conflict; and protect the safety and quality of patient care.

The Conflicts Resolution Committee voting members include an equal number of members of the Medical Executive Committee and members who were nominated in the Petition, and a non-voting Chair. The Conflicts Resolution Committee will discuss and attempt to resolve the conflict described in the petition. The Conflicts Resolution Committee Chair will report the results of the committee's efforts back to the Medical Executive Committee not more than 30 days after the Conflicts Resolution Committee was appointed. Unless a majority of the Conflicts Resolution Committee's voting members requests continuation of the Conflict Resolution Committee's deliberations and the request is approved by the Medical Executive Committee, the Conflicts Resolution Committee will dissolve thirty (30) days after its Chair reported the results of the committee's efforts to the Medical Executive Committee. Under no circumstances will deliberations continue beyond sixty (60) days after the Conflicts Resolution Committee members are appointed.

### 15.3 Professional Liability Insurance

Professional Liability Insurance: Each member (excluding Honorary Staff) shall maintain professional liability insurance in not less than the minimum amounts determined by the Medical Executive Committee annually with an insurance carrier admitted to market insurance in the State of California or a physician mutual cooperative trust, operated in compliance with California law. Practitioners shall carry professional liability insurance with an insurance carrier or risk retention group that is:
A) an admitted insurance carrier, as determined by the State of California Department of Insurance, with a Bests (or equivalent rating system) rating of B+ or better; or
B) a non-admitted insurance carrier or risk retention group as long as the practitioner meets the following criteria:
Annually, any physician whose professional liability insurance is provided through either a non-admitted insurance carrier or risk retention group must furnish to the medical staff office a written statement from such risk retention group or non-admitted insurance carrier certifying to the following information:
Non-Admitted Insurance Carriers:

a. An A.M. Bests rating (or equivalent) of B+ or better.
b. A positive Standard and Poor's Outlook (or equivalent).
c. Confirmation that the non-admitted insurance carrier meets all applicable legal and regulatory requirements of the state in which such carrier is domiciled, and assurance that such carrier is not on such state insurance commissioner's supervision or watch list.
d. Meets National Association of Insurance Commissioners (NAIC) accreditation or equivalent requirements.
e. Meets financial solvency requirements of the state or country of its domicile.

1. Risk Retention Groups:
    1. Evidence of good standing with insurance commissioner's office in state or country of domicile.
    2. Meets financial solvency requirements of its state or country of domicile.
    3. No adverse financial information on risk retention group website (www.RRR.com).
    4. An A.M. Bests Rating (or equivalent) of B+ or better.
    5. Positive Standard and Poor's Outlook (or equivalent).

It is the responsibility of the medical staff member to furnish such information annually in a format satisfactory to the Hospital and medical staff. Additional criteria may be sought if the carrier is unable to provide the necessary certification as required above. Hospital and medical staff may elect to waive one or more of the above criteria based on evaluation and recommendations of the PH&S Office of Risk Management.

Required Coverage: The minimum amounts of coverage shall be determined by the Medical Executive Committee (see Medical Staff Services Department for amount). If any change in these limits occur, the Medical Executive Committee shall designate when the change shall be implemented by the member. The insurance coverage shall apply to all procedures the member has privileges to perform in the Hospital.

Proof of Insurance: Proof of insurance coverage must be provided in the form of current certificates of insurance, which shall be maintained in each member's credentials file. Information about insurance coverage must be provided at the time of appointment and reappointment and upon request from the Medical Staff.

At the time of initial appointment and reappointment and upon request from the Medical Staff, each applicant or member must provide information on any professional liability claims filed against him/her or her, any malpractice claims reported to his/her insurance carrier, any letters of intent to sue he/she or she received, any claims pending, any judgment entered against him/her or her, and any settlement made where there was a monetary payment. In addition, the applicant or member must state whether he/she or she was denied professional liability insurance, had his/her policy canceled, had limitations placed on his/her or her scope of practice, or has been notified of any intent to deny, cancel, or limit coverage.

Reporting Changes: Each member shall report any reduction, restriction, cancellation, or termination of the required professional liability insurance or change in insurance carrier as soon as reasonably possible to the Medical Staff Services Department.

Failure to Maintain Professional Liability Insurance: The automatic suspension procedure set forth in the Medical Staff Bylaws shall be followed in the event a member fails to maintain insurance in the required amount.

### 15.4 Dues

All members with the exception of Honorary and other categories as determined by the Medical Executive Committee shall be required to pay annual dues. A failure to pay such dues, following receipt of the third and final notice, which shall be sent, via Certified Mail, Return Receipt Requested, shall be deemed a resignation of membership and privileges.

### 15.5 Notice

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests, and other communications required or permitted to be served on or given to a party or parties by another, pursuant to these Bylaws, shall be in writing and shall be delivered personally or by United States Postal Service, first-class postage prepaid, certified or registered, return receipt requested. In the case of notice to Hospital, Medical Staff or officers or Committee thereof, the notice shall be addressed as follows:

_____
[Name and Proper Title of Addressee]

_____
[Name of Department, Division, or Committee]
Little Company of Mary - San Pedro Hospital
1300 West Seventh Street
San Pedro, California 90732

In the case of a notice to a practitioner, or other party, the notice shall be addressed to the address as it appears in the records of the Hospital. If personally delivered, such notice shall be effective upon delivery, and if mailed as provided for above, such notice shall be effective two (2) days after it is placed in the mail. Any party may change its address as indicated above, by giving written notice of such change to the other party in the manner as above indicated.

### 15.6 Secret Written Ballot

Whenever these Bylaws require voting by secret, written mail ballot, the mail ballots shall be returned in an unmarked envelope, which shall be placed inside a properly identified return envelope on which the Staff member has printed and signed his/her name. The Staff member's name shall be verified against the Medical Staff records.

### 15.7 Medical Staff Credentials Files

### 15.7-1 Insertion of Adverse Information

Any person may provide information to the Medical Staff about the conduct, performance or competence of its members, pursuant to Section 7.1-1. When a request is made for insertion of adverse information into the Medical Staff member's credentials files, the respective department chair and Chief of Staff shall review this request. After this review, a decision will be made by the respective department chair and Chief of Staff to:

a. Not insert the information;
b. Insert the information with a notation that no further review is warranted; or
c. Insert the information with a notation that a request has been made to the Medical Executive Committee for an investigation as outlined in Section 7.1-2 of these Bylaws.

### 15.7-2 Review of Adverse Information at the Time of Reappraisal and Reappointment

Prior to recommendation on reappointment, the department chair, as part of the reappraisal function, shall review any adverse information in the credentials file pertaining to a member. Following this review, the department chair shall determine whether documentation in the file warrants further action.

a. If it does not appear that an investigation and/or adverse action on reappointment is warranted because of the adverse information, the department chair shall so inform the Medical Executive Committee;
b. If an investigation and/or adverse action on reappointment is warranted, the department chair shall so inform the Medical Executive Committee.

No later than [60] days following final action on reappointment, the Medical Executive Committee shall, except as provided in this section:

a. Initiate a request for corrective action, based on such adverse information and on the department chair's recommendation relating thereto, or
b. Cause the substance of such adverse information to be summarized and disclosed to the member.

The member shall have the right to respond thereto in writing, and the Medical Executive Committee may elect to remove the adverse information on the basis of such response.

### 15.7-3 Confidentiality

The records of the Medical Staff and its Committees responsible for the evaluation and improvement of the quality of patient care provided in the Hospital shall be maintained as confidential. Access to such records shall be limited to duly appointed officers and Committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities, subject to the requirement that confidentiality be maintained. Information shall be disclosed or available to the Board of Directors of the Hospital or its designee to allow the Board of Directors to discharge its lawful obligations and responsibilities and shall be maintained as confidential.

Information in the credentials file of any member may be disclosed with the member's consent, or to any Medical Staff, Hospital, professional licensing board, medical school, or underwriting committee. However, any disclosure outside of the Medical Staff or the Hospital, except with the member's consent, shall require the authorization of the Chief of Staff and the concerned department chair.

In the event a Notice of Charges is filed against a member, access to his/her own credentials file shall be governed by Section 8.4-1.

### 15.7-4 Member's Access to File

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

a. Timely notice of this request shall be made by the member to the Chief of Staff, or his/her or her designee;
b. The member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A written summary of all other information, including, but not limited to materials such as peer review committee findings, letters of reference, proctoring reports and complaints, shall be prepared for the member if requested in writing, by the designated officer of the Medical Staff, at the time the member reviews his/her credentials file or within a reasonable period of time, as determined by the Medical Staff. This summary shall disclose the substance, but not the sources, of the information summarized;
c. The review by the member shall take place in the Medical Staff Services Department, during normal working hours, in the presence of an officer or designee of the Medical Staff.

### 15.7-5 Corrections, Deletions and Additions to the Credentials File

a. When a member has reviewed his/her file as provided under Section 15.6-4, he/she may request, in writing, that the Chief of Staff make a correction or deletion of information in his/her credentials file. The request shall include a statement of the basis for the action requested.
b. The Chief of Staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Committee, after such review, whether or not to make the correction or deletion requested. The Medical Executive Committee then, by a majority vote, shall either ratify or initiate action contrary to this recommendation.
c. The member shall be notified promptly, in writing, of the decision of the Medical Executive Committee.
d. A member shall have the right to add to his/her own credentials file, upon written request to the Medical Executive Committee, a statement responding to any information contained in the file, regardless of any action taken pursuant to this Section.

## ARTICLE XVI

## REVIEW, REVISION, ADOPTION AND AMENDMENT OF BYLAWS

### 16.1 Procedures

The Medical Staff Bylaws and Rules and Regulations of the Medical Staff are compatible with the Board of Directors Bylaws and are compliant with laws and regulations. These Bylaws may be adopted, amended, or repealed by one of the following methods:

a. At any regular or special meeting of the Medical Staff, provided that notice of such business is sent to all members not later than thirty (30) days before such meeting. The notice shall include the exact wording of the proposed addition or amendment, if applicable, and the time and place of the meeting. In order to enact a change, the affirmative vote of a majority of the Active Medical Staff members present at the meeting shall be required.
b. By mail ballot utilizing the process outlined in Section 15.5 of these Bylaws and provided the ballot packet includes the exact wording of the proposed addition or amendment. The notice shall be mailed to all Active Medical Staff members at least thirty (30) days before the closing date for submitting ballots. A majority of the Active Medical Staff members eligible to vote is required for approval by this method.

### 16.2 Practitioner Rights

Any practitioner may challenge a rule or policy established by the Medical Executive Committee. In the event a rule, regulation or policy is felt to be inappropriate, any physician may submit a petition, signed by at least 25% of the members of the Active Staff. When such petition has been received by the Medical Executive Committee it will either:

Provide the petitioners with information clarifying the intent of such rule, regulation or policy, and/or refer the matter to the Conflicts Resolution Committee.

In addition to the mechanisms set forth above, by which the medical staff may adopt medical executive committee-proposed amendment(s) to these bylaws, the medical staff may adopt amendments to the bylaws (without Medical Executive Committee support) and propose such amendment(s) directly to the Board of Directors for its approval, but only in accordance with the following procedure:

A proposal to amend the bylaws may be initiated by submitting to the medical staff office a petition signed by at least 25% of the voting active medical staff members proposing a specific bylaws amendment or amendments (which will constitute notice of the proposed bylaws amendment(s) to the Medical Executive Committee). Any such petition must identify two active medical staff members who will serve as representatives and act on behalf of the petition signers in the process described below (including any conflict management processes).

Upon submission of such a petition, the Medical Executive Committee will determine whether it supports the proposed bylaws amendment(s) and if so, the medical staff office will arrange for a vote on the proposed bylaws amendment(s) by the voting members of the active medical staff according to the process described above for voting on Medical Executive Committee-proposed bylaws amendments.

If the medical staff adopts the Medical Executive Committee-supported proposed bylaws amendment(s) by a vote of the medical staff conducted according to the process described above, then the proposed bylaws amendment(s) will be submitted to the Board of Directors for approval. If the medical staff does not adopt the Medical Executive Committee-supported proposed bylaws amendment(s) they will be deemed withdrawn.

If the Medical Executive Committee does not support the proposed bylaws amendment(s), the Medical Executive Committee 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 these bylaws. If the conflict management process is not invoked within 30 days, it will be deemed waived and the proposed bylaws amendment(s) will be deemed withdrawn.

If the conflict is not resolved by withdrawal of the proposed Bylaws amendment(s) as modified in the conflict management process, then the proposed bylaws amendment(s) will be submitted (in original form or, if the originally proposed bylaws amendment(s) have been modified in the conflict management process, then as modified) to the medical staff for a vote. The proposed bylaws amendment(s) will be submitted to the Board of Directors if a majority of the active medical staff members who are eligible to vote cast their ballots in favor of the proposed bylaws amendment(s)

A copy of the Medical Executive Committee's written statement of its decision and reasons issued at the conclusion of the conflict management process will be provided to the Board of Directors along with any proposed bylaws amendment(s) submitted to the Board of Directors after such process.

Such proposed bylaws amendment(s) will become effective immediately upon Board of Directors approval, which will not be withheld unreasonably.

If the Board of Directors does not approve the proposed bylaws amendment(s) then the matter will be referred to the conflict management process of the Bylaws for management of conflicts between the Board of Directors and medical staff.

Subject to approval by the Board of Directors, 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 Board of Directors may unilaterally amend the medical staff rules and regulations or policies.

Proposals for new rules and regulations or policies of the medical staff, or amendments to existing rules and regulations or policies, may be submitted to the Medical Executive Committee by any voting member(s) of the medical staff, or by the Hospital CEO 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 25% or more of the voting members of the active medical staff (which will constitute notice of the proposal to the Medical Executive Committee) must identify two active medical 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 medical staff for comment as described below, before the Medical Executive Committee submits the proposal to the Board of Directors 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 these bylaws under Article XVI, Section 15.2. 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 medical staff for comment as described below before the proposal is submitted to the Board of Directors for approval.

With respect to any proposal that does not bear the signatures of 25% of the Active Staff members, the Medical Executive Committee has the discretion to do any of the following:

a) Disseminate the proposal, as submitted, to the medical staff for comment;

b) Modify the proposal and disseminate it, as modified, to the medical staff for comment, or

c) Reject the proposal and not disseminate it to the medical staff for consideration

Except as otherwise provided in this Article, before the Medical Executive Committee submits a proposal for adoption or amendment of rules and regulations to the Board of Directors for approval, the Medical Executive Committee will disseminate the proposal to the medical staff in a reasonable manner, which may include posting it in a newsletter or bulletin, distributing it at a general medical staff meeting, or any other method regularly used by the medical staff office to provide notices to members. Voting members of the medical staff will be given an opportunity to submit written comments, through the medical 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 medical 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 signature of 25% or more of the voting members of the Active medical staff, but the Medical Executive Committee disseminated the proposal to the medical staff for comment, then after the comment period ends the Medical Executive Committee, at its discretion may do either of the following:

Submit the proposal to the Board of Directors for approval, in its original form as modified in light of the comments; or

Reject the proposal and not submit it to the Board of Directors

Upon approval by the Board of Directors, new rules and regulations, policies , or amendments to existing rules and regulations or policies, will be announced promptly to the medical staff in a reasonable manner, as described above.

Duly adopted rules and regulations, and policies will be binding on all applicants to and members of the medical and AHP staff as well as to any practitioners who are granted temporary privileges.

If a proposal is not approved by the Board of Directors, then the Medical Executive Committee (or the designated representatives of the group of medical staff members who submitted a non-Medical Executive Committee-supported proposal that went directly to the Board of Directors ) may invoke the conflict management process set forth in Article XVI, Section 15.2 of these Bylaws within 30 days of receiving notice that the proposal was not approved by the Board of Directors.

If the Medical Executive Committee receives documentation of an urgent need to amend the medical staff rules and regulations to comply with law or regulation, the Medical Executive Committee may adopt the necessary amendment provisionally and submit it to the Board of Directors for provisional approval, without prior notification of the medical staff. Immediately following the Medical Executive Committee's adoption and the Board of Directors' provisional approval of such an urgent provisional amendment to the rules and regulations, the Medical Executive Committee will notify the medical staff (by an acceptable method of providing such notice as described above), and offer an opportunity for any interested medical staff member to submit written comments to the Medical Executive Committee within 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 25% of the voting active medical staff members express opposition to the amendment in writing.

If the comments indicate substantial conflict over the provisional amendment, then the Medical Executive Committee will implement the conflict management process set forth in Section 18.2 of these Bylaws, and may submit a revised amendment to the Board of Directors for approval if necessary.

In the event of a conflict between these bylaws and any provision of the medical staff rules and regulations or policies, as determined by the Medical Executive Committee, the bylaws will prevail.

Changes adopted by the Medical Staff shall become effective only after approval by the Board of Directors, which approval shall not be unreasonably withheld. If such approval of the Board of Directors is not given within ninety (90) days of the Board's receipt of such changes, the matter shall be submitted to the Joint Conference Committee for review and recommendation.

### 16.3 Effect of the Bylaws

Upon adoption and approval as provided in Article XVI, in consideration of the mutual promises and agreements contained in these Bylaws, the Hospital and the Medical Staff, intending to be legally bound, agree that these Bylaws shall constitute part of the contractual relationship existing between the Hospital and the Medical Staff members, both individually and collectively.

# GENERAL RULES AND REGULATIONS

# OF THE

# MEDICAL STAFF

# PROVIDENCE LITTLE COMPANY OF MARY MEDICAL CENTER SAN PEDRO

Approved:
Bylaws Committee:
Medical Executive Committee: 11-19-18; 4-15-19; 7-15-19
Board of Directors: 11-27-18; 4-18-19; 7-26-19

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## ARTICLE I

## ADMISSION AND DISCHARGE OF PATIENTS

A. A patient may be admitted to the hospital only by a member of the medical staff having such admitting privileges. Members shall call the Admitting Department for direct admits prior to sending the patient to the hospital from the office. The attending physician, or where applicable, practitioner shall provide admission orders to nursing. All admissions will be governed by the official admitting policy of the hospital. Patients will not be admitted (sent to the floor) without admitting orders. Physicians are required to provide admitting orders prior to or at the time of the patient's admission. If a patient is admitted through the Emergency Department and admitting orders are not received within one hour (60 minutes) of contact, this may result in the patient being assigned to another provider.

B. A member of the medical staff shall be responsible for the medical care and treatment of each patient in the hospital, for visiting the patient daily, for the promptness, completeness and accuracy of the medical record, for necessary special instructions and for transmitting reports of the condition of the patient to the referring physician and to relatives of the patient. Member's signing out or transferring care to another member must communicate/hand-off the patient. That hand-off communication shall include at least the following:

1. Up-to-date information regarding the patient's care, condition and any recent or anticipated changes provided in an interactive environment that allows the giver and receiver of the information to ask/answer questions.

C. All patients shall be assigned to the nursing unit concerned with the treatment of the disease, which necessitated admission. Private patients or emergency patients presenting for admission who have no attending physician shall be assigned to members from the Emergency Department call schedule to which the illness of the patient indicates assignment.

D. Except in an emergency, no patient shall be admitted to the hospital until the provisional diagnosis or valid reason for admission has been stated. In the case of emergency, such statement shall be recorded as soon as possible.

E. In urgent direct admits cases where it appears the patient will have to be admitted to the hospital, the physician shall, when possible, first contact the admitting Department to ascertain whether there is an available bed.

F. Physicians admitting emergency cases shall be prepared to justify to the Utilization Review/Medical Records Committee of the medical staff and the administration of the hospital that said emergency admission was a bonafide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.

G. Each member shall be located close enough (office and residence) to the Hospital to provide continuous care to their patients and to meet any applicable on call and emergency requirements.

H. The Admitting Department will admit patients on the basis of the following order of priorities:
   1. Emergency admissions.
   2. Urgent admissions - this category includes those so designated by the attending physician.
   3. Routine/Elective admission - this will include elective admissions that would involve all services. When all potential admissions for a specific day are not possible, the Nursing Staffing Department or Nursing Supervisor shall determine the priority of admissions.

I. Areas of restricted bed utilization and assignment of patients shall be as follows: Obstetrics and Critical Care.
   Patients may be admitted without regard to the above restrictions only after consultation with the chief of the service or his/her designated person of the geographic area to which the patient is to be admitted. It is understood that when deviations are made to the assigned areas as mentioned above, the Admitting Department will correct these assignments at the earliest possible moment in keeping with transfer priority.

J. Patient Transfers: Transfer priorities shall be as follows:
   1. Emergency Department to appropriate bed.
   2. From Obstetric Unit to general care area when medically indicated.
   3. From Critical Care to general care area.
   4. From temporary placement in an inappropriate geographical or clinical area to the appropriate area for that patient.

K. Patients shall be transferred to another health care facility in accordance with the hospital's transfer policy and applicable law.

L. Admission to Critical Care – Per admission criteria as noted in the Critical Care Committee Rules and Regulations. If any questions as to the validity of admission to or discharge from the Critical Care should arise, that decision is to be made in collaboration with the Department of Case Management and the attending physician in consultation with the director of the unit and the Administrative Director of Nursing for the unit.

M. The attending physician or other practitioner, where applicable, is required to abide by policies and procedures as set forth in the Utilization Review Plan of the hospital. Such attending physician or practitioner is required to document the need for continued hospitalization after specific periods of stay. This documentation must contain:

   1. An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.
   2. The estimated period of time the patient will need to remain in the hospital.
   3. Plans for post-hospital care.

   Upon request from the Utilization Review/Medical Records Committee, the attending physician or other practitioner must provide written justification of the necessity for continued hospitalization of any patient including an estimate of the number of additional days of stay and the reason therefore. This report must be submitted within 24 hours of receipt of such request. Failure to comply with this policy will be brought to the attention of the Medical Executive Committee for appropriate action.

N. Patients shall be discharged only upon a written order of the attending physician or other practitioner authorized to discharge patients pursuant to Bylaws and Rules and Regulations of the Medical Staff. Should a patient leave the hospital against the advice of the attending physician or practitioner or without proper discharge, documentation of the incident shall be made in the patient's medical record.

O. It shall be the responsibility of the attending physician or practitioner to discharge his/her patients by 11:00 A.M. on the day of discharge.

P. Preadmission testing for elective patients shall be completed prior to admission whenever possible.

Q. In the event of a hospital death, the deceased shall be pronounced dead by the attending physician or his/her designee within a reasonable time. Exception: specific job classifications of registered nurses may pronounce specific patients in accordance with Hospital Standardized Procedure. Policies in respect to release of dead bodies shall conform to local law.

R. Every member of the medical staff is expected to be actively interested in securing autopsies. Autopsy guidelines shall be approved by the Medical Staff. No autopsy shall be performed without written consent of a relative or legally authorized agent. All autopsies shall be performed by the hospital pathologist or physician delegated this responsibility. Provisional anatomic diagnoses shall be recorded on the medical record within 72 hours and the complete report of the findings shall be made a part of the record within 60 days.

The currently approved guidelines for autopsy selection are noted below. These do not limit performance of autopsies or inhibit the solicitation of an autopsy in any particular case. They are used to emphasize the situations in which an autopsy is most beneficial.

1. deaths reported to the Coroner but the case was not accepted by the Coroner
2. deaths in which autopsy may help to explain unknown and unanticipated medical complications
3. deaths in which the cause of death is not known with certainty on clinical grounds.
4. cases believed to have educational value for medical or hospital staff.
5. deaths in which autopsy may help to allay concerns of the family and to provide reassurance to them.
6. deaths in patients who have participated in clinical trials.
7. any OB or neonatal deaths when the cause of death is unknown.

S. Patients who shall not be admitted to this hospital shall be those as indicated in the Administrative Policy Manual.

## ARTICLE II

## MEDICAL RECORDS

A. The attending physician shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. Practitioners, including dentists and podiatrists, shall also be responsible for preparation of complete and legible patient care records.

B. A history and physical examination ("H&P") shall include: chief complaint, history of present illness, relevant past, social and family histories (appropriate to the patient’s age), a summary of the patient's relevant psychosocial needs (as appropriate to the patient's age), a review/inventory of body systems, relevant physical examination, conclusions drawn from the admission H&P, a statement on the course of action planned for the patient for this episode of care, diagnosis or diagnostic impression and reason for admit.

The H&P report shall be prepared by the attending member, unless he/she delegates this responsibility to another member or he/she is required by the Medical Staff Bylaws or Rules and Regulations to delegate or share this responsibility with another member. (See the Medical Staff Bylaws Section 6.4 pertaining to the completion of H&P reports when a podiatrist, dentist or psychologist is the co-admitting member.) However, if a patient is referred to the hospital by a non-member, that non-member's history and physical may be included in the record and may be used by the treating member. The admitting or treating member still bears the burden for performing a history and physical (dictated or short form as required by the Medical Staff).

H&P for Inpatient Admissions Other than for Operative and Other Invasive Procedures and Deliveries: The H&P must be performed within 24 hours after admission. H&P's from prior admission may be used if the following conditions are met:

1. The H&P was performed less than 30 days prior to the admission; and
2. An update/interval note is completed and a physical examination is performed and documented in the patient's medical record within 24 hours after admission.

H&P for Operative and Other Invasive Procedures: The H&P must be performed prior to admission and in the patient record prior to the operation/procedure being performed. If performed prior to admission, an update/interval note must be done. H&P's performed more than 30 days prior to admission must be re-performed. In addition, short form H&P's may be handwritten in lieu of dictated H&P's.

H&P for Deliveries: The prenatal record may be utilized as the H&P as long as the following conditions are met:

1. The prenatal record contains the required elements; and
2. If the last prenatal visit was within 30 days; and
3. The patient is examined and the prenatal record is updated to reflect the patient's condition upon admission.

If an H&P is to be performed dictated or written rather than utilize the prenatal record, it must be performed within 24 hours prior to admission. If done prior to 24 hours of admission, an update/ interval note must be done.

The prenatal record to include all required elements with interval/update note or H&P must be on the record prior to delivery.

Image Guided Biopsies: The physician will perform a focused assessment which includes a review of the patient's past medical history related to the procedure, current medications, and known allergies.

H&P for Outpatient Admissions for Diagnostic Studies or other ambulatory services, (Series Injections, Physical Therapy, Laboratory Testing, Radiological Testing, outpatient physical therapy, outpatient behavioral health program/services, hematology/oncology services, infusions, etc): An H&P is not required.

Update/Interval Notes: These must address appropriate assessments that include a physical examination of the patient to update any components of the patient's current medical status that may have changed since the H&P was performed and/or to address any areas where more current data is needed. For surgical patients, the update note must include certification that the necessity for the procedure is still present and that the H&P is current.

If a Consultation Report or an Emergency Department (ED) Dictated Note contains those required elements for an H&P Report, the Consultation Report or ED Dictated Note may be used as the H&P.

C. The operative/procedure reports shall include pre-operative and post-operative diagnosis, the operation/procedure(s) performed, a description of the techniques used, a description of the findings, estimated blood loss, as indicated, a notation of any tissue removed or altered and the names of the primary and assistant surgeons. The operative/procedure reports shall be dictated within 24 hours of completion of the operation/procedure.

An operative/procedure progress note (immediate post procedure note) shall be legibly written immediately following the surgery/procedure. This note shall include the surgery/procedure(s) performed, name of the primary surgeon and any assistants, findings, specimens removed, disposition of specimens, estimated blood loss, if applicable, and pre-operative, post-operative diagnosis, and any unusual events or complications that occurred during surgery/procedure.

Immediately is defined as upon completion of the operation or procedure, before the patient is transferred to the next level of care (before the patient leaves the Recovery Room).

The transcribed operative/procedure report shall be made available in the medical record as soon as possible after the surgery/procedure and shall be authenticated by the surgeon.

The following procedures which are usually done at the beside do not require a dictated operative report; a hand written note or completion of the Immediate Post- Procedure Note shall suffice:

1. Lumbar puncture
2. Thoracentesis
3. ECT
4. Central lines
5. Incision & drainage
6. Paracentesis
7. Arthrocentesis
8. Chest tube placement
9. Circumcision
10. Wound debridement
11. Bone marrow aspirations/biopsies
12. Fine needle aspirations
13. Suturing
14. Endotracheal intubation

D. Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's medical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment. Progress notes will be made daily or more often if necessary and an admission progress note will be made on the day of admission to include a plan of treatment. These should be of sufficient quality so that another physician could take over the case based on the information in the medical record.

Each psychiatrist or psychologist with patients in the Hospital shall visit their patients at least five (5) times per week or more often if necessary and enter a progress note in the patient's medical record at the time of each visit. These visits may be used to supplement the requirement for daily visits as outlined in these Rules and Regulations.

The content and frequency of progress notes at post acute care sites will be made in accordance with licensing requirements specific to post acute care sites.

E. Consultations shall include evidence of a review of the patient's record by the consultant, pertinent findings on the examination of the patient, the consultant's opinions and recommendations. This shall be made a part of the patient's record. A limited statement such as "I concur," does not constitute and acceptable report of consultation. When operative procedures are involved, the consultant's note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

The attending physician or practitioner, where applicable, is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. Communication regarding the need for consultation shall be between physicians/practitioners. He/she will provide written authorization to permit another attending physician or practitioner to attend or examine his/her patient, except in an emergency. When a consultation is requested, a patient is to be seen in consultation within 24 hours and a note is to be in the chart (dictation preferred) within 48 hours of the request being made, unless the clinical situation warrants otherwise.

The physician or practitioner shall be responsible for notifying the consultant.

Availability of Physicians on ED Call for ED and Inpatient Consults: In cases (inpatients) where the primary care physician is unable to secure a consultation, the ED Call specialist on call for the specialty where a consult is needed shall be requested to and shall provide the consult on the inpatient.

F. Entries should be made as soon as possible after clinical events occur, to ensure accuracy and to provide information relevant to the patient's continuing care.

Patient records shall be completed and authenticated by the responsible member within fourteen (14) days following the patient's discharge. Each entry that is made in the patient's record shall be authenticated and dated by the person making the entry; these entries shall also be timed by The person making the entry. The date and time (if any) shall be the date and time that the entry is made, regardless of whether the contents of the note relate to a previous date or time.

Indications of authentication shall include written (original or facsimile) signatures or initials, or computer entry. The use of electronic signature is acceptable throughout the patient's medical record.

See the Physician Sanctions policy for action to be taken if charts are not completed within fourteen (14) days following discharge.

A medical record shall not be permanently filed until it is completed by the responsible member. If the member is deceased, has moved from the area, is on leave of absence, or has resigned, and all efforts to complete the record have been exhausted, the Manager of Health Information Services will make a determination whether to permanently file the record subject to approval of the Utilization Review/Medical Records Committee prior to filing the record(s).

G. Final diagnosis shall be recorded in full without the use of symbols and abbreviations and dated and signed by the responsible physician or, where appropriate, other practitioner, at the time of discharge of all patients. This will be deemed equally important as the actual discharge order.

H. Symbols and abbreviations may be used only when they have been approved by the medical staff. An official record of approved abbreviations shall be kept on file in the Health Information Management Department. These shall be reviewed and approved on an annual basis by the Utilization Review/Medical Records Committee.

I. A discharge summary is required on all inpatients including deaths (see below for exceptions) and must include the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, final diagnoses, the condition of the patient on discharge, and plans for follow-up care, including discharge instructions to the patient and/or family and discharge medications, dietary and activities advice. In all cases, the attending physician shall be responsible for the discharge summary.

A final progress note may be substituted for the discharge summary in the case of patients with problems of a minor nature who require less than a 48 hour period of hospitalization, normal newborn infants and uncomplicated obstetric deliveries. The progress note must include the final diagnoses, patient's condition at discharge, discharge instructions and follow-up care required. In addition, a dictated or legibly written discharge summary is required for patients admitted to and discharged from the Critical Care Center for conditions other than dialysis shunt thrombolysis and whose length of stay is less than 24 hours.

J. Access to medical records of all patients shall be offered to members of the medical staff for bonafide study and research consistent with preserving the confidentiality of patient identifiable information concerning the individual patients. All such projects shall be approved by the Institutional Review Board Committee of the Board of Directors before records can be studied. Subject to the discretion of the Hospital Chief Executive, former members of the medical staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

All access to patient records is subject to the requirements of applicable law.

K. Written consent of the patient is required for release of the medical information to persons not otherwise authorized to receive this information.

L. Records may only be removed from the hospital's jurisdiction and safekeeping in accordance with a court order, subpoena or statute. Unauthorized removal of charts from the hospital is grounds for suspension of the member for a period to be determined by the Medical Executive Committee of the Medical Staff.

In case of readmission of a patient, all relevant previous records shall be available for the use of the attending physician. This shall apply whether the patient is being attended by the same medical staff member or by another.

## ARTICLE III

## GENERAL CONDUCT OF CARE

A. Each entry that is made in the patient's record shall be authenticated, dated, and timed by the person making the entry. The date and time shall be the date and time that the entry is made, regardless of whether the contents of the note relate to a previous date or time.

A verbal order may only be issued for: telephone orders, emergency situations, cardiopulmonary resuscitation activities or rapid transfers and may be dictated by a member of the medical staff to a duly authorized person functioning within his/her scope of practice and signed by the responsible practitioner. Duly authorized persons include the following: Drug orders may be given to a registered nurse, licensed vocational nurse, licensed pharmacist or respiratory care practitioner (therapies and drugs used for respiratory therapy only) and physical therapists (therapies and drugs used for physical therapy only). In addition to the above, non-drug orders may also be given to a dietician (dietary related orders only) and laboratory personnel (laboratory related orders only). All orders dictated over the telephone shall be signed by the appropriately authorized person to whom dictated with the name of the practitioner per his/her own name. A responsible practitioner shall authenticate medication orders within 48 hours. Authentication for verbal medication orders must include the practitioner signature and the date and time signed. The responsible practitioner shall be the practitioner who issued the order or the practitioner to whom he or she transferred responsibility for the patient. The practitioner accepting responsibility for the patient may countersign the verbal orders issued by the other practitioner if they appear proper. If there is any question about the order (e.g., why it was given or whether it was accurately noted), the responsible practitioner should refer the matter back to the practitioner who issued the order, who shall clarify the order and countersign it within the required time.

B. Medication orders must be reviewed and either re-ordered, revised or cancelled by the responsible physician/member when the patient changes levels of care.

C. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia National Formulary, American Hospital Formulary Service, AMA Drug Evaluations, or New and Non-Official Remedies, with the exception of drugs for bonafide clinical investigations or drugs approved by the Pharmacy and Therapeutics Committee.

Investigational medications may be used only if the member complies with the policy governing use of investigational medications and secures Institutional Review Board approval. All uses must be in compliance with the federal Protection of Human Subjects regulations, which are described in the CAHHS Consent Manual. Investigational medications must be dispensed by the Hospital pharmacy according to established procedure for handling investigational medications.

D. Any qualified practitioner with clinical privileges in this hospital can be called for consultation within his/her area of expertise.

E. Except in an emergency, practitioners are expected to seek consultation as required by their delineation of privileges as approved by the Board of Directors.

Except in an emergency, consultation is required in the following instances:

1. In unusually complicated situations where specific skills of other members may be needed;
2. In instances where the patient exhibits severe psychiatric symptoms or if there is a possible or suspected drug or chemical overdose or attempted suicide;
3. In instances where a member may be required to have consultations on all or some of his or her cases as determined by the Medical Executive Committee. In such situations, the member shall be responsible for informing the assigned consultants of each admission and for arranging for timely consultations;
4. When otherwise required by Hospital, Department or elsewhere in these Medical Staff Rules.

F. All orders for and interpretation of tests pertaining to the medical treatment of podiatric and dental patients shall be done by the physician responsible for the treatment of the medical problems of the patient. Podiatrists or dentists shall order and interpret tests pertaining to podiatric or dental treatment.

G. The attending physician or practitioner, where applicable, is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. Communication regarding the need for consultation shall be between physicians/practitioners. He/she will provide written authorization to permit another attending physician or practitioner to attend or examine his/her patient, except in an emergency.

H. If a nurse has any reason to doubt or question the care provided to any patient or believes appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of his/her superior, who in turn may refer the matter to the Chief Nursing Officer. If warranted, the Chief Nursing Officer may bring the matter to the attention of the chair of the department wherein the practitioner has clinical privileges. Where circumstances are such as to justify such action, the chair of the department may request consultation.

I. When a patient in the hospital is in need of urgent care by his/her physician or other practitioner and when his/her physician or other practitioner, or his/her designated replacement is not available, the chair of the department or his/her representative shall be contacted and carry out suitable treatment. All such cases will then be reviewed by the department with the attending physician or practitioner in attendance. If the department considered the infraction of care to be major or frequent, the problem will be referred to the Medical Executive Committee for suitable disciplinary action.

J. Physical therapy shall be given only on the signed order of a person lawfully authorized to give such an order. When physical therapy is ordered, the patient shall be evaluated by the physical therapist and a treatment program shall be established to include the modalities, frequency and duration of treatments. This program and any modifications shall be approved by the person who signed the order for service.

## ARTICLE IV

## CARE OF PATIENTS HAVING OPERATIVE AND/OR OTHER INVASIVE PROCEDURES

A. All policies regarding surgical suites and post anesthesia recovery room, as well as policies regarding surgical staff, shall be the responsibility of the Department of Orthopedic Surgery, Anesthesia, OBGY and Surgery.

B. Patients having non-emergent operative or other invasive procedures where there the possibility for administration of blood or blood components exists will have an assessment regarding the appropriateness of the procedure. Documentation of this assessment will be made in the patient's medical record that the risks, benefits and alternatives to the procedure and the possibility administration of blood and blood products have been discussed with the patient.

A surgical operation shall be performed only on consent of the patient or his/her legal representative, except in cases of emergency.

C. All tissue removed at operation shall be sent to the hospital pathologist who shall make such examination as he/she may consider necessary to arrive at a pathological diagnosis. The pathological report signed by the pathologist shall be added to the medical report.

D. The policies, regulations and rules for the surgical suite shall be those as indicated in the Surgery Policies and Procedures Manual.

E. A History & Physical, as defined in Article II, #B, must be on the patient's chart prior to the initiation of an operative or invasive procedure, except in emergencies. In an emergency situation, the member shall complete a short form H&P report and this shall be placed in the patient’s record.

F. Appropriate screening tests will be performed and recorded for pre-operative patients, based on the needs of the patient as determined by the surgeon and/or anesthesiologist prior to surgery.

## ARTICLE V

## GENERAL RULES INVOLVING OBSTETRICAL CARE

A. All policies regarding the Perinatal Unit as well as policies regarding Medical Staff shall be the responsibility of the Department of OBGY. The Department shall review functions within the applicable units and recommend additions or changes in policy or rules when indicated.

B. Only obstetrical and gynecological cases will be admitted to the unit except those cases wherein the chair of the Department has been notified and permission received. Male patients will not be admitted to the unit.

C. The rules and regulations of the Department of OBGY shall specify conditions that require consultation with, or care by a qualified consultant in the department.

## ARTICLE VI

## COVERAGE

Each member shall arrange coverage for their patients. The attending member is responsible for informing the covering member about the beginning and ending dates of coverage and for assuring that the covering member will be available and qualified to assume responsibility for patients during the attending member's absence. The attending member shall also make the covering member aware of the status and condition of each hospitalized patient involved. A failure to arrange appropriate coverage shall be grounds for corrective action. In the event the attending member's alternate is not available, the department chair or Chief of Staff must be contacted. He/she will assume responsibility for caring for the patient or appoint an appropriate member who will assume responsibility until the attending member can be reached.

## ARTICLE VII

## CHAIN OF COMMAND

See Service Area Policy: Chain of Command; Patient Care Conflict Resolution.

## ARTICLE VIII

## EMERGENCY SERVICES

A. An E.D. Call Panel has been established for referring patients who need hospital care to qualified members. All emergency patients who do not have a practitioner practicing on the Staff will be assigned to a member according to the rotational E.D. call panel. Members sharing the responsibility for on-call backup coverage to the Emergency Department will be assigned definite call days. The call day is 24 hours from 7:00 A.M. to 7:00 A.M. A roster of members by specialty will be available in the Emergency Department.

   Members shall be placed on the Emergency Department (ED) call list for the respective specialty in accordance requirements for ED call as outlined in Section 3.6 of the Medical Staff Bylaws.

   Prior to a final adverse decision, a member whose participation on the E.D. Call Panel may be denied or terminated will be given a statement of the reasons for the proposed action and an opportunity to appear before the Medical Executive Committee to explain why it should not take the proposed action. The Chief of Staff may restrict a member's participation on the E.D. Call Panel at any time and until such time as a final decision is reached by the Medical Executive Committee. Any adverse decision as to a member's participation on the E.D. Call Panel shall entitle the member to a hearing under Article VIII of the Medical Staff Bylaws.

B. Once the ED call list is published, it is each member’s responsibility to obtain coverage for days he/she is unavailable and for notifying the Medical Staff Services Department of these changes. Requests for temporary removal from ED call for specific days due to vacations or other temporary absences may be accommodated depending on the nature of the request. These requests shall be in writing and shall be submitted prior to the finalization of the ED call schedule for the involved month.

Members of the Medical Staff on ED call must respond when requested, by the ED physician or his/her representative, to see a patient. The need for physical presence shall be at the sole discretion of the ED physician. Members on call must communicate (by phone) with the Emergency Department physician when called within at least 30 minutes. Response time for physical presence shall be within 60 minutes from the time the ED physician requests physical presence. Response time for physical presence may be extended past 60 minutes ONLY if the ED physician agrees.

Any disagreements about ED call, be it response time by phone, request for physical presence or response time for physical presence, shall be addressed after the event by the Chairs of the Departments of Emergency Medicine and the member's department. Members shall never dispute a request by the ED MD for physical presence during the event.

Each panelist must let the Hospital know how to reach him or her immediately and remain close enough to the Hospital to be able to arrive within the specified 60 minute period for physical response.

When scheduled on call, each member shall accept the care of all patients who are appropriately referred without discrimination on the basis of the patient's race, creed, sex, age, national origin, ethnicity, citizenship, religion, pre-existing medical condition (except to the extent it is pertinent to medical care), physical or mental handicap, insurance status, economic status, or ability to pay.

The Emergency Department will document the names of all members who do not respond to a call from the Emergency Department when they are on the call list and forward them to the Medical Staff for follow-up.

A patient can be admitted in the name of the panelist member if both the panelist member and E.D. member concur, but if the Emergency Department member so specifies, the panelist member must see the patient at that time. The panelist member must be notified about each admission prior to the patient leaving the Emergency Department.

Panelist members may see unassigned patients in the Emergency Department. The panelist member retains responsibility for billing and collecting of fees. The Hospital has no responsibility for this relationship and each panelist member releases the Hospital from any obligation in this regard.

C. Availability of Physicians on ED Call for ED and Inpatient Consults: In cases (inpatients) where the primary care physician is unable to secure a consultation, the ED Call specialist on call for the specialty where a consult is needed shall be requested to and shall provide the consult on the inpatient.

D. An appropriate medical record will be kept for each patient receiving care and treatment in the Emergency Department.

## ARTICLE IX

## DISASTER PLAN/ASSIGNMENTS

There shall be a plan (Disaster Plan) for the care of mass casualties at the time of a major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. The plan shall be developed by the Medical Staff and Hospital Administration.

All voluntary members shall be assigned to posts, either in the Hospital, another community hospital, or a mobile casualty station in the event of a mass disaster. The member shall be responsible for reporting to his or her assigned station and performing the assigned duties unless the Disaster Assignment Chair changes the assignment.

If patients are evacuated from the Hospital premises, the attending member or department chair and Chief of Staff shall be consulted. All policies concerning direct patient care will be a joint responsibility of the department chairs and the Hospital Chief Executive. In their absence, the vice chairs and alternate in administration are next in line of authority.

See Bylaws Section 6.6 for details regarding Disaster Privileges.

## ARTICLE X

## SPECIAL CARE UNITS

There shall be a Critical Care/Code Blue Committee, responsible for the development of rules and regulations for those units. The Critical Care/Code Blue Committee reports through the Department of Medicine.

## ARTICLE XI

## ALLIED HEALTH PROFESSIONALS

A. QUALIFICATIONS

Allied Health Professionals (AHPs) are eligible for practice privileges in this Hospital only if they satisfy the minimum qualifications as outlined on the privilege delineation forms and the following:

1. Comply with any credentialing guidelines, 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 generally recognized professional level of quality and efficiency established by the Hospital, and that they are qualified to exercise practice privileges within the Hospital; and
2. Are determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective professions; to work cooperatively with others in the Hospital setting; and to be willing to commit to and regularly assist the Hospital in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials.

Allied health professionals are not members of the Medical Staff.

## B. DELINEATION OF CATEGORIES OF AHPS ELIGIBLE TO APPLY FOR PRACTICE PRIVILEGES

The Board of Directors shall, periodically review and identify the categories of AHPs, based upon occupation or profession, which shall be eligible to apply for practice privileges in the Hospital. For each eligible AHP category, the Board of Directors shall identify the mode of practice in the Hospital setting (i.e., independent or dependent) and the practice privileges and prerogatives that may be granted to qualified AHPs in that category.

The Board of Directors shall secure recommendations from the Medical Executive Committee 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 delineation of categories of AHPs eligible to apply for practice privileges and the corresponding practice privileges, prerogatives, terms, and conditions for each such AHP category, when approved by the Medical Executive Committee and the Board of Directors, shall be set forth in the Medical Staff Rules and Regulations.

Those categories eligible to apply for practice privileges in the Hospital at the present time shall be set forth in the Initial Application for Allied Health Professionals.

## C. PROCEDURE FOR GRANTING PRACTICE PRIVILEGES

An AHP must apply and qualify for practice privileges; and practitioners who desire to supervise or direct AHPs who provide dependent services must apply and qualify for privileges to supervise approved AHPs. Applications for initial granting of practice privileges, and annual renewal thereof, shall be submitted and processed in a parallel manner to that provided in Articles VI and VII of the Medical Staff Bylaws for practitioners, unless otherwise specified in the Medical Staff Rules and Regulations.

An AHP who does not qualify for an AHP category identified as eligible for practice privileges in the manner required by Section B above may not apply for practice privileges, but may submit a written request to the Hospital Chief Executive, asking that the Board of Directors consider identifying the appropriate category of AHPs as eligible to apply for practice privileges. The Board of Directors may refer the request to the Medical Executive Committee for appropriate review and recommendation; and the Board of Directors shall thereafter consider and make a decision on such request.

Each AHP shall be assigned to the clinical department appropriate to his/her occupational or professional training and, unless otherwise specified in the Rules and Regulations, shall be subject to terms and conditions paralleling those specified in Article III of the Medical Staff Bylaws, as they may logically be applied to AHPs and appropriately tailored to the particular AHP's profession.

D. PREROGATIVES

The prerogatives, which may be extended to an AHP, shall be defined in the Medical Staff Rules and Regulations or Hospital policies. Such prerogatives may include:

1. Provision of specified patient care services under the supervision or direction of a physician member of the Medical Staff and consistent with the practice privileges granted to the AHP and within the scope of the AHP's licensure or certification. AHPs and or qualified RN's who demonstrate current competence may perform Medical Screening Examination of patients, in various departments, under specific instances outlined in the Providence LCMMC San Pedro Standardized Procedure and or Hospital Policy which address Medical Screening Examination(s).
2. AHPs shall not be members of any division, department or committee, but will be assigned to the appropriate division, department or committee for evaluation of credentials, determination of privileges, supervision, proctoring, peer review and performance improvement.
3. Attendance at the meetings of assigned division, department or committee and attendance at Hospital education programs in the field of practice.

E. RESPONSIBILITIES

Each AHP shall:

1. Meet those responsibilities required by the Medical Staff Rules and Regulations, and if not so specified, meet those responsibilities specified in Section 3.6 of the Medical Staff Bylaws as are generally applicable to the more limited practice of the AHP.
2. Retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services.
3. Participate, as appropriate, in patient care audit and other performance improvement activities, evaluation, and monitoring activities required of AHPs in supervising initial appointees of his/her same occupation or profession, or of a lesser included occupation or profession, and in discharging such other functions as may be required from time to time.

F. CORRECTIVE ACTION

1. Any person may make a request to the Medical Executive Committee for an investigation or corrective action whenever an Allied Health Professional engages in conduct that is perceived to be harmful to patient safety, detrimental to the delivery of quality patient care, or disruptive of Hospital operations. The investigation and review of any corrective action taken shall be carried out as specified in this section.
2. The Medical Executive Committee may appoint a standing or ad hoc committee or other designee to carry out an investigation, which shall proceed in a prompt manner and may include an informal meeting with the Allied Health Professional. At the conclusion of its investigation, the committee or designee shall forward a report, together with any recommendation for corrective action, to the Medical Executive Committee.
3. The Medical Executive Committee shall consider the report and recommendation of the committee or designee and shall make its own recommendation concerning any corrective action.
4. In the event that the Medical Executive Committee recommends suspension or termination of AHP status or reduction in clinical privileges, the Allied Health Professional shall be entitled to a review hereunder. If the Allied Health Professional waives his/her right to review, the matter shall be forwarded, together with the supporting materials, to the Board of Directors for a final decision.

5. Where immediate action is necessary to prevent imminent danger to the health of any individual (including an imminent threat to the operations of the Hospital), any person or entity entitled to request an investigation or corrective action hereunder may restrict an Allied Health Professional's status or privileges immediately. The Allied Health Professional then shall have the right to meet informally with the Medical Executive Committee, which shall have the authority to continue, modify, or terminate the restriction. In the event the restriction continues in any significant form, the Allied Health Professional shall have the right to obtain review hereunder. The restriction shall remain in effect pending any such review.
6. In the event of a final decision to impose corrective action on an Allied Health Professional, the Hospital may make a report to the National Practitioner Data Bank under standards and procedures to be determined by it and to the appropriate licensing board if applicable.
7. An Allied health Professional shall be given the opportunity to have any of the following recommended actions reviewed, according to the procedures described below, before it becomes final and effective (except for a summary restriction, which shall be effective immediately):
    a. Denial of an application for appointment or reappointment to AHP status;
    b. Denial of a request for initial or additional privileges (except special privileges);
    c. Reduction or suspension in existing privileges (except special privileges); or,
    d. Suspension or expulsion from AHP status.
8. Notwithstanding the above, an Allied Health Professional shall have no right to obtain review in any of the following instances:
    a. When an application is denied because it is incomplete;
    b. When an application is denied because the Allied Health Professional is not from a category that the Hospital has accepted for practice on its premises;
    c. When an application is denied or AHP status or clinical privileges are revoked because of the existence of an employment, contractual, panel, or other relationship between the Hospital and any other AHP in the affected category which limits the number of AHPs in that category who may practice at the Hospital;
    d. When an application is denied or AHP status or clinical privileges are revoked because the physician who is required by law or Medical Staff policy to act as the Allied Health Professional's sponsoring physician: (a) has given up or been deprived of that right; (b) no longer agrees to act as the sponsoring physician; or, (c) has resigned or otherwise been separated from the Medical Staff; or
    e. When the AHP's certificate or license expires, is revoked, or is suspended.
9. The procedures set forth below shall apply to AHPs from all categories that the Hospital has accepted for practice on its premises, with the exception of clinical psychologists. Clinical psychologists shall be entitled to those hearing procedures set forth in Article VIII of the Medical Staff Bylaws.
10. The Allied Health Professional shall be notified of his/her right to obtain review as soon as practicable after the Medical Executive Committee has decided to make an adverse recommendation or has taken summary action. To obtain review, the Allied Health Professional shall submit a written request to the MEC within fifteen (15) days of the notice to the Allied Health Professional. In the event that the Allied Health Professional does not request review in this manner, he/she shall be deemed to have waived any review rights.
11. Review shall be in the form of a meeting with a panel or committee appointed by the Medical Executive Committee. Within a reasonable time in advance of the meeting, the Chief Executive Officer shall give the Allied Health Professional written notice of the time and date of the meeting and a written summary of the reasons for the recommendation or action. If appropriate, this summary shall include references to representative patient care situations or to relevant events. The panel or committee may include an AHP from the appropriate category as a member.

12. The panel or committee shall set guidelines to assure that the meeting is held in an orderly manner and that the Allied Health Professional has a reasonable opportunity to challenge the recommendation or action and to respond to the reasons given for it. A practitioner holding Medical Staff or AHP status at the Hospital may accompany and represent the Allied Health Professional at the meeting. In its sole discretion, the panel or committee may permit the Allied Health Professional and the Medical Executive Committee to be accompanied or represented by legal counsel or other representative at the meeting, and it may choose to be advised by legal counsel without regard to whether the parties are represented by counsel.
13. A record shall be made of the meeting, to be maintained by the panel in the form of minutes, a tape recording, or a Certified Shorthand Reporter. If a record is maintained by means of a tape recording or a Certified Shorthand Reporter, any party requesting the original of the transcript will bear the cost of the preparation of the transcript.
14. The recommendation or action of the Medical Executive Committee shall be affirmed unless the Allied Health Professional proves, by a preponderance of the information presented, that the recommendation or action was arbitrary and capricious.
15. Following the meeting, the panel or committee shall issue a written decision and report, a copy of which shall be provided to the Allied Health Professional and to the Board of Directors.
16. The Board of Directors shall consider the decision and report. In its discretion, the Board of Directors may allow the Allied Health Professional to submit a written statement to it commenting on the decision and report. The Board of Directors then shall make the final decision on the matter, in accordance with its own procedures.

## ARTICLE XII

## DISASTER PLAN

See Hospital Emergency Incident Command System (HEICS) Manual for plan.

## ARTICLE XIII

## DRUG/ALCOHOL TESTING

In accordance with Section 3.6 of the Bylaws, the ongoing responsibilities of each member includes refraining from practicing in the hospital and other hospital related facilities while under the influence of any mind altering chemical. To this end, members are encouraged to make referrals and self-referrals to the Medical Staff Aid Committee for assistance with chemical dependency issues. In addition, any member may be subject to drug/alcohol testing if reasonable suspicion exists that the individual is acting under the influence of alcohol, drugs or any other mind-altering substance.

Reasonable suspicion may include, but is not necessarily limited to:

A. Observable phenomena, such as direct observation of drug possession, drug use, fresh needle tracks, or possession of drug related paraphernalia.
B. Apparent physical symptoms of being under the influence of a substance. (See Note)
C. An episode or pattern of abnormal conduct or erratic behavior.
D. Information provided by a reliable and credible source.
E. Evidence that the individual has tampered with a previous drug/alcohol test.

If a member of the Medical Staff is suspected of being under the influence of any mind-altering substance, such suspicion will be reported by the observing individual to his/her immediate supervisor or hospital Nursing Supervisor who will then notify the Chief of Staff. At the discretion of the Chief of Staff, or his/her designee, and depending upon the circumstances, including the timing of the report with respect to the information reported, the individual may be referred to the Medical Staff Aid Committee, required to submit to clinical examination, and/or required to take such other action as may be determined by the Chief of Staff or designee. For clinical examination the individual will go to the Emergency Department, escorted if necessary by Security, and will undergo clinical evaluation by the emergency physician, which may include obtaining blood and/or urine specimens for substance testing if indicated. If the member refuses examination, including blood and/or urine testing, as requested by the examining physician, the member's clinical privileges shall be automatically suspended.

Note: Evidence of intoxication or impairment may include, but is not limited to: odor of alcohol on breath, slurred or inarticulate speech, abnormal eye findings (pupil size, nystagmus), abnormalities of cognition or cognitive function, somnolence, and abnormal muscle coordination.

**Reporting Procedure—Incapacitated Member:** Consistent with medical staff confidentiality policies and patient safety, the following steps will be taken in the event that a member of the Medical Staff appears to be physically or emotionally incapacitated (whatever the cause) and it is questionable that he/she can perform patient services safely:

A. Any person becoming aware of such a situation (refer to above) should contact his/her supervisor immediately who will then contact the hospital nursing supervisor. If a medical staff member makes an observation it should be reported to the Chief of Staff immediately.
B. If, in the judgment of the nursing supervisor, immediate action is needed, the Chief of Staff of the hospital will be notified directly by the nursing supervisor. If the Chief of Staff is unavailable, the nursing supervisor will contact the next available individual as follows:
    1. Vice Chief of Staff.
    2. Secretary-Treasurer of the Medical Staff.
C. If, in the opinion of the Chief of Staff or designee, a reasonable suspicion of impairment exists, a physical exam will be performed by a licensed emergency physician which may include obtaining blood and/or urine specimens for substance testing if indicated. All copies of any such emergency examination record shall remain confidential and be transmitted directly to the Chief of Staff.
D. As soon as circumstances permit, a report shall be prepared by the person making the observation and by the nursing supervisor.
E. Referrals and self-referrals to the Medical Staff Aid Committee are encouraged at all times, but evidence of current incapacitation of a Medical Staff member must be reported as described here.

## ARTICLE XIV
## ORGANIZED HEALTH CARE ARRANGEMENT (OCHA) UNDER HIPAA

San Pedro Peninsula Hospital (dba Little Company of Mary – San Pedro Hospital), as part of the Little Company of Mary Service Area, and the medical staff members have established a Little Company of Mary Service Area Organized Health Care Arrangement under 45 CFR 164.501, as a clinically integrated health care setting, including all Little Company of Mary Health System facilities, services and programs, the employees, and practitioners and other clinicians who are members of the medical staff and/or who otherwise have medical staff privileges at Little Company of Mary-San Pedro Hospital in the Little Company of Mary Service Area ("LCMSA OHCA"). Under the LCMSA OHCA, all of the members, including members of the medical staff, may rely on a Joint Notice of Privacy Practice and Acknowledgment. Further, members of the LCMSA OHCA may use and disclose protected health information in the conduct of their joint operations and joint activities, all in a manner consistent with the requirements of HIPAA.

Notice of Privacy Practices. Each member of the medical staff shall be required to use and conform to the terms of the Joint Notice of Privacy Practice developed and used by the Little Company of Mary Service Area with respect to protected health information created or received as part of each medical staff member's participation in the LCMSA OHCA and to comply with all applicable Little Company of Mary-San Pedro Hospital, medical staff and HIPAA requirements, policies and procedures relating to the confidentiality of protected health information.

Each medical staff member is responsible for their own compliance with applicable state and federal laws relating to protected health information. The establishment of the LCMSA OHCA shall not in any way create additional liabilities by or among the members of the LCMSA OHCA or cause one or more LCMSA OHCA members to assume responsibilities for the acts or omissions of any other member of the LCMSA OHCA, and each member of the LCMSA OHCA shall be individually responsible for their own acts or omissions with respect to compliance with HIPAA requirements.

The MEC may establish from time to time such additional rules and requirements to assure conformity with the above requirements, including requiring each medical staff member at the time of their initial appointment and any subsequent reappointment, to sign and acknowledge their individual responsibilities with respect to the above requirements.

## ARTICLE XV
## RESEARCH

Members who desire to conduct research should be encouraged to conduct reasonable research projects utilizing patient records and other data sources. The members should be given, whenever possible, access to all appropriate equipment and resources necessary for the research project.

All research undertaken by members or others involving Hospital patients must be approved by the St. Joseph Health Centralized Instituional Review Board. Decisions to approve research are based on evaluation of the risks, benefits and resources required of the Hospital. All research must be conducted in accordance with the rules and policies governing research, approved by the Institutional Review Board.

A member may use or allow the use of the Hospital's name in published works only with the permission of the Administration. However, members may identify themselves as members of the Hospital's Medical Staff within the limits of accepted professional ethics and practices.

## ARTICLE XVI

## PERFORMANCE IMPROVEMENT/PEER REVIEW

The Medical Staff is accountable to the Board of Directors and has a leadership role in the organizational performance improvement activities. The Medical Staff shall provide leadership through the clinical departments, the Physician Performance Committee, and the Medical Executive Committee for the process of measurement, assessment, and improvement of processes as defined in policies/procedures relating to performance improvement activities.