Medical Staff Bylaws
and **Rules and Regulations**
of **the Medical Staff**
of

Saint John's Health Center

PROVIDENCE Health & Services

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Preamble

BECAUSE Providence Saint John's Health Center ("Heath Center") is a non-profit corporation organized under the laws of the State of California; and BECAUSE its purpose is to serve as a general health center providing patient care, medical education, and research; and BECAUSE it is recognized that the Medical Staff is responsible for the quality of medical care in the Health Center, subject to the ultimate authority of the Health Center's Board of Directors, and that the cooperative efforts of the Medical Staff, the Chief Executive Officer, and the Board of Directors are necessary to fulfill the Health Center's obligation to its patients; THEREFORE, the physicians, dentists, and podiatrists practicing in this Health Center hereby organize themselves into a Medical Staff in conformity with theses Bylaws.

Definitions

1. "**Allied Health Personnel**" means psychologists, physician assistants, nurse practitioners, certified nurse midwives, and similar persons who are qualified and if necessary, appropriately licensed, to provide limited care to patients and who have been granted privileges to provide their services in the Health Center, as independent practitioners or dependent practitioners under the overall supervision of the Medical Staff.

2. "**Approved Fellowship**" means a post-residency training program which meets the requirements of the Medical Staff as established and approved by the Medical Executive Committee.

3. "**Board of Directors**" means the Board of Directors responsible for conducting the affairs of Providence Saint John's Health Center, which for purposes of these Bylaws and except as the context otherwise requires shall be deemed to act through the authorized actions of the Providence Saint John' Health Center Community Ministry Board, the officers of the corporation and through the Chief Executive of the Health Center.

4. "**Chair**" of a Department or Section means a member of the Medical Staff appointed by the President of the Medical Staff with the approval of the Chief Executive Officer to provide supervision of a Department or Section of the Medical Staff, and to serve as chair of their Departmental or Sectional committee.

5. "**Chief Executive Officer**" means the individual appointed by the Board of Directors to act in its behalf in the overall management of the Health Center.

6. "**Director**" of a department or unit means the member of the Medical Staff appointed by the Chief Executive Officer in consultation with the President of the Medical Staff to provide overall planning and professional or technical supervision for a department or special care unit of the Health Center.

7. "**Medical Executive Committee**" means the Medical Executive Committee of the Medical Staff.

8. "**Fellow**" means a physician, dentist, or podiatrist who is in a post-residency training program and who meets the minimum requirements for Medical Staff membership and who has been accepted to a fellowship program approved by Providence Saint John's Health Center.

9. "**General Staff Meeting**" means a meeting of all members of the Medical Staff.

10. "**Intern**" means a physician or dentist-in-training who holds an MD, DO, or DDS degree or their equivalent from an accredited allopathic, osteopathic, or dental school and is currently in their first post-graduate year (PGY 1).

11. "**Chief Medical Officer**" means the physician appointed by the Board of Directors to serve as the chief medical administrative officer for the Health Center and provides liaison between the Medical Staff and the Health

Center's administration and Board of Directors. The Chief Medical Officer must be a member of the medical staff.

12. "**Medical Staff**" means those physicians, dentists, and podiatrists, licensed by the State of California, who have been appointed to the Medical Staff.

13. "**Medical Student**" means a student in good standing at and sponsored by an accredited, United States school of allopathy or osteopathy.

14. "**Member**" means a physician, dentist, or podiatrist who has been appointed to the Medical Staff.

15. "**Physician**" means an individual with an MD or DO degree or equivalent who is licensed by the State of California to practice medicine.

16. "**Practitioner**" means a member of the allied health personnel staff.

17. "**President of the Medical Staff**" means the member of the Medical Staff elected by the Medical Staff and approved by the Board of Directors to serve as President of the Medical Staff organization.

18. "**Resident**" means a physician, dentist, or podiatrist in training who holds an MD, DO, DDS, or DPM, or equivalent degree from an accredited allopathic, osteopathic, dental, or podiatric school and is licensed to practice by the State of California.

19. "**Special Notice**" means written notification sent, in all cases, by personal delivery, special messenger, or certified mail, return receipt requested. Such notification sent by certified mail shall be deemed to be received on the date indicated by the return receipt or four business days after mailing, whichever comes first.

Article I: Name

The name of this organization shall be the Providence Saint John's Medical Staff.

Article II: Purposes

The purposes of this organization are:

1. To assure that all patients admitted or treated in any of the facilities, departments, or services of the Health Center shall receive appropriate care;

2. To promote a high level of professional performance of all practitioners authorized to practice in the Health Center through the appropriate delineation of the clinical privileges that each practitioner may exercise in the Health Center and through an ongoing review and evaluation of each practitioner's performance in the Health Center;

3. To provide an educational setting that will promote scientific standards and that will lead to the continuous advancement of members' professional knowledge and skill.

4. To participate in Health Center planning, policy-making, and budgeting processes;

5. To propose, and to enforce approved rules and regulations, polices, and procedures for the Medical Staff;

6. To provide a means whereby issues concerning the Medical Staff and the Health Center may be discussed by the Medical Staff and the Board of Directors, the Chief Executive Officer, and the Chief Medical Officer.

Article III: Membership in the Medical Staff

Section 1: Nature of Medical Staff Membership

Membership in the Medical Staff of Providence Saint John's Health Center is a privilege which shall be extended only to professionally competent physicians, dentists, and podiatrists who initially and continuously meet the qualifications, standards, and requirements set forth in these Bylaws.

Section 2: Qualification for Membership

a. Every qualified person is eligible for membership on the Medical Staff without discrimination on account of the person's creed (or lack thereof), race, color, sex, or national origin.

b. To be eligible for appointment to the Medical Staff, an applicant must have completed the formal training (e.g., residency and/or fellowship) required by any applicable specialty or sub-specialty American Board within the area in which the applicant seeks privileges. Only physicians, dentists, and podiatrists, with an unencumbered, unsuspended, unrestricted, non-probationary license to practice by the State of California, identified by a National Practice Identified (NPI) and not excluded for just cause from any health care program funded, in whole or in part, by the federal government, who can satisfactorily document their identity, background, professional experience, training, education and competence, their adherence to the ethics of their profession, their good reputation, their current and adequate physical and mental health status to exercise requested clinical privileges, and their ability to work with others in a health center environment with sufficient adequacy to assure the Medical Staff and the Board of Directors that any patient treated by them in the Health Center will be given appropriate medical care, shall be qualified for membership on the Medical Staff. No physician, dentist, or podiatrist shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Health Center merely by virtue of the fact that they are duly licensed to practice medicine, dentistry, or podiatry, by this or by any other state, or that they are a member of some professional organization, or that they had in the past, or presently have, such privileges at another health center, or had such privileges at this Health Center in the past.

c. Each candidate or member must provide information about their professional liability experience and insurance coverage, and provide evidence of current professional liability insurance coverage which meets or exceeds the minimal level required by the Board of Directors and is issues by a carried approved by the Board of Directors. Each candidate or member must ensure that his/her professional liability insurance policy includes coverage for the scope of clinical privileges requested/approved. Upon expiration or termination of Medical Staff membership, the member is required to obtain and maintain extended reporting period (i.e., "tail") coverage for a minimum of seven years in the amounts and terms as required by the Board of Directors. Such extended reporting coverage shall be maintained for claims which arise from professional services provided by the member at the Health Center during membership on the Medical Staff of the Health Center.

Section 3: Conditions and Duration of Appointment

a. Acceptance of membership on the Medical Staff shall constitute the member's agreement that they will strictly abide by the ethical principles and guidelines adopted by the Board of Directors, including the Sexual Harassment Policy and the Ethical Standards of Business Conduct and Conflict of Interest Disclosure Policy, and that they will support the philosophy of Providence Health & Services which recognizes of the human person and the worth of the individual. These principles and philosophy are stated in the Bylaws of Saint John's Health Center which are available from the Chief Executive Officer. All members of the medical staff are required to abide by the terms of the Notice of Privacy Practices prepared and distributed to patients as required by the deferral patient privacy regulations. All members agree that they will abide by all Federal and State Laws and Regulations.

b. Initial appointments and reappointments to the Medical Staff, resignations, and administrative terminations shall be approved by the Board of Directors. The Board of Directors shall act on appointments, reappointments, revocation of appointments only after there has been a recommendation from the Medical Staff as provided in these Bylaws, provided that in the event of delay on the part of the Medical Staff, the Board of Directors may act without such recommendation on the basis of documented evidence of the applicant's or staff member's professional and ethical qualifications obtained from reliable sources.

c. Appointments and reappointments shall be made for a period of not more than two years. The Medical Executive Committee shall have the authority to establish policies and procedures defining the manner in which appointments and reappointments are staggered within the two year constraint.

d. Appointments or reappointments to the Medical Staff shall confer on the appointee only such clinical privileges as are specified in the notice of appointment or reappointment respectively, in accordance with these Bylaws.

e. Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgement of every Medical Staff member's obligation to provide continuous care and supervision of their patients, to abide by the Medical Staff Bylaws, Rules and Regulations, to accept committee assignments, to accept consultation assignments, and to participate in staffing the outpatient and special care units or services, to complete medical records in a timely fashion (as set forth in the Rules and Regulations), to notify the Medical Staff Services Department of any professional liability settlements and judgments within 30 days, to notify the Medical Staff Services Department of all formal investigations and/or disciplinary actions taken against their medical license or by another health center within seven days of notification, to notify the Medical Staff Services Department of any proposed or actual exclusion of the member from any health care program funded, in whole or in part, by the Federal government within seven days of notification, and to notify the Medical Staff Services Department of any felony charge filed or conviction obtained within seven days of filing or conviction, respectively.

f. A physician, dentist, or podiatrist, other than the Chief Medical Officer, employed by the Health Center in a purely administrative capacity with no clinical duties or privileges, is subject to the regular personnel policies of the Health Center and to the terms of their contract or other conditions of employment, and need not be a member of the Medical Staff.

g. A medico-administrative officer, i.e., a physician, dentist, podiatrist, with administrative and clinical responsibilities, or physician, dentist, or podiatrist who contracts with the Health Center to provide clinical services, must be a member of the Medical Staff. Their clinical privileges must be delineated in

accordance with these Bylaws. The Medical Staff membership and clinical privileges of any medico-administrative officer shall not be terminated without due process as provided in these Bylaws, unless otherwise provided in their contract.

h. Coverage of the Emergency Department on a rotational basis is an obligation which may be imposed by each of the Departments. Service in this coverage is at the discretion of the Health Center and is not a clinical privilege or right of membership on the Medical Staff.

i. Compliance with the Emergency Medical Treatment and Active Labor Act ("EMTALA") including, but not limited to, the requirement that physician who are providing on-call coverage for the Emergency Department must come to the Health Center, if so requested, within a reasonable time following initial contact by the Emergency Department and providing any necessary stabilizing treatment to patients regardless of the patient's ability to pay.

j. A medical history and physical examination must be completed and documented by a physician, an oral and maxillofacial surgeon or other qualified licensed individual in accordance with state law and the Medical Staff and Health Center Bylaws, Rules and Regulations, and policies, no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.

    i. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.

k. Members of the Medical Staff must obtain, continuously maintain, and provide to the Medical Staff Services Department, including any changes thereto, accept receipt and regularly check an email address/account for the purpose of receiving notices and communications approved for dissemination to Members of the Medical Staff by the Chief Medical Officer or Chief Executive Officer or their designees.

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

    i. General

        1. It is the policy of the Medical Staff to require that its members fulfill their Medical Staff obligations in a manner that is within generally accepted bounds of professional interaction and behavior. The Medical Staff is committed to supporting a culture and environment that values integrity, honesty, and fair dealing with each other, and to promoting a caring environment for patients, practitioners, employees, and visitors.

        2. Rude, combative, obstreperous behavior, as well as willful refusal to communicate or comply with reasonable rules of the Medical Staff and the Health Center may be found to be disruptive behavior. It is specifically recognized that patient care and Health Center operations can be adversely affected whenever any of the foregoing events occurs with respect to interactions at any level of the Health Center, in that all personnel play an important part in the ultimate mission of delivering quality patient care.

3. In assessing whether particular circumstances in fact are affecting quality patient care or Health Center operations, the assessment need not be limited to care of specific patients, or to direct impact on patient health. Rather, it is understood that quality patient care embraces – in addition to medical outcome – matters such as timeliness of services, appropriateness of services, timely and thorough communications with patients, their families, and their insurers (or third party payors) as necessary to effect payment for care, and general patient satisfaction with the services rendered and the individuals involved in rendering those services.

ii. Conduct Guidelines

1. Upon receiving Medical Staff membership and/r privileges at the Health Center, the member enters a common goal with all members of the organization to endeavor to maintain the quality of patient care and appropriate professional conduct.

2. Members of the Medical Staff are expected to behave in a professional manner at all times and with all people – patients, professional peers, Health Center staff, visitors, and others in and affiliated with the Health Center.

3. Interactions with all persons shall be conducted with courtesy, respect, civility, and dignity. Members of the Medical Staff shall be cooperative and respectful in their dealings with other persons in and affiliated with the Health Center.

4. Complaints and disagreements shall be aired constructively, in a non-demeaning manner and through official channels.

5. Cooperation and adherence to the reasonable Rules of the Health Center and the Medical Staff is required.

6. Members of the Medical Staff shall not engage in conduct that is offensive or disruptive, whether it is written oral, or behavioral.

m. Members of the Medical Staff must provide current and updated Conflict of Interest Disclosure forms.

Section 4: Dues

a. All Medical Staff members, except members of the Honorary and Retired staffs, unless specified otherwise herein, may be assessed and be liable for dues annually, at rates determined by the Medical Executive Committee.

Section 5: Leave of Absence

a. At the recommendation and discretion of the Medical Executive Committee and upon approval of the Board of Directors, a member may obtain a voluntary leave of absence upon submitting a written request to the Medical Executive Committee stating the reason and approximate period of leave desired, which may not exceed one year. If requested by the member, recommended by the Medical Executive Committee and approved by the Board of Directors, such leave may be extended for up to an additional two one-year periods. A request for an extension will be evaluated on an individual basis by members of the clinical department. During the period(s) of leave, the member shall not exercise clinical privileges and membership rights and responsibilities shall be inactive. The physician shall be obligated

to pay Medical Staff dues in the full amount, unless specifically waived by the Medical Executive Committee, maintain appropriate professional liability insurance coverage and submit a complete application for reappointment to the Medical Staff prior to the due date.

b. At least 30 days prior to the termination of the leave of absence, or at any earlier time, the member may request reinstatement of privileges by submitted a written notice to that effect to the Medical Executive Committee. The member shall submit a summary of relevant activities during the leave, if the Medical Executive Committee so requests. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the Medical Staff member's privileges, and the procedures for reappointment as set forth in Article VI.

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

Article IV: Categories of the Medical Staff

Section 1: The Medical Staff

The Medical Staff shall be divided into Active, Associate, Provisional, Consulting, Telehealth, Affiliate, Fellowship, Honorary and Retired staffs. The Departmental Committees will make recommendations to the Medical Executive Committee in regard to criteria and determination of staff category for members of their Department. The Medical Executive Committee shall have the authority to establish policies and procedures relating to the determination of staff category for members.

Section 2: The Active Staff

The Active Staff shall consist of members who regularly admit or treat patients at the Health Center, who participate significantly in clinical or Medical Staff activities at Providence Saint John's Health Center and who must be available to respond to their Health Center patient's needs in a timely and appropriate manner. They shall assume all the functions and responsibilities of membership in the Active Staff, including, where appropriate, emergency and outpatient care and consultation assignments. Members of the Active Staff shall be appointed to a specific department, shall be eligible to vote, to hold office, to serve on Medical Staff Committees and shall be required to pay Medical Staff dues. They shall be expected to accept duties assigned by the President of the Medical Staff and to attend Medical Staff meetings, as set forth in Article XV of these Bylaws. Members of the Active Staff are required to demonstrate proficiency related to the Health Center's electronic health record system.

Section 3: The Associate Staff

The Associate Staff shall consist of members who have some clinical activity at the Health Center, who do not meet the criteria for Active Staff membership, and who must be available to respond to their Health Center patient's needs in a timely and appropriate manner. Associate Staff members shall be appointed to a specific department but shall not be eligible to vote or hold office in this Medical Staff organization. Associate Staff members shall be eligible to and expected to serve on committees, except the Medical Executive Committee, and they may vote on matters before such committees. They shall be required to pay Medical Staff dues and expected to accept duties assigned by the President of

the Medical Staff. Members of the Associate Staff are required to demonstrate proficiency related to the Health Center's electronic health record system.

Section 4: The Provisional Staff

The Provisional Staff shall consist of members who are newly appointed to the Medical Staff and who must be available to respond to their Health Center patient's needs in a timely and appropriate manner. Ordinarily, members are initially appointed to the Provisional Staff and serve in that category for not less than six months nor more than two full years, during which they must demonstrate satisfactory clinical activity. If, at the time of reappointment, a Provisional Staff member is placed on a conditional status for any reason, then their appointment to the Provisional Staff may be extended for a period not to exceed one year at the sole discretion of the Board of Directors upon recommendation from the Medical Executive Committee. The chair of the Department to which the Provisional Staff member is appointed, or the chair's designee (a Medical Staff member of the Department) serves as proctor for each Provisional Staff member (Refer to Proctoring Policy). The proctor provides guidance and counsel to the Provisional Staff member regarding Medical Staff and Health Center standards and affairs, and assesses the performance of the Provisional Staff member for the Departmental chair. Provisional Staff membership is a probationary status, and certain clinical privileges may be restricted. Provisional Staff members shall be appointed to a specific department, but they shall not be eligible to vote or hold office in this Medical Staff organization. Provisional members shall be eligible and expected to serve on committees, except the Executive and Departmental committees. They shall be required to pay Medical Staff dues and expected to accept duties assigned by the President of the Medical Staff and to attend Medical Staff meetings as set forth in Article XV of these Bylaws. Members of the Provisional Staff are required to demonstrate proficiency related to the Health Center's electronic health record system.

Section 5: The Consulting Staff

The Consulting Staff shall consist of members who act at Providence Saint John's Health Center 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 upon a determination by the Medical Executive Committee of a special need for their services to be available to patients of the Health Center. Consulting 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 Consulting 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 X of these Bylaws. The Consulting Staff shall be appointed to a specific Department. They shall not admit patients or serve as attending physicians for patients in Providence Saint John's Health Center. Consulting 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 unless they are subject to medical record suspension fines, in which case they shall be required to pay the full amount of medical staff fines assessed. Members of the Consulting Staff are required to demonstrate proficiency related to the Health Center's electronic health record system.

Section 6: The Honorary Staff

Upon invitation by the Medical Executive Committee in appreciation for outstanding and significant services to the Health Center or Medical Community, the Honorary Staff shall consist of physicians, dentists, and podiatrists who do not practice at the Health Center but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous longstanding service to the Health Center, and who continue to exemplify high standards of professional and ethical conduct. Honorary Staff members are not eligible to admit patients to the Health Center or to exercise clinical privileges in the Health Center, or to vote or

hold office in the Medical Staff organization, but they may serve upon committees except the Medical Executive Committee and Departmental committees with or without vote at the discretion of the Medical Executive Committee. They may attend educational programs.

Section 7: The Retired Staff

The Retired Staff shall consist of members who have retired from active practice and, at the time of their retirement, were members in good standing of the Medical Staff, and who continue to adhere to appropriate professional and ethical standards. Retired Staff members are not eligible to admit patients to the Health Center or to exercise clinical privileges in the Health Center, or to vote or hold office in this Medical Staff organization, but they may serve on committees except the Medical Executive Committee and Departmental committees with or without vote at the discretion of the Medical Executive Committee. They may attend educational programs.

Section 8: The Fellowship Staff

The Fellowship Staff shall consist of members who are fellows accepted to and active in a fellowship program approved by Providence Saint John's Health Center, and who can respond to their Health Center patient's needs in a timely and appropriate manner. Fellowship staff members shall be assigned to a specific Department, but shall not be eligible to vote or hold office in this Medical Staff organization. They shall not serve as attending physicians or primary surgeons for patients at Providence Saint John's Health Center. They shall not be required to pay medical staff dues. Fellowship staff membership ends with termination of their affiliation with such fellowship program. Members of the Fellowship Staff are required to demonstrate proficiency related to the Health Center's electronic health record system.

Section 9: The Telehealth Staff

The Telehealth Staff shall consist of members who are contracted or sub-contracted with the Health Center to provide telehealth services, who shall act at the Health Center only through electronic means. They shall not admit patients or serve as attending physicians for patients at Providence Saint John's Health Center. Members of the Telehealth Staff shall be appointed to a specific department, undergo the credentialing process per Article VI of these Bylaws, shall not be eligible to vote or hold office in this Medical Staff and shall not eligible to serve on committees or vote on matters. They shall be required to pay Medical Staff dues. They shall not be required to attend Medical Staff meetings.

Section 10: The Affiliate Staff

The Affiliate Staff shall consist of members who do not admit, write orders, or perform procedures, but who may submit history and physical examinations and consultation reports. They will have access to the medical record on a read-only basis. Members who do not meet the criteria for Active, Associate, or Provisional Staff may be placed into this category. Members of the Affiliate Staff shall be appointed to a specific Department, shall not be eligible to vote or hold office, but may serve on committees, except the Medical Executive Committee, without vote, at the discretion of the Medical Executive Committee. They shall be required to pay Medical Staff dues. They shall be expected to accept duties assigned by the President of the Medical Staff and to attend Medical Staff meetings, as set forth in Article XV of these Bylaws.

Article V: Medical Education

Section 1: Continuing Medical Education

Continuing Medical Education is important in maintaining and improving the quality of patient care. The Medical Staff and Providence Saint John's Health Center are committed to continuing medical education to demonstrate their dedication to providing high quality medical care. Demonstrated educational needs and/or opportunities to improve

care are identified through quality assessment activities and are referred to the appropriate committee of the Medical Staff for program planning, as established by the Medical Executive Committee. Continuing medical education activities shall conform to the California Medical Association's requirements and those requirements set forth by Federal and State Agencies.

Section 2: Post-Graduate Education

a. Fellowships

i. All proposed fellowships shall be approved by the Medical Executive Committee and by the Board of Directors of the Health Center.

ii. All approved fellowships shall have a designated Program Director who shall be an Active or Associate member of the Medical Staff and who is designated by the Medical Executive Committee. The Program Director shall be responsible for the conduct of the program and the fellows and shall be subject to the ongoing approval of the Medical Executive Committee.

iii. All approved fellowships must include a contractual agreement between the fellow and the sponsoring entity prohibiting the fellow(s) from independent receipt of patient referrals and from independent admitting/attending privileges.

b. Residents

i. Resident affiliations at Providence Saint John's Health Center must be approved by the chair of the academic department in which the resident is currently enrolled, and the Medical Executive Committee.

ii. Residents may be approved to provide specific supervised clinical services as established and approved by the Medical Executive Committee based upon recommendations of the appropriate Departmental committee.

iii. Such clinical service shall be under the supervision of an Active or Associate member of the Medical Staff and who has been approved by the Medical Executive Committee or it's designee to supervise the training of such residents.

c. Medical Students

Medical students, affiliated with a program approved by the Medical Education Committee, may be authorized by the Chief Medical Officer to have limited clinical contact or access to clinical information. Medical students shall not participate in patient care, but shall be allowed to observe only, in the attendance of designated members of our Medical Staff.

Article VI: Procedure for Appointment and Reappointment

Section 1: Application for Appointment

a. All application for appointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Chief Executive Officer or a designee after consultation with the Medical Executive Committee.

b. The application shall include detailed information concerning the applicant, including but not limited to the following:

i. names and locations of institutions where the applicant received education and training, and the nature and dates of such activities;

ii. locations and dates of all current and previous clinical practice and health center appointments;

iii. references from individuals who have been determined to be acceptable to our Medical Staff;

iv. details concerning any completed or pending disciplinary or legal investigations, reviews, or actions involving or affecting the applicant's professional status or activities, including, but not limited to:

1. criminal charges or convictions (The Health Center retains the option of performing a criminal background check);

2. voluntary or involuntary resignation while under or in anticipation of investigation, revocation, suspension, or reduction of clinical privileges or membership by any health center, medical group, or society;

3. revocation, suspension, or limitation of the applicant's license to practice their profession, or of their Federal drug registration;

4. professional review organization sanction;

5. Medicare Program or Office of the Inspector General of the Department of Health and Human Services investigation or sanction;

6. or any proposed or actual exclusion from any health care program, funded, in whole or in part, by the Federal government.

v. professional liability insurance coverage and any awards, settlements, or claims related to professional liability;

vi. status and verification of board qualification or certification;

vii. current and all past professional license(s), and if applicable, current DEA registration;

viii. continuing medical education activities completed;

ix. adequacy of the physical and mental health status of the applicant to safely and competently exercise the clinical privileges requested;

x. positive identity documentation, for example, a photocopy of a current, valid government-issued identification document containing a recent passport-style photograph of the applicant and the applicant's signature;

xi. any other information deemed appropriate.

c. The application shall require the applicant's acknowledgment that they have received access to the Medical Staff Bylaws, Rules and Regulations, consent to third parties for the Medical Staff to review their records, and a pledge:

   i. to maintain an ethical practice;

   ii. to refrain from fee splitting;

   iii. to provide for continuous care of their patients; and,

   iv. to abide by applicable Health Center and Medical Staff Bylaws, Rules, and Regulations, and policies~~,~~ and procedures.

d. Pursuant to the requirements of Section 805.5 of the Business and Professions Code, the Medical Staff shall immediately request, from the agency that issues the applicant's license, a copy of any report that has been made with respect to the applicant under Section 805 of the California Business and Professions Code. The applicant's request for staff appointment is not complete and will not be acted on by any Medical Staff committee until such agency's response has been received by the Medical Staff.

e. The applicant shall have the burden of producing adequate information for a proper evaluation of the applicant's identity, competence, training, experience, judgment, character, ethics, and other qualifications, and for resolving any doubts about such qualifications.

f. The application shall be submitted to the Medical Staff Services Department. The application may be considered complete when all the requirements detailed above in this article have been met and appropriate reference letters and verifications have been completed and received. The completed application form and other pertinent materials are reviewed by the Clinical Departmental Committee and a recommendation is forwarded to the Credentials Committee for evaluation of the applicant's credentials.

g. By applying for appointment to the Medical Staff, each applicant thereby signifies willingness to appear for interviews in regard to their application, authorizes the Health Center to consult with members of other health centers with which the applicant has been associated and with others who may have information bearing in their competence, character, and ethical qualifications, consents to the Health Center's inspection of all records and documents that may be material to an evaluation of their professional qualifications and competency to carry out the clinical privileges they request as well as of their moral and ethical qualifications for staff membership, releases from liability the Health Center, all its representatives and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and their credentials, and releases from liability all individuals and organizations who provide information to the Health Center in good faith and without malice in connection with evaluating the applicant's competence, ethics, character, and other qualifications for staff appointment and clinical privileges.

h. The application form shall include a statement that the applicant agrees to be bound by the applicable terms of the Health Center and the Medical Staff Bylaws, Rules and Regulations, if granted membership and/or clinical privileges and in all matters relating to consideration of their application.

i. No application shall be processed until the applicant remits the required non-refundable application fee. The Medical Executive Committee determines the amount of this fee.

j. Applications are considered incomplete until sufficient information has been obtained to the satisfaction of the Departmental Committee, Credentials Committee, and the Medical Executive Committee.

Section 2: Appointment Process

a. All application for appointment shall be referred to the committee of the Department in which the applicant seeks privileges. The Departmental committee to which an application is referred shall review applications in a timely manner, not to exceed three months, and shall provide the Credentials Committee with a written report and its recommendations as to staff appointment for each applicant.

b. Within three months after receipt of the completed applications for membership from the Department committee, the Credentials Committee shall complete its investigations, and make a written report to the Medical Executive Committee. Prior to making this report, the Committee shall examine the character, professional competence, qualifications, and ethical standing of the application and shall determine, through references given by the applicant and from other sources available to it, including the report from the department in which privileges are sought, whether the applicant has established the necessary qualifications for the category of staff membership and clinical privileges as requested.

c. In evaluating the application, the Credentials Committee shall consider the applicant's proposed use of the Health Center facilities and their primary area of practice. The Committee shall also consider any policy approved by the Board of Directors regarding the needs of the Health Center in relation to the availability of beds and services, and the balance of the Medical Staff and also the needs of the community. The Committee's report when completed shall be forwarded to the Medical Executive Committee, together with the completed application and a recommendation that the applicant be either appointed to the Medical Staff or rejected for Medical Staff membership, or that the application be deferred for further consideration. If the Credentials Committee recommends appointment to the Medical Staff, they shall further recommend the Medical Staff category and privileges that might be granted to the applicant.

d. At its next regular meeting, after receipt of the application and the report and recommendations of the Credentials Committee, the Medical Executive Committee shall determine whether to recommend to the Board of Directors that the applicant be appointed to the Medical Staff, that the applicant be rejected for Medical Staff membership, or that the application be deferred for further consideration. All recommendations to appoint must specifically recommend the staff category and the clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges. Prior to making its recommendation to the Board of Directors, for probable cause, the Medical Executive Committee may require the applicant to submit to, and authorize release to the Medical Executive Committee, a medical or psychological examination. This examination is to be performed by a practitioner who is mutually accepted by the Medical Executive Committee and the applicant in order to enable the Committee to resolve any doubt regarding the applicant's qualifications for membership. Failure of an applicant to abide by such a requirement shall be deemed a failure by the applicant to carry the burden of producing adequate information for proper evaluation of the applicant's qualifications.

e. When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up within three months with a subsequent recommendation for appointment with specified clinical privileges, or for rejection for staff membership.

f. When the recommendation of the Medical Executive Committee is favorable to the applicant, the Medical Staff President shall promptly forward the application with all supporting documentation and recommendations to the Board of Directors.

g. When the recommendation of the Medical Executive Committee is adverse to the applicant, either in respect to appointment or clinical privileges, the Chief Executive Officer shall promptly so notify the applicant by special notice. No such adverse recommendation shall be forwarded to the Board of Directors until after the applicant has exercised or has been deemed to have waived the right to a hearing provided for in Article X of these Bylaws.

h. At its next regular meeting after receipt of a favorable recommendation, the Board of Directors or its Medical Executive Committee shall act on the matter. If the decision of the Board of Directors is adverse to the applicant in respect to either appointment or clinical privileges, the Chief Executive Officer shall promptly notify the applicant of such adverse decision, including the basis or reason thereof, by special notice, and such adverse decision shall be held in abeyance until the applicant has exercised or has been deemed to have waived rights under Article X of these Bylaws.

i. Except as otherwise provided in Article X, Section 8, at its next regular meeting after all the applicant's rights under Article X have been exhausted or waived, the Board of Directors or its Medical Executive Committee shall act in the matter. The decision of the Board of Directors with respect to appointment, rejection and clinical privileges shall be final, except that the Board of Directors may defer action by referring the matter to the Joint Conference Committee. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Board of Directors shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation, and new documentation in the matter, if any, the Board of Directors shall make a decision either to appoint the applicant to the staff or to reject the applicant for staff membership. All decisions to appoint shall include a delineation of the clinical privileges which the applicant may exercise.

j. When the decision of the Board of Directors is final, it shall send special notice of such decision through the Chief Executive Officer to the President of the Medical Staff, and the applicant.

k. Following denial of a prior application or non-administrative termination from the Medical Staff, reapplications for appointment to the Medical Staff shall not be accepted nor considered unless the applicant has been invited by the Medical Executive Committee to submit an application.

Section 3: Reappointment Process

a. All applications for reappointment shall be referred to the committee of the Department to which the member is assigned. Each Departmental committee reviews reappointment applications at least quarterly and provides the Credentials Committee with a written report and its recommendations regarding reappointments for each applicant. At least 30 days prior to the final expiration of each member's appointment, the Credentials Committee shall complete its review of all pertinent information available on each member scheduled for periodic appraisal, for the purpose of determining its recommendations for reappointments to the Medical Staff, and for delineation and granting of clinical privileges for the ensuing period. In conducting its review, the Credentials Committee shall file a request, pursuant to Section 805.5 of the California Business and Professions Code, for a copy of any report that has been made with respect to the member under consideration for reappointment, in accordance with Article VI, Section 1 "d." hereinabove.

b. Each recommendation concerning the reappointment of a member and the clinical privileges and staff category to be granted upon reappointment shall be based upon that member's professional competence and clinical judgment in the treatment of patients, ethics and conduct, physical and mental

health status as being satisfactory to safely and competently exercise the clinical privileges requested, attendance at Medical Staff meetings and participation in staff affairs, documented evidence of continuing medical education, compliance with Medical Staff Bylaws, Rules and Regulations, cooperation with Health Center personnel, use of the Health Center's facilities for their patients, relations with other practitioners, and general attitude toward patients, the Health Center, and the public. There must also be an assessment of the member's clinical competence and quality of care based on peer review information and clinical data. Each clinical department must define the level of clinical activity necessary to maintain clinical privileges for each staff category within each specialty/subspecialty, subject to approval by the Medical Executive Committee.

c. At least 15 days prior to the expiration of a member's appointment, the Credentials Committee shall make written recommendations to the Medical Executive Committee concerning the reappointments or non-reappointment of the member including any changes in staff category or clinical privileges to be granted the member for the ensuing period. Where non-reappointment or a decrease in staff category or clinical privileges is recommended, the reason for such recommendation shall be stated and documented. At the time of reappointment, the primary health care institution of each member will be queried to help assess the member's quality of patient care.

d. At least ten days prior to the expiration of a member's appointment, the Medical Executive Committee shall make written recommendations to the Board of Directors through the Medical Staff President, concerning the reappointment or non-reappointment of the member including changes in staff category or clinical privileges to be granted to the member for the ensuing period. Prior to making its recommendation to the Board of Directors, for cause, the Medical Executive Committee may require the applicant to submit to, and authorize release to the Medical Executive Committee, of a medical or psychological examination. This examination is to be performed by an appropriate practitioner who is mutually accepted by the Medical Executive Committee and the applicant in order to enable the Committee to resolve any doubt regarding the applicant's qualifications for continued membership. Failure of an applicant to abide by such a requirement shall trigger the Corrective Action Process pursuant to Article IX of these Medical Staff Bylaws. Where non-reappointment or a decrease in staff category or clinical privileges is recommended, the reasons for such recommendation shall be stated.

e. Thereafter, the procedure provided in Section 2, subsections h, I, j, and k of this Article VI, relating to the recommendations of applications for initial appointment, shall be followed.

f. In acting on matters of reappointment the Health Center, all its representatives, and its Medical Staff, shall be acting pursuant to the same rights, privileges, immunities and authority as are provided for in Section 1, Article VI, of these Bylaws.

g. Members who have been administratively terminated or resign in anticipation of administrative termination from the Medical Staff for failure to submit an application for reappointment in a timely manner, failure to correct a previous probation or condition, or failure to pay medical staff dues must wait a minimum of 24 months before submitting another application for Medical Staff membership, absent a finding of special circumstances by the Medical Executive Committee.

Article VII: Allied Health Personnel

Section 1: Introduction

Allied Health Personnel are persons:

a. who are practitioners, other than physicians, dentists, and podiatrists, who have specialized training, experience, and competency qualifying them to provide limited or specialized clinical services to patients, and who have not been excluded from any health care program funded, in whole or in part, by the Federal government, and;

b. who have been granted privileges to provide such limited services for patients of Providence Saint John's Health Center.

Section 2: Categories of Allied Health Personnel (AHP)

a. The Board of Directors, with the recommendation of the Medical Executive Committee will decide which type of AHP will be assigned to which category.

b. Independent AHP are practitioners such as clinical psychologists who may provide services to patients without the supervision of a physician.

c. Dependent AHP practitioners are certified nurse midwives, nurse practitioners, acupuncturists, registered nurse first assistants, and physician assistants, who provide services to patients only under the supervision of a designated physician.

Section 3: AHP Privileges

a. Application for Privileges

i. All application for privileges shall be in writing, shall be signed by the applicant, and shall be submitted on a prescribed form.

1. Licensed Dependent Allied Health Personnel are not eligible to request privileges which are not held by their supervising physicians, except under special circumstances as determined on a case-by-case basis by the Medical Executive Committee at its sole discretion.

ii. The application for privileges shall include:

1. documentation of training and experience and appropriate references and releases;

2. documentation of appropriate unencumbered, unsuspended, unrestricted, non-probationary license by the State of California to practice within their requested AHP specialty or certification as required by law or regulation;

3. evidence of required professional liability insurance coverage for the scope of clinical privileges requested, which meets or exceeds the minimal level required by the Board of Directors and is issued by a carrier approved by the Board of Directors;

4. agreement to comply with applicable provisions of Medical Staff and Health Center Bylaws, Rules and Regulations, and Policies and Procedures;

5. acknowledgment that granting of privileges does not create rights of membership such as those outlined in Article VIII of the Medical Staff Bylaws, and that privileges may be

suspended or terminated by the President of the Medial Staff, the Chief Medical Officer, as set forth in Article VII, Section 3, subsection b, paragraph c, subparagraph i.

b. Credentialing Process

i. For Independent AHPs, the credentialing process is similar to the appointment process for Medical Staff appointment (Article VI, Section 2).

ii. For Dependent AHPs, the credentialing process is similar to the appointment process for Medical Staff appointment (Article VI, Section 2).

c. Allied Health Personnel, except clinical psychologists, shall have no rights to a hearing or appellate review pursuant to Article X based on the denial of an application for privileges or any limitation or removal thereof. Instead, Allied Health Personnel suspended or terminated pursuant to Article VII, Section 3, subsection a, paragraph b, subparagraph v shall be entitled to the following fair hearing and appellate procedures:

i. A practitioner who is suspended or terminated under Article VII, Section 3, subsection a, paragraph b, subparagraph v shall be provided with written notice by the individual taking such action of such suspension or termination. Upon a written request made within ten days, the practitioner shall be provided with a notice which shall include a concise description of the acts or omissions or other reasons which form the basis for the adverse action, and a notice and description of the practitioner's right to request a hearing and appellate review. A failure of the practitioner to request a hearing to which such practitioner is entitled by these Bylaws within the time frame and in the manner herein provided shall be deemed to be a waiver of the practitioner's right to such hearing and to any appellate review and an acceptance of the adverse decision.

ii. A practitioner's request for a hearing must be received in writing by the individual who suspended or terminated the practitioner, either the President of the Medical Staff or the Chief Medical Officer (the "Representative"), within ten days of the practitioner's receipt of the notice of the adverse action. The request must include the practitioner's written response to the basis of the adverse action, if any, including any documentation in support thereof that the practitioner would like to be considered in the hearing.

iii. Within 15 days of the Representative's receipt of the practitioner's request, the Representative shall send the practitioner a notice of hearing which shall include the time, place, and date of the meeting (which shall be no more than 30 days from the Representative's receipt of the practitioner's request for a hearing) and the nature of the discussions to take place at such a hearing. The hearing shall take place at the Health Center and shall be comprised of the Representative and the practitioner. The nature of the discussion shall be the basis for the suspension or termination as stated in the notice of suspension or termination, and the practitioner's response as set forth in the request for a hearing. The Representative shall consider the oral and written information provided by the practitioner, and shall render a written decision to uphold, amend, or set aside the suspension or termination, and shall provide such decision to the practitioner in writing within ten days of the hearing.

iv. Within ten days after the practitioner's receipt of an adverse decision, the practitioner may, by notice to the CEO, request an appellate review by held on the record on which the adverse decision was based. If such a request is not made within ten days, the practitioner shall be

deemed to have waived the right to an appellate review and to have accepted the adverse decision.

v. The CEO shall conduct the appellate review within 30 days of the CEO's receipt of the request for appellate review. The CEO will exercise his / her independent judgment whether evidence exists to support the decision. New or additional matters not raised during the original hearing shall not be introduced at the appellate review except under unusual circumstances, and the CEO shall, in the CEO's sole discretion, determine whether such new matters shall be accepted.

vi. Within ten days of the conclusion of the appellate review, the CEO shall make a final decision in the matter and shall send notice thereof to the practitioner, by special notice. The CEO's decision shall be final and shall not be subject to further hearing or appellate review.

c. Scope of Privileges:

i. Are consistent with training, experience, demonstrated competency, and within limits of applicable licensing laws;

ii. Require a proctoring period and review and renewal of privileges at least every two years;

iii. May include appropriate consultation, examinations, performance of procedures, oral/written orders if privileged to do so and co-signed by the supervising physician within per policy; but may not include admitting or independent care privileges.

Section 4: Renewal of AHP Privileges

Prior to the periodic expiration of privileges, each AHP will be requested to reapply for continuing privileges. Recredentaling will be based on clinical competency, ethical behavior, effective and cooperative relationships with patients and staff, current licensing, current malpractice insurance, and participation at the Health Center. The recredentialing process and approval will be similar to that described in Section 3 above.

Section 5: Prerogatives and Responsibilities

a. To provide services as requested by a member to patients at Providence Saint John's Health Center within the scope of privileges granted.

b. To make appropriate entries in patient's medical records to document findings, services, and recommendations within the scope of privileges granted and applicable laws and regulations.

c. To attend educational or administrative meetings at which attendance is authorized or required by the Chair of the Clinical Department under whom the AHP exercises their privileges.

d. To pay any fees required or processing of application or review and renewal of privileges.

Article VIII: Clinical Privileges

Section 1: Clinical Privileges

a. Every practitioner practicing at the Health Center by virtue of Medical Staff membership or otherwise shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted by the Board of Directors, except as provided in Sections 2 and 3 of this Article VIII.

b. Every application for staff appointment must contain a request for the clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, licensure, experience, competence, ability to exercise such privileges, references and other relevant information and available data, including an appraisal by the clinical Department in which such privies are sought. The applicant shall have the burden of establishing qualifications and competence to exercise the clinical privileges requested.

c. Initial requests for privileges shall be evaluated on the basis of the Health Center's needs and ability to support the requested privileges and assessment of the applicant's general competencies with respect to the requested privileges, as evidenced by the applicant's license, education, training, experience, demonstrated professional competence, judgment and clinical performance~~,~~ (as confirmed by peers knowledgeable of the applicant's professional performance), health status, the documented results of patient care and other quality improvement review and monitoring. This may include performance of a sufficient number of procedures each year to develop and maintain the applicant's skills and knowledge and compliance with any specific criteria applicable to the privileges requested. Privilege determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where an applicant exercises privileges.

d. Granting clinical privileges during reappointment shall be based upon the direct observation of care provided, review of records of patients treated in this or other health centers, relevant information from performance improvement activities, practitioner specific data compared to aggregate, if available, and review of the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical care. Granting of these privileges may require documentation of a sufficient number of procedures performed to maintain clinical competence over the time period in question.

e. New or increased clinical privileges shall be considered only upon the written application of the member on a form approved by the Medical Executive Committee, and such application for additional privileges shall be processed in the same manner as an initial application for Medical Staff appointment.

f. Privileges granted to members such as dentists and podiatrists shall be based on their education, training, experience, competence, references and other relevant information. The scope and extent of these surgical procedures shall be specifically delineated and granted in the same manner as all other surgical privileges. These privileges shall be under the overall supervision of the Chair of the Department of Surgery. All such patients shall receive the same basic medical appraisal as patients admitted to other surgical services. If necessary, a physician member shall be designated by the dentist or podiatrist as co-admitting and attending physician, and shall be responsible for completing the admission general medical history and physical examination, if applicable, and for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

Section 2: Temporary Appointment and Temporary Privileges

a. Temporary Appointment~~:~~

i. Upon receipt of an application for membership from an appropriately licensed physician, dentist or podiatrist, the Chief Executive Officer, Chief Medical Officer or designee may, upon the basis of information than available which may reasonably be relied upon as to the competence and

ethical standing of the applicant, and with the concurrence of the President of the Medical Staff and the Departmental chair concerned, grant temporary appointment and appropriate clinical privileges to the applicant for a term not to exceed 120 days. In exercising such privileges, the temporary appointee shall act under the supervision of the chair of the department to which the temporary appointee is assigned.

ii. Special requirements of supervision and reporting may be imposed by the Departmental chair concerning any physician, dentist or podiatrist granted temporary appointment.

iii. Temporary appointments may be immediately terminated at any time by the Chief Executive Officer, Chief Medical Officer, or President of the Medical Staff after consultation with the appropriate Departmental chair. If the termination is effective immediately and the member has been providing care to a patient in the Health Center at that time, the Departmental chair, or, in the Chair's absence, the Chief Medical Officer or the President of the Medical Staff, shall assign a member to assume responsibility for the care of such patient(s) until discharge from the Health Center. The wishes of the patient(s) shall be considered where feasible in the selection of such substitute member.

b. Temporary Consultative Privileges

i. To fulfill an important patient care, treatment, and service need, with the concurrence of the appropriate Departmental chair, the Chief Executive Officer, Chief Medical Officer, or President of the Medical Staff may grant temporary privileges for consultation involving a specific patient, to a physician, dentist, or podiatrist currently licensed to practice who is not an applicant for membership, and in accordance with the procedures approved by the Medical Staff. Prior to exercising such temporary privileges the practitioner must first sign an acknowledgement that they agree to be bound by the Health Center and Medical Staff Bylaws, Rules and Regulations, in all matters relating to his/her temporary privileges. The physician, dentist, or podiatrist shall furnish documentation per the procedures approved by the Medical Staff. Such temporary privileges shall be restricted to consultation for not more than four patients in any one year by any physician, dentist, or podiatrist.

ii. Temporary Consultative Privileges issues to expert proctors can be issued as many times as deemed necessary by the Department Chair.

c. Temporary Disaster Privileges

i. In the case of a disaster in which the disaster plan has been activated and the Health Center is unable to handle the immediate patient needs, the President of the Medical Staff, or in his/her absence, the Vice-President of the Medical Staff or President-Elect, may grant disaster privileges. In the absence of the President of the Medical Staff, the Vice-President of the Medical Staff or President-Elect, the Chief Executive Officer, or the Chief Medical Officer or their designee may grant the disaster privileges consistent with this subsection. The granting of privileges under this subsection shall be on a case-by-case basis at the sole discretion of the individual authorized to grant such privileges. An initial granting of disaster privileges is reviewed by a person authorized to grant disaster privileges within 72 hours to determine whether the disaster privileges should be continued.

ii. The verification process of the credentials and privileges of individuals who receive disaster privileges under this subsection shall be developed in advance of a disaster situation. This

process shall begin as soon as the immediate disaster situation is under control, and shall meet the following requirements in order to fulfill important patient care needs:

1. The Medical Staff identifies in writing the individual(s) responsible for granting disaster privileges.

2. The Medical Staff describes in writing the responsibilities of the individual(s) responsible for granting disaster privileges.

3. The Medical Staff describes in writing a mechanism to manage the activities of individuals who receive disaster privileges. There is a mechanism to allow staff to readily identify these individuals.

4. The Medical Staff addresses the verification process as a high priority. The Medical Staff has a mechanism to ensure that the verification process of the credentials and privileges of individuals who receive disaster privileges begins as soon as the immediate situation is under control. This privileging process is identical to the process established under the Medical Staff Bylaws for granting temporary privileges to fulfill an important patient care need.

5. Those authorized under subsection a. may grant disaster privileges upon presentation of a valid picture identification issues by a state, Federal or regulatory agency and at least one of the following:

    a. A current picture Hospital identification card clearly identifying professional designation.

    b. A current license to practice.

    c. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or Federal organization or group.

    d. Identification indicating that the individual has been granted authority by a Federal, state, or municipal entity to render patient care in disaster circumstances.

    e. Identification by current health Center or Medical Staff member(s) with personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

iii. Current professional licensure of those providing care under disaster privileges is verified from the primary source as soon as the immediate emergency situation is under control or within 72 hours from the time the volunteer licensed independent practitioner presents him/herself to the Health Center, whichever comes first. If primary source verification cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the Health Center documents will of the following:

1. The reason(s) verification could not be performed within 72 hours of the practitioner's arrival.

2. Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services.

3. Evidence of an attempt to perform primary source verification as soon as possible.

iv. Members of the Medical Staff shall oversee those granted disaster privileges.

d. A physician, dentist, or podiatrist shall not be entitled to the procedural rights afforded by Article X because of their inability to obtain temporary appointment or privileges or because of any termination or suspension or temporary appointment or privileges.

Section 3: Emergency Privileges

In the case of an emergency, any physician, dentist, or podiatrist member to the degree permitted by their license and regardless of service or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Health Center necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such physician, dentist, or podiatrist must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or they do not desire to request privileges, the care of the patient shall be assigned to an appropriate member as described in Section 2, subsection a, paragraph c above. For the purpose of this section, an "emergency" is defined as a condition in which serious, permanent harm might result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

Section 4: Protection from Liability

In matters relating to clinical privileges, all members and other practitioners, and all appropriate Health Care personnel, including members of the Board of Directors and Health Center management, shall be acting pursuant to the same rights, privileges, immunities, and authority as are provided for in Section 1, Article VI, of these Bylaws.

Article IX: Corrective Action

Section 1: Procedure

a. Criteria for Initiation

Whenever the activities or professional conduct of a member with clinical privileges are considered to be lower than the standards or aims of the Medical Staff, or to be disruptive to the operations of the Health Center, corrective action against such member may be requested by any officer of the Medical Staff, by the Chair of any clinical department, by the Chair of any standing committee of the Medical Staff, by the Chief Medical Officer, by the Chief Executive Officer, or by the Board of Directors.

b. Initiation

All requests for corrective action shall be in writing, shall be made to the Medical Executive Committee and the appropriate Department Chair, and shall be supported by reference to the specific activities or conduct constituting the grounds for the request. An investigation begins when the Medical Executive Committee authorizes the initiation of the investigation of a Medical Staff member.

c. Expedited Initial Review

i.. Regardless of whether a request for corrective action has been made pursuant to Article IX, Section 1, subsection b, whenever information suggests that corrective action may be warranted, the President of the Medical Staff, Department Chair, or their designee may, on behalf of the Medical Executive Committee, immediately conduct whatever interviews or other information-gathering activities they deem reasonable. The information developed during this initial review shall be presented to the Medical Executive Committee, which shall decide whether or not to initiate a corrective active investigation or recommend corrective action.

ii. If the complaint is o harassment or discrimination that involves a patient or patient visitor, the President of the Medical Staff or his/her designee(s), together with representatives of administration, and/or an attorney for the Health Center shall conduct an initial expedited review on behalf of the Medical Executive Committee. In cases of complaints of harassment or discrimination where the alleged harasser is a Medical Staff member and the complainant is not a patient or patient visitor, an expedited initial review shall be conducted by the President of the Medical Staff or his/her designee(s), and the Health Center's Vice-President of Human Resources or his/her designee(s), or by an attorney for the Health Center. The interviews of the member shall be conducted by the President of the Medical Staff or his/her designee(s), and the member shall be informed of the nature of the allegations. If the President of the Medical Staff does not conduct the review personally, he / she shall be kept apprised of the status of the initial review. The information gathered from an expedited initial review shall be referred to the Medical Executive Committee if it is determined that corrective action may be indicated against the member.

d. If the Medical Executive Committee decides to initiate a corrective action investigation or to recommend any of the corrective actions specified in Article X, Section 1, subsection a, the Medical Executive Committee shall direct the chair of Department wherein the member has such privileges, to appoint an ad hoc committee to investigate the matter and to notify by certified or hand delivered mail the member who is under investigation. This activity shall be reported to the Medical Executive Committee. If, however, the request for corrective action is predicated on cases already being reviewed in committee, the Department chair may report the activity of that committee to the Medical Executive Committee in lieu of appointing another ad hoc committee to investigate the matter.

e. Within 30 days after the Department's receipt of the request for corrective action, the Department shall make a report of its investigation to the Medical Executive Committee, unless the Medical Executive Committee, in its sole discretion, finds good cause to postpone the report. Prior to making of such report, the member against whom corrective action has been requested shall have an opportunity for an interview with the Departmental ad hoc investigating committee unless the member had the opportunity to meet with a Departmental committee. At such interview, he/she shall be informed of the specific nature of the charges against him/her, and shall be invited to discuss, explain, or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. Minutes of such interview shall be made by the Department and included with its report to the Medical Executive Committee.

f. Within 30 days following receipt of a report from the Department concerning an investigation of a request for corrective action, the Medical Executive Committee shall take action upon the matter, unless the Medical Executive Committee finds good cause to postpone taking action. If the corrective action could involve a reduction or suspension of clinical privileges or a suspension or expulsion from the Medical Staff, the member may request to make an appearance before the Medical Executive

Committee, or the Medical Executive Committee may require such appearance, prior to its taking action on such request. This appearance shall be conducted on terms and in the manner set by the Medical Executive Committee, shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearing shall apply thereto. Minutes of such appearance shall be made by the Medical Executive Committee.

g. The action of the Medical Executive Committee on a request for corrective action may be to reject or modify the recommendation for corrective action, to issue a warning, a letter of admonition, or a letter of reprimand, to impose terms of probation or a requirement for consultation, to recommend reduction, suspension, or revocation of clinical privileges, to recommend than an already imposed summary suspension of clinical privileges be terminated, modified, or sustained, to recommend that the member's staff membership be suspended or revoked, or to impose or recommend any other corrective action that the Medical Executive Committee determines is reasonable and warranted.

h. Any recommendation by the Medical Executive Committee for reduction, suspension or revocation of clinical privileges, or for suspension or expulsion from the Medical Staff shall entitle the affected member to the procedural rights provided in Article X of these Bylaws if such action would result in a report to the Medical Board of California pursuant to Business and Professions Code Section 805.

i. The President of the Medical Staff shall promptly notify the Chief Executive Officer in writing of all requests for corrective action received by the Medical Executive Committee and shall continue to keep the Chief Executive Officer fully informed of all action taken in connection therewith. After the Medical Executive Committee has made its recommendation in the matter, the procedure to be followed shall be as provided in Article IX and Article X, if applicable, of these Bylaws.

Section 2: Summary Suspension

a. When action must be taken immediately in the best interest of patient care in the Health Center, either of the following may suspend summarily all or any portion of the clinical privileges of a member: The President of the Medical Staff, or the Medical Executive Committee. In the event of unavailability of the above designated parties or because of the immediacy of the situation, the following may exercise the right to suspend a member: The Chief Executive Officer, the Board of Directors, or the Chief Medical Officer. Summary suspension shall become effective immediately upon imposition. If the summary suspension is imposed by the Chief Executive Officer, the Board of Directors, or the Chief Medical Officer it shall remain in effect for two working days unless continued or removed by the President of the Medical Staff or Medical Executive Committee.

b. The Medical Executive Committee shall schedule a meeting to address the summary suspension within ten days of the suspension's imposition to determine (1) if the summary suspension was appropriate, (2) if the summary suspension should be continued, and (3) whether additional investigation or correction action may be warranted. The member shall be invited to make an appearance at that meeting, on the same terms set forth in Article IX, Section 1, subsection f. Summary suspension shall be reported to the Medical Board of California and the National Practitioner Data Bank in accordance with applicable law.

c. The Medical Executive Committee may recommend continuance, modification, or termination of the terms of the summary suspension.

d. Immediately upon the imposition of a summary suspension, the President of the Medical Staff, Chief Medical Officer, or responsible Departmental chair shall have authority to provide for alternative medical coverage for the patients of the suspended member still in the Health Center at the time of

such suspension. The wishes of the patients shall be considered in the selection of such alternative medical coverage.

Section 3: Automatic Suspension

a. License

i. Revocation, suspension or expiration:

1. A practitioner whose license, certificate or other legal credential authorizing him/her to practice in this State is revoked, suspended, or expires shall immediately and automatically be suspended from practicing in the Health Center. A practitioner whose license is expired shall have his/her privileges automatically suspended until such time as verification of current licensure can be obtained. If documentation of the renewed license is not obtained within 14 days of the suspension, a recommendation will be made for administrative termination of the practitioner's Medical Staff / AHP membership and clinical privileges. Practitioners whose membership and/or clinical privileges are administratively terminated shall have no hearing rights under Article X of these Bylaws.

2. A practitioner who fails to obtain or fails to maintain any certificate or credential required by law for the performance of a specific diagnostic or therapeutic procedure shall have his/her privileges to perform such procedure immediately and automatically revoked.

ii. Restriction:

1. Whenever a practitioner's license, certificate or other legal credential authorizing him/her to practice in this State is limited or restricted, any privileges which are within the scope of such limitation or restriction shall be automatically limited or restricted in a similar manner, and shall remain limited or restricted throughout the term of the restriction.

iii. Probation:

2. Whenever a practitioner is placed on probation by the State licensing or certifying authority, his/her membership status and privileges automatically and immediately shall be subject to the same terms and conditions of probation, and shall remain subject to those terms throughout the terms of the probation.

b. Drug Enforcement Administration (DEA) Certificate

i. A practitioner whose DEA Certificate is expired, revoked or suspended shall immediately and automatically be divested of the right to prescribe medications covered by such Certificate. Whenever a practitioner's DEA Certificate is subject to probation, the practitioner's right to prescribe medications shall automatically be subject to the same terms of the probation. As soon as possible after such automatic suspension or probation, the Medical Executive Committee shall convene to review and consider the facts under which the DEA certificate was revoked, suspended, or probation imposed. The Medical Executive Committee may then take such further corrective action as is appropriate to the facts disclosed in its investigation.

c. Failure to Meet Mandatory Appearance Requirement

i. Failure of a practitioner to appear at any meeting with respect to which he/she was given such special notice shall, unless excused by the Medical Executive Committee upon a showing of good cause, result in an 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 or of the Board of Directors, or through corrective action, if necessary.

d. Medical / Electronic Health Records

i. An automatic suspension shall, after warning of delinquency, be imposed for failure to complete medical records in a timely fashion. Such suspension shall take the form of withdrawal of a member's admitting privileges, and/or consulting and surgical privileges and shall be effective until medical records are completed. For the purpose of enforcing this Section, justified reasons for delay in completing medical records shall include, without limitation:

1. That the member is ill, on vacation, out of town, or justifiably unavailable for a period of time;

2. That the member is waiting for the results of a late report and the record is otherwise complete except for the discharge summary and the final diagnosis;

3. That a member has dictated reports and is waiting for Health Center personnel to transcribe them.

e. Professional Liability Insurance Coverage

i. A practitioner who fails to maintain the required levels of professional liability insurance coverage for the scope of clinical privileges held with a carried approved by the Board of Directors, or whose professional liability insurance is revoked, suspended, or expires, shall be immediately and automatically suspended from exercising all clinical privileges until such time as proof of such coverage is provided, including coverage of any acts or potential liabilities that may have occurred or arisen during the period of a lapse in coverage. If documentation of the renewed appropriate professional liability insurance coverage is not obtained within 14 days of the suspension, a recommendation will be made for administrative termination of the practitioner's Medical Staff / AHP membership and clinical privileges. Practitioners whose membership and/or clinical privileges are administratively terminated shall have no hearing rights under Article X of these Bylaws.

f. Conviction of a Felony

i. A practitioner who has been convicted of a felony may be suspended by the Medical Executive Committee from practicing in the Health Center. This suspension shall become effective immediately regardless of whether or not an appeal is taken or pending from said judgment. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Board, or through corrective action, if necessary.

g. Failure to Pay Dues

i. If a practitioner fails to pay required dues by the date specified per written warning of delinquency, the practitioner's Medical Staff membership and clinical privileges shall be automatically suspended, and a recommendation will be made for administrative termination of the practitioner's Medical Staff membership and clinical privileges. Practitioners whose membership and/or clinical privileges are administratively terminated shall have no hearing rights under Article X of these Bylaws.

h. Automatic Action Based Upon Actions Taken by another Peer Review Body after a Hearing

i. The Medical Executive Committee may impose any adverse action that has been taken by another peer review body (as that term is used in California Business and Professions Code Section 809, et seq.) after a hearing that meets the requirements of Business and Professions Code Section 809, et seq. The adverse action may be an action taken by the original peer review body, including, but not limited to, denying membership and/or privileges, restricting privileges, or terminating membership and/or privileges. The action may be taken only if the Medical Executive Committee has made a determination, reasonable under the circumstances, that (1) the other peer review body took action based upon standards that were essentially the same as those in effect at this Health Center at the time the action is taken, (2) the practitioner has exhausted or waived any hearing rights and any appeal offered by the original peer review body, and (3) the action by the other peer review body became final within the past 36 months. The Medical Executive Committee need not await a final disposition in any judicial proceeding that may be brought challenging the action at the original peer review body before imposing the action.

ii. The practitioner shall not be entitled to any hearing or appeal to address the action unless the Medical Executive Committee takes an action that is more restrictive than the final action taken by the original peer review body. Any hearing and appeal that the practitioner requests shall not address the merits of the action taken by the original peer review body that were already reviewed at the original peer review body's hearing, and shall be limited to only the question of whether the action is more restrictive than the original peer review body's action.

iii. After the imposition of the action, the practitioner may challenge the action on procedural grounds only by submitting a statement to the Chief Executive Officer and the President of the Medical Staff establishing one of three grounds:

1. The practitioner has not exhausted or waived any hearing rights and any appeal offered by the original peer review body;

2. The action by the other peer review body become final more than 36 months ago; or

3. The practitioner successfully overturned the original peer review action in court.

iv. Nothing in this section shall preclude the Medical Executive Committee or the Board of Directors from taking a more restrictive action than another peer review body based upon the same facts or circumstances.

i. The imposition of an automatic suspension pursuant to this Section shall not give rise to any right to heating or appellate review pursuant to Article X, except for the question of whether the grounds supporting the automatic suspension have occurred.

Section 4: Exclusion from a Federal Health Care Program

a. New applicants to the Medical Staff or Allied Health Personnel Staff who are currently sanctioned and involuntarily excluded, under applicable law, from any Federal Health Care Program shall be notified that their applications will not be processed because they do not meet the basic qualifications for membership. They shall further be notified that they have no right to a hearing regarding the matter pursuant to Article X of these Medical Staff Bylaws.

b. The Medical Staff membership and clinical privileges of a member who is excluded from a Federal Health Care Program may be automatically terminated. The member shall not be entitled to a hearing under Article X of these Medical Staff Bylaws. However, the member may submit a statement to the Chief Executive Officer and the President of the Medical Staff contesting the allegation for which he /she has been excluded. After the expiration of the term of the exclusion, a member must reapply as an initial applicant before obtaining Medical Staff membership or clinical privileges.

c. Whenever a member's Medical Staff membership and clinical privileges are terminated pursuant to this Section, the Chief Medical Officer or the President of the Medical Staff shall take all necessary steps to ensure that the care of any patients currently under the member's care in the Health Center is transferred to another appropriate member. The wishes of the patient shall be considered, where feasible, in choosing a substitute member.

Section 5: Confidentiality and Protection from Liability

a. Medical Staff, Department, division and/or committee minutes, files, and records, including information regarding any members or applicants to this Medical Staff, shall, to the fullest extent permitted by law, be confidential. Dissemination of such information and records shall only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff, or, where no officially adopted policy exists, only with the express approval of the Medical Executive Committee or its designee.

b. In matters relating to corrective action, all Medical Staff members and other practitioners, and all appropriate Health Center personnel, including members of the Board of Directors and Health Center management, shall be acting pursuant to the same rights, privileges, immunities, and authority as are provided for in Article VI of these Bylaws.

Article X: Hearing and Appellate Review Procedure

Section 1: Hearing and Appellate Review

a. Grounds for Hearing

Any one or more of the following actions or recommended actions shall be deemed actual or potential adverse action and shall constitute grounds for a hearing if recommended for medical disciplinary cause or reason and if the action or recommendation, if adopted by the Board of Directors, would result in a

report to the applicable licensing authority pursuant to California Business and Professions Code Section 805:

i. Denial of Medical Staff membership;

ii. Denial of Medical Staff reappointment;

iii. Suspension of Medical Staff membership;

iv. Expulsion from Medical Staff membership;

v. Denial of requested clinical privileges;

vi. Reduction in clinical privileges;

vii. Suspension of clinical privileges;

viii. Termination of clinical privileges;

ix. Any other action which, if ratified by the Board of Directors, would require that a report be filed with the applicable licensing authority pursuant to Business and Professions Code Section 805 or 805.01.

b. Adverse Medical Executive Committee Recommendations

i. When any member, applicant, or eligible Allied Health Personnel receives special notice of an adverse recommendation of the Medical Executive Committee that, if ratified by decision of the Board of Directors, would constitute grounds for a hearing pursuant to Article X, Section 1, subsection a, the member or Allied Health Personnel shall be entitled, upon written request, to a hearing before an ad hoc committee of the Medical Staff. If the recommendation of the ad hoc committee following such a hearing is still adverse to the affected member, or Allied Health Personnel, he/she shall then be entitled, upon written request, to an appellate review by the Board of Directors before a final decision is rendered.

c. Adverse Board of Directors Decision

i. When any member or eligible Allied Health Personnel receives special notice of an adverse decision by the Board of Directors taken after the Board has consulted with and then directed the Medical Executive Committee to reconsider a favorable decision; and where the Medical Executive Committee fails to take action in response to direction from the Board, the Board may issue the adverse action and the practitioner may request a hearing. A hearing held in this circumstance must comply with all procedures and rules applicable to peer review proceedings established by both State law and these Bylaws. If such rearing does not result in a recommendation favorable to the member or eligible Allied Health Personnel, he/she shall then be entitled, upon written request, to an appellate review by the Board of Directors before a final decision is rendered.

d. Individual Evaluations versus Requests to Review Rules and Requirements

i. The sole purpose of the hearings and appeals provided in this Article is to evaluate individual Medical Staff members on the bass of Bylaws, Rules and Regulations, policies and standards of the Medical Staff and Health Center. The Judicial Review Committees and Arbitrators provided for under this Article have no authority to modify, limit, or overrule any established Bylaw , Rule, Regulation, policy or requirement (collectively "Rules or Requirements"), and shall not entertain challenges to such rules and requirements. Any Medical Staff member wishing to challenge an established Rule or Requirement must first notify the Medical Executive Committee and the Board of Directors of the Rule or Requirement he/she wishes to challenge and the basis for the challenge. The Board of Directors shall then consult with the Medical Executive Committee regarding the request. No Medical Staff member shall initiate any judicial challenge to a Rule or Requirement until the Board of Directors, following consultation with the Medical Executive Committee, has reviewed the Rule or Requirement in question and has either decided not to reconsider, or has upheld the particular Rule or Requirement.

e. Substantial Compliance

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

f. Hearings Prompted by Board of Directors Action

i. For the purposes of this Article, if the hearing is based on adverse action by the Board of Directors, the chair of the Board of Directors shall fulfill the function of the President of the Medical Staff, and references to the Medical Executive Committee shall be understood as references to the Board of Directors.

g. Definitions / Applicability of Terms

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

1. As used in this Article, the term "**member**" may include applicant or eligible Allied Health Personnel in matters relating to denial of appointment.

2. "**Medical disciplinary cause or reason**" refers to a basis for disciplinary action involving an aspect of a practitioner's competency or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

3. "**Date of receipt**" of any notice or other communication is defined under "Definitions" listed at the beginning of these Bylaws.

4. The procedures set forth in this Article for hearings before ad hoc committees of the Medical Staff shall also apply to hearings before ad hoc committees appointed by the Board of Directors under Section 1, subsection c except as otherwise specifically provided.

h. Exception to Hearing and Appellate Review

i. The denial, termination, or reduction of temporary appointment or privileges shall not give rise to any right to a hearing or appellate review unless the Health Center is required to report such denial, termination, or reduction to the Medical Board of California pursuant to Business and Professions Code Section 805 or to the National Practitioner Data Bank.

ii. Practitioners employed by the Health Center in a purely administrative capacity with no clinical responsibilities are subject to the regular personnel policies of the Health Center and to their contract or other terms of employment and need not be members of the Medical Staff. If they are members of the Medical Staff, their membership on the Medical Staff or clinical privileges may not be terminated without the procedures as provided in these Bylaws, unless otherwise stated by contract.

iii. Physicians, Dentists, or Podiatrists who contract with the Health Center to provide medico-administrative and/or clinical services must be members of the Medical Staff. Their clinical privileges and membership on the Medical Staff may not be terminated without the procedures as provided in these Bylaws, unless otherwise stated by contract.

Section 2: Request for Hearing

a. Notice of Action

i. Within 15 days after the Medical Executive Committee or the Board of Directors has taken an action or made a recommendation that constitutes grounds for a hearing under Article X, Section 1, subsection a, the Chief Executive Officer and President of the Medical Staff or designee(s) shall send the applicant or practitioner a Notice of Action which identifies the action or recommendation and includes a general statement of reasons for the action or recommendation. The Notice of Action which identifies the action or recommendation and includes a general statement of reasons for the action or recommendation. The Notice of Action shall inform the application or practitioner that he/she shall have 30 days following the date of receipt of the Notice of Action within which to request a hearing by the Judicial Review Committee, and that if the applicant or practitioner does not request a hearing within the time and in the manner set forth in this Article, he/she shall be deemed to have accepted the action or recommendation.

ii. If the practitioner does not request a hearing in the time frame and in the manner required by these Bylaws to challenge the action or recommendation, then any disciplinary action taken against the practitioner and any report made concerning the matter may be based only upon the reasons contained in the Notice of Action, unless a new Notice of Action is sent to the practitioner. However, this shall not preclude any Notice of Charges from differing from the Notice of Action by adding or deleting charges, acts, omissions, or reasons.

iii. A summary of the following hearing rights shall be specified in the Notice of Action:

1. That the practitioner shall have 30 days to request a hearing.

2. That the Hearing Body and Presiding Officer shall not gain a direct financial benefit from the outcome;

3. A record of the proceedings shall be made, copies of which may be obtained by the applicant or practitioner at his/her own expense;

4. The parties have a right to call, examine, and cross-examine witnesses, to present evidence which is relevant, and to submit a written statement at the close of the hearing;

5. The parties have a right, at the conclusion of the hearing, to receive a written recommendation from the hearing panel and a final written decision from the Board of Directors, including a statement of the basis for its action;

6. If applicable, the action of the Medical Executive Committee (or Board of Directors) will be reported to the applicable licensing authority, pursuant to California Business and Professions Code Section 805, and to the National Practitioner Data Bank pursuant to 42 U.S.C. Section 11101 et seq., in accordance with applicable law.

7. If the applicant or practitioner wishes to be accompanied by an attorney at the hearing pursuant to Article X, Section 8, subsection g, the applicant or practitioner must specify this intention in his/her request for a hearing. Otherwise, the applicant or practitioner's right to such attorney assistance shall be waived.

8. The failure of a practitioner to request a hearing to which they are entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of the right to such hearing and to any appellate review and an acceptance of the adverse recommendation.

b. When the waived hearing or appellate review relates to an adverse recommendation of the Medical Executive Committee or of a Judicial Review Committee of the Medical Staff, the same shall thereupon become and remain effective against the practitioner pending decision of the Board of Directors in this matter. When the waived hearing or appellate review relates to an adverse decision by the Board of Directors, the same shall thereupon become and remain effective against the practitioner in the same manner as a final decision of the Board of Directors.

c. Request for Hearing

i. The applicant or practitioner shall have 30 days following receipt of a Notice of Action to request a hearing. The request shall be in writing, addressed to the Chief Executive Officer. In the event the applicant or practitioner does not request a hearing within the time and in the manner described, the applicant or practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

Section 3: Notice of Hearing: Time and Place of Hearing

a. Within 60 days after receipt of a request for hearing from an applicant or practitioner entitled to the same, the President of the Medical Staff or the Board of Directors, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the Chief Executive Officer, notify the member of the time, place, and date so scheduled, by special notice. The hearing shall commence not less than 30 days, nor more than 60 days from receipt by the Chief Executive Officer, of the request for hearing, unless both parties consent to a delay or the Hearing Officer finds good cause for the delay.

Section 4: Notice of Charges

a. At least 30 days prior to the hearing's commencement and together with the notice stating the date, time and, place of the hearing, the Chief Executive Officer shall state clearly and concisely in writing the reason(s) for the adverse final proposed action taken or recommended, including the acts or omissions with which the practitioner is charged and a list of the charts in question, where applicable. The notice may include acts or omissions that occurred or were discovered after the adverse action or recommendation is made if such acts or omissions could support a finding that the action or recommendation is reasonable and warranted. A supplemental notice may be issued at anytime, provided the practitioner is given 30 days to prepare and respond.

Section 5: Composition of Judicial Review Committee

a. When a hearing is requested, the body whose decision prompted the hearing, may either appoint a Judicial Review Committee or a mutually agreed upon Arbitrator (the "Hearing Body") to review the matter. The President of the Medical Staff and the Chief Executive Officer or designee(s) (if the MEC initiated the action) or the Chief Executive Officer (if the Board of Directors initiated the action) shall have the authority to appoint the Hearing Body.

   i. If the Appointing Authority has determined that a Judicial Review Committee shall review the matter, the Appointing Authority shall appoint a Judicial Review Committee which shall be composed of not less than three members of the Active Medical Staff. At least two additional members may be appointed to serve as alternates. The members of the Judicial Review Committee shall not gain a direct financial benefit from the outcome, nor have acted as an accuser, investigator, fact finder or initial decision maker in the same matter at any level. Where feasible, the Judicial Review Committee shall include an individual practicing in the same specialty as the practitioner involved. One of the appointed Medical Staff members shall be designated as chair. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Judicial Review Committee. In the event it is not feasible to appoint a fully qualified Judicial Review Committee from the Active Medical Staff, qualified practitioners from the Provisional, Associate, or Courtesy Staff categories, or qualified practitioners from outside of the Medical Staff may be appointed.

   ii. If the hearing is based upon an adverse action by the Board of Directors, the Chair of the Board shall fulfill the functions assigned in this section to the President of the Medical Staff, and the Board of Directors shall assume the role of the Medical Executive Committee. The Board of Directors may, but need not, grant appellate review of decisions resulting from such hearings.

Section 6: Hearing Officer

a. The President of the Medical Staff and the Chief Executive Officer or designee(s) shall appoint a hearing officer to preside at the hearing. The Hearing Officer shall be an attorney-at-law or a member of the State of California Administrative Law Judge Office qualified to preside over an administrative hearing and preferably have experience in medical staff matters. The Hearing Officer shall gain no direct financial benefit from the outcome of the hearing and must not act as a prosecuting officer or as an advocate. The practitioner shall be notified of the appointment of the Hearing Officer and shall have five days after receipt of the written notice to consent or object to such appointment. If the practitioner objects, the reasons for such objection must be set forth in writing at the time of the objection. The Appointing Authority shall consider the practitioner's objection and shall determine, in its sole discretion, whether the practitioner has shown good cause to withdraw and replace the Hearing Officer.

b. The Hearing Officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have authority and discretion to make all rulings on questions which pertain to matters of law, procedure, or the admissibility of evidence. He/she shall have the authority to consider and rule upon any request on which the parties cannot agree after hearing from both sides and may impose any safeguards for the protection of the hearing process and that justice requires. If the Hearing Officer determines that either side in the hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as seems warranted by the circumstances, including limiting the scope of examination and cross-examination and setting fair and reasonable time limits on either side's presentation of its case. When no attorney is accompanying any party to the proceedings, the Hearing Officer shall have the authority to interpose and rule on appropriate objections regarding such matters.

c. The Hearing Officer shall not be entitled to vote. The Hearing Officer shall be from a legal firm that does not regularly represent the Health Center, the Medical Staff, the member or the applicant.

Section 7: Pre-Hearing Procedures

a. Discovery

i. This provision provides the exclusive right to and method of discovery in proceedings pursuant to this Article. The parties to the hearing shall have the following rights:

1. Both sides shall have the right at their respective expense, to inspect and copy any documentary information relevant to the charges which the other side has in its possession or control, as soon as practical after the party's request. Failure to provide access to the information at least 30 days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party shall not extend to confidential information referring solely to individually identifiable practitioners, other than the effected practitioner.

2. Each party shall furnish to the other a written list of the names of witnesses intended to be called to testify at the hearing.

3. Each party shall furnish a list of the exhibits intended to be introduced at the hearing.

4. The practitioner shall be provided with a list of the members of the Judicial Review Committee and of the hearing officer, if any. No exparte contact of the members of the committee relating to the hearing shall be permitted. The information required to be provided by this section shall be provided by the Medical Executive Committee at least 15 days prior to the hearing and by the practitioner at least ten days prior to the hearing, unless otherwise specified.

b. Motions

i. Each party shall provide special notice of any procedural disputes or motions that it intends to bring before the Judicial Review Committee at least ten days prior to the hearing. The Hearing

Officer may order that the first session of the hearing be reserved exclusively for resolution of such disputes and motions with the taking of evidence on the merits of the matter to be heard at a later session.

c. Voire Dire

i. Both sides shall have the right to a reasonable opportunity to ask members of the Judicial Review Committee and the Hearing Officer questions that are directly related to determining impartiality or whether they meet the qualifications set forth in these Bylaws. Challenges to any member of the Judicial Review Committee or Hearing Officer shall be ruled on by the Hearing Officer.

Section 8: Conduct of Hearing

a. A certified court reporter shall be present to make a record of the proceedings. The cost of attendance of the reporter shall be borne by the Health Center. The cost of any transcripts shall be borne by the party requesting it.

b. The personal presence of the member for whom the hearing has been scheduled shall be required. A member who fails without good cause to appear and proceed at such hearing shall be deemed to have waived rights in the same manner as provided in Section 2 of this Article X and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in Section 2, Article X.

c. Postponement or extensions of time beyond the times expressly set forth in these Bylaws may be granted upon agreement of the parties or may be requested by any party to the proceedings. Granting of such postponements shall be by the Hearing Officer only for good cause shown.

d. The Hearing Officer, shall preside over the hearing to determine the order of procedure during the hearing to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence and to maintain decorum.

e. Admissibility of Evidence

i. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter, including hearsay, which responsible persons customarily rely on in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. In making rulings pursuant to this Section, the Hearing Officer shall endeavor to promote a less formal rather than more formal, hearing process and also to promote the swiftest possible resolution of the matter, consistent with the standards of fairness set forth in these Bylaws. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems such actions appropriate.

f. The parties shall be entitled to submit memoranda concerning ay issue of procedure or of fact. Such memoranda shall become part of the hearing record but shall not be considered as evidence unless submitted as such.

g. Representation

i. The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, or character, including failure to comply with the Bylaws or Rules and Regulations of the Medical Staff. Accordingly, the practitioner is entitled to representation at the hearing as follows:

1. The Medical Executive Committee, when its action has prompted the hearing, shall appoint one of its members or some other Medical Staff member to represent it at the hearing, to present the facts in support of its adverse recommendation, and to examine witnesses.

2. The Board of Directors, when its action has prompted the hearing, shall appoint one of its members or a member of the medical or administrative staff to represent it at the hearing, to present the facts in support of its adverse decision and to examine witnesses.

3. The representative of the body whose decision prompted the hearing shall not be accompanied by an attorney if the practitioner is not accompanied by an attorney. The foregoing shall not be deemed to deprive any party of its right to the assistance of legal counsel for the purpose of preparing for the hearing.

4. Attorneys for either party may accompany their clients in the hearing sessions in order to advise their clients, although any such attorney shall not examine witnesses, shall not address the Hearing Body or Hearing Officer, and shall not make any oral statement whatsoever in the hearing.

5. Whether or not attorneys are present in the hearing pursuant to this Article, the practitioner and the body whose decision prompted the hearing may be represented at the hearing by a practitioner licensed to practice medicine in the State of California who is not also an attorney at law.

6. The Hearing Officer shall not allow the presence of attorneys at the hearing to be disruptive or cause a delay in the hearing process.

7. The practitioner and the Medical Executive Committee may stipulate to allow greater participation by attorneys in the hearing than this Article provides.

8. The above provisions shall not limit the ability of either party to engage an attorney to advise the party regarding the hearing process, whether or not the other party is advised by an attorney.

9. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision.

10. The affected member shall be responsible for coming forward with evidence in support of the challenge to the adverse recommendation or decision.

11. The applicable burden of proof shall be by the preponderance of evidence. Except as provided for initial applicants, the body whose decision prompted the hearing shall bear the burden of persuading the Judicial Review Committee by a preponderance of the

evidence that the action or recommendation is reasonable and warranted based on the evidence available during the hearing.

12. In cases of summary action, if the Judicial Review Committee finds that the summary action is not reasonable and warranted based on the evidence available during the hearing, the Judicial Review Committee shall make a finding as to whether the action was reasonable and warranted based on the evidence available to the authority imposing the suspension at the time it was imposed.

13. For the purposes of these proceedings, "**reasonable and warranted**" means the action or recommendation is within the range of reasonable alternatives that may be warranted under the circumstances, and not necessarily that the action or recommendation is the only measure or the best measure that can be taken or formulated in the Judicial Review Committee's opinion.

14. In hearings involving the denial of initial appointment for Medical Staff membership or initial application for new privileges, the burden shall be borne by the applicant. Such applicants shall not be permitted to introduce information not produced upon the request of the Medical Staff during the application process, unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence. In all other cases, the burden shall be borne by the Medical Executive Committee or the Board of Directors, whichever is appropriate. The burden of the first proceeding with evidence in all cases shall be on the Medical Executive Committee, or the Board of Directors, whichever is appropriate.

h. The parties to the hearing shall have the following rights:

i. to call and examine witnesses;

ii. to introduce written evidence and exhibits;

iii. to cross-examine any witness on any matter relevant to the issue of the hearing, to challenge any witnesses and to rebut any evidence;

iv. to present and rebut any evidence determined by the Hearing Officer to be relevant;

v. to be provided with all of the information made available to the Judicial Review Committee; and

vi. to submit a written statement at the close of the hearing, within guidelines as to length, format, and submission dates approved by the Hearing Officer, in consultation with the Judicial Review Committee, if applicable.

i. If the member who requested the hearing does not testify, they may be called and examined as if under cross-examination.

j. The hearing provided for in these Bylaws are for the purpose of intraprofessional resolution of matters bearing on professional conduct, professional competency, or character, including failure to comply with the Bylaws or Rules and Regulations of the Medical Staff. Accordingly, the practitioner is entitled to representation at the hearing as follows:

i. If the practitioner wishes to be accompanies by an attorney, he/she shall state the notice of such intent in accordance with the written Request for Hearing under Article X, Section 2, subsection a.

ii. The representative of the body whose decision prompted the hearing shall not be accompanied by an attorney if the practitioner is not accompanied by an attorney. The foregoing shall not be deemed to deprive any party of its right to the assistance of legal counsel for the purpose of preparing for the hearing.

iii. Attorneys for either party may accompany their clients in the hearing sessions in order to advise their clients, although any such attorney shall not examine witnesses, shall not address the Hearing Body or Presiding Officer, and shall not make any oral statement whatsoever in the hearing.

iv. Whether or not attorneys are present I the hearing pursuant to this Article, the practitioner and the body whose decision prompted the hearing may be represented at the hearing by a practitioner licensed to practice medicine in the State of California who is not also an attorney at law.

v. The Presiding Officer shall not allow the presence of attorneys at the hearing to be disruptive or cause a delay in the hearing process.

vi. The practitioner and the Medical Executive Committee may stipulate to allow greater participation by attorneys in the hearing than this Article provides. Otherwise, the above provisions of this Article shall prevail.

Section 9: Decision of the Judicial Review Committee

a. The decision of the Judicial Review Committee shall be based on the evidence presented at the hearing. This evidence may consist of the following:

i. Oral testimony of witnesses;

ii. Documents submitted in evidence; and

iii. Any other evidence deemed admissible under Section 8 above.

b. The Judicial Review Committee shall limit its review and decision to the action taken as set forth in the Notice of Charges; the record produced at the hearing and, whether or not the party has met his/her burden of proof and persuasion as set forth in these Bylaws. The Judicial Review Committee shall not have authority to expand the scope of its review and decision beyond the issues set forth in the Notice of Charges.

c. Within 30 days after final adjournment of the hearing, as determined by the hearing officer, the Judicial Review Committee shall render a decision which shall be accompanied by a written report, delivered along with the hearing record to the Medical Executive Committee, Chief Executive Officer, Board of Directors, and the practitioner. The decision may recommend confirmation, modification, or rejection of the original adverse recommendation. The decision shall include a concise statement of the Judicial Review Committee's findings of fact with respect to the reasons for the original recommendations with

its conclusions in support of the decision. The decision of the ad hoc hearing committee shall be considered final, subject only to such rights of appeal or review as described in these Bylaws.

Section 10: Appellate Review by the Board of Directors

a. Within 15 days after receipt of a notice of an adverse recommendation or decision after a hearing as above provided, either party may, by written notice to the Board of Directors delivered through the Chief Executive Officer, request an Appellate Review by the Board of Directors. Such notice may request that the Appellate Review be held only on the record on which the adverse recommendation or decision is based, or may also request that oral argument be permitted a part of the Appellate Review. The request for appeal shall include a brief statement as to the reasons for the appeal.

b. Grounds for Appeal

The grounds for appeal of the Judicial Review Committee's decision shall be:

i. substantial and prejudicial deviation from the procedures required by this Article in the conduct of hearing so as to deny a fair hearing;

ii. the Judicial Review Committee's decision is arbitrary, capricious, or unsupported by the evidence.

c. If such Appellate Review is not requested within 15 days, the affected parties shall be deemed to have waived the right to the same and to have accepted such adverse recommendations or decision, and the same shall become effective immediately, pending decision of the Board of Directors on the matter.

d. Within 30 days after receipt of such notice of request for Appellate Review, the Board of Directors shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall, through the Chief Executive Officer by special notice, notify the practitioner of the same. The date of the Appellate Review shall be not less than 30 days nor more than 90 days from the date of receipt of the written notice of request for Appellate Review, except that an Appellate Review on a summary suspension which is then in effect shall be held as soon as arrangements therefore may reasonable be made, but not more than 90 days from the date of receipt of such notice unless such time limit is otherwise waived by the parties.

e. The Appellate Review shall be conducted by the Board of Directors as a whole, or by a duly appointed Appellate Review Committee of the Board of Directors or not less than three Board members. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appellate Review Committee, so long as that person did not participate in the matter at any previous level (e.g., accuser, investigator, fact finder, or initial decision maker). The Appellate Review Committee may select an attorney who did not participate in the proceedings before the Judicial Review Committee to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal.

f. The Board of Directors or its appointed review committee shall act as an Appellate Review Committee. It shall review the record created in the proceedings and shall consider the written statements submitted by the interested parties for the purpose of exercising its independent judgment whether a preponderance of the evidence exists to support its decision. If oral argument is requested as part of the review procedure, both parties shall be present at such Appellate Review, shall be permitted to speak and shall answer questions put to them by any member of the Appellate Review Committee. The affected member or applicant has the right to be represented by an attorney or any other

representative designated by such member or applicant. The Medical Executive Committee or Board of Directors, whichever is appropriate, may be represented by one of its members or an attorney. The member of applicant may waive this right in which case the Medical Executive Committee or the Board of Directors will not be represented by an attorney who appears at the Appellate Review procedure. Should the member or the applicant choose to have an attorney present, the Medical Staff and the Board of Directors must receive written notification within three weeks of receipt of notice of the date of the Appellate Review.

g. New or additional matters not raised during the original hearing or in the Judicial Review Committee report, or otherwise reflected in the record, shall be introduced at the Appellate Review only under unusual circumstances, and the Appellate Review Committee shall, in its sole discretion, determine whether such new matters shall be accepted. Introduction of such evidence shall be subject to the same rights of cross-examination or confrontation provided in front of the Judicial Review Committee. If the appealing party chooses to submit a written statement, it shall be submitted at least ten days prior to the date set for the Appellate Review and the other party shall be given an opportunity to submit a responding written statement that shall be submitted at least three days prior to the date set for the Appellate Review.

h. The Appellate Review Committee may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of oral statements, if allowed, the Appellate Review shall be closed. The Appellate Review Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. The Appellate Review Committee may apply its independent judgment to the evidence in the record in determining whether or not the appealing party has established the existence of the grounds set forth in the Bylaws and on that basis may affirm, modify, or reverse the decision of the Judicial Review Committee or, in its discretion, refer the matter for further review and consideration. Upon the conclusion of such deliberations, the Appellate Review shall be declared finally adjourned.

i. The Appellate Review Committee may recommend that the Board of Directors affirm, modify, or reverse the action taken by the Judicial Review Committee, or, in its discretion, may recommend the matter be remanded back to the Judicial Review Committee for further review and decision.

j. Within 45 days after the conclusion of the appellate review, the Board of Directors shall make its final decision in writing in the matter and shall send notice thereof to the Chief Executive Officer, who shall deliver copies thereof to the Medical Executive Committee and to the affected member, by special notice. If this decision is in accordance with the Executive Committee's last recommendation in the matter, it shall be immediately effective and final, and shall not be subject to further hearing or appellate review.

Section 11: Time Limits

a. The time limits established by various sections in this Article for actions by the Medical Executive Committee, Judicial Review Committee, Appellate Review Committee, and the Board of Directors are guidelines and are not to be construed as mandatory. Failure to comply with these limits shall have no effect on the pendency of any proceedings.

Section 12: Exhaustion of Remedies

a. The member, applicant, or eligible Allied Health Practitioner must exhaust the remedies, including appellate procedures, afforded by this Article prior to resorting to any judicial remedy.

Article XI: Officers

Section 1: Officers of the Medical Staff

a. The officers of the Medical Staff shall be:

   i. President of the Medical Staff;

   ii. President-Elect of the Medical Staff;

   iii. Vice President of the Medical Staff;

   iv. Members at Large (2).

Section 2: Qualifications of Office

a. Officers must be members of the Active Staff at the time of nomination and election and must remain members of the Active Staff in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

b. The President of the Medical Staff and the President-Elect of the Medical Staff shall have served previously as an elected officer of the Staff or have completed a term as a clinical department chair or section chair.

Section 3: Election of Officers

a. Members of the Medical Staff may submit names of potential candidates to the Nominating Committee for its consideration.

b. The Nominating Committee shall consist of one or more members of the Active Staff from each department, and shall be appointed by the President of the Medical Staff with approval of the Medical Executive Committee. All Nominating Committee members shall disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware, including contractual, employment, or other relationships with the Health Center or any health care organization, which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. In September of each year, the Committee shall offer two or more nominees for either the President-Elect or Vice President office, whichever is applicable. For the election of Members at Large, the Committee shall offer two or more nominees.

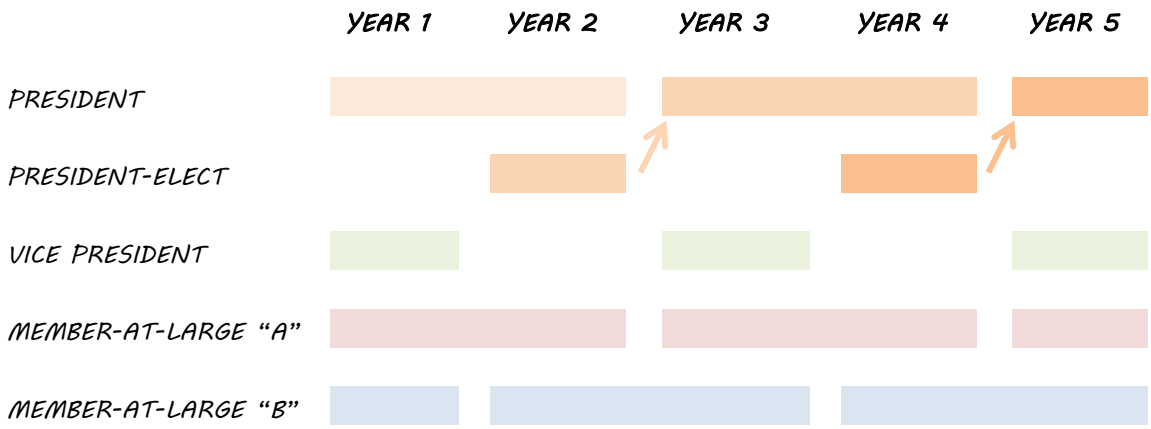
c. The list of nominees offered by the Nominating Committee shall be forwarded to the Board of Directors and the Medical Executive Committee for review. The Board of Directors shall be provided 14 calendar days in which to provide any comments. Any comments provided by the Board of Directors within that period will be considered by the Medical Executive Committee and will be included in the ballot materials distributed to the Medical Staff.

d. At the conclusion of the Board of Director's review and comment period, the Medical Executive Committee shall approve a final slate of nominees who shall be candidates for each office.

e. Officers shall be elected by secret ballot during the last quarter of each year. All nominees for election shall disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware, including contractual, employment, or other relationships with the Health Center or any health care organization, which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. Such disclosure shall accompany the ballot. The candidate receiving a plurality of the votes cast shall be elected. Only members of the Active staff shall be eligible to vote.

Section 4: Term of Office

a. The President shall serve for a two-year term. The President-Elect and Vice President shall each serve a one-year term. The President-Elect shall serve a one-year term, commencing with the second year of the President's term, and then become President at the expiration of the current President's term. A Vice President shall be elected every other year for a one-year term, to run concurrently with the first year of a President's two-year term. One Member at Large shall be elected each year for a two-year term. At any given time, there will be two Members at Large in office. A President may be re-elected but cannot serve more than two terms which must be non-consecutive. Officers shall take office on the first day of the calendar year following their election.



Section 5: Vacancies in Office

a. Vacancies in the office during the year, except for the President of the Medical Staff, shall be filled by the Medical Executive Committee. If there is a vacancy in the office of the President of the Medical Staff, the President-Elect of the Medical Staff, if one is serving, or, otherwise the Vice President of the Medical Staff shall serve out the remaining term.

Section 6: Duties of Officers

a. President of the Medical Staff

i. The President of the Medical Staff shall serve as the chief administrative officer of the Medical Staff to:

1. act in coordination and cooperation with the Chief Executive Officer and Chief Medical Officer in all matters of mutual concern within the Health Center, including but not limited to appointment of department and committee chairs;

2. call, preside, and be responsible for the agenda of all general meetings of the Medical Staff;

3. serve as chair of the Medical Executive Committee;

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

5. be responsible for the enforcement of Medical Staff Bylaws, Rules, and Regulations, for implementation of sanctions where they are indicated, and for the Medical Staff's compliance with the procedural safeguards in all instances where corrective action has been requested against a member in cooperation with the Chief Executive Officer and Chief Medical Officer.

6. appoint the Chairs of each clinical department;

7. appoint, remove, and replace committee chairs and members to all standing, special, and multi-disciplinary Medical Staff committees except the Medical Executive Committee;

8. represent the views, policies, needs, and grievances of the Medical Staff to the Chief Executive Officer, Chief Medical Officer, and to the Board of Directors;

9. receive~~,~~ and interpret the policies of the Board of Directors to the Medical Staff in cooperation with the Chief Medical Officer;

10. be responsible for the educational activities of the Medical Staff in cooperation with the Chief Medical Officer.

b. Vice President of the Medical Staff or President-Elect of the Medical Staff:

   i. In the absence of the President of the Medical Staff, the Vice President or President-Elect shall assume all the duties and have the authority of the President of the Medical Staff. The Vice President or President-Elect shall be a member of the Medical Executive Committee and of the Joint Conference Committee. The Vice President or President-Elect shall automatically success the President when the President fails to serve for any reason.

c. The Members at Large shall be members of the Medical Executive Committee. The Members at Large shall perform such duties as directed by the President of the Medical Staff.

Section 7: Removal of Officers

a. Medical Staff Officers may be removed from office by a two-thirds majority vote of those Active staff members of the Medical Staff voting at a regular or special general staff meeting at which a quorum has been established. The action may be taken with or without cause.

Article XII: Departments, Sections, and Hospital-Based Services

Section 1: Departments

a. The departments of the Medical Staff shall be Medicine, Surgery, Obstetrics/Gynecology, and Pediatrics. Each will have a chair who is appointed as a member of the Medical Executive Committee.

Section 2: Hospital-Based Services

a. The hospital-based services of the Medical Staff and Health Center include Anesthesiology, Radiology, Pathology, Emergency Medicine, Nuclear Medicine, and such others as the Medical Executive Committee and Board of Directors may deem necessary. They shall be assigned as a section to an appropriate department. They shall have a Medical Director per Article XII, Section 6. A section chief may be appointed by the Medical Director in consultation with the department chair and may be one and the same person. Each hospital-based service shall have regular section meetings on a date established by the chief. They shall report on meetings, proceedings, and activities to their departmental committee.

Section 3: Organization of Departments and Sections

a. Each department shall be organized as a separate part of the Medical Staff, and each may contain sub-units designated as sections. Each department shall have a chair and each section shall have a chief.

Section 4: Qualifications, Selection, and Tenure of Department Chairs

a. Each chair shall be a member of the Active Staff qualified by training, experience, and demonstrated ability for the position, including certification by the relevant specialty board.

b. Each chair shall be appointed or removed by the President of the Medical Staff, for a three-year term; a chair may success for one additional term.

c. In the event that a chair cannot complete the three-year term to which they were appointed, the President of the Medical Staff, shall appoint a successor to serve for the remainder of the unexpired term.

d. Removal of a chair during his/her term of office may be brought by a recall petition signed by two-thirds of all active members of the department. Such removal will be effective as of the date the petition is presented to the Medical Executive Committee. Removal of a chair during his/her term also may be brought by the President of the Medical Staff. Such removal requires ratification by affirmative majority vote by the Medical Executive Committee.

Section 5: Functions of Department Chairs

a. Each chair shall be accountable to the Medical Executive Committee for all professional activities and the quality of patient care within their department, including orientation and continuing education of all persons in the department and continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.

b. Chairs of departments shall be members of the Medical Executive Committee, giving guidance on the overall medical policies of the Health Center and making specific recommendations and suggestions regarding their own departments in order to assure quality patient care.

c. Each chair of a department shall be a chair of their departmental committee and direct this committee in conducting patient care review required by these Bylaws, including continuous assessment and improvement of quality of care, treatment, and service as well as maintenance and oversight of quality control programs as appropriate.

d. Each chair shall be responsible for enforcement of the Medical Staff Bylaws, Rules and Regulations and of the Health Center Bylaws within their department.

e. Each chair shall be responsible for the implementation of Health Center and Medical Staff policies and procedures and the development, for approval by the Medical Executive Committee, of criteria for the granting of clinical privileges within their department.

f. Each chair shall transmit to the Medical Executive Committee, via Credentials Committee, their department's recommendations concerning Medical Staff appointments and reappointments, classifications, and delineation of clinical privileges for all members of their department.

g. Each chair shall participate in the administration of their department through cooperation with the nursing service, departmental director, the Chief Medical Officer, and the Health Center administration in matters affective patient care, including personnel, equipment, supplies, special regulations, procedures and policies.

h. Each chair shall participate with administration in planning for the growth and development of services and facilities for their department.

i. Each chair shall assist in the preparation of such annual reports, including budgetary planning, pertaining to their department as may be required by the Medical Executive Committee, the Chief Medical Officer, the Chief Executive Officer, or the Board of Directors.

j. Each department chair shall consult with the President of the Medical Staff to appoint section or subcommittee chiefs to whom they may delegate responsibilities for various duties as related to the functions of the section or subcommittee.

k. Each chair is responsible for assessing and recommending to the relevant Health Center authority off-site sources for needed patient care services not provided by the department.

l. Each chair, in collaboration with administration, assists in the determination that sufficient resources, including space, equipment, staffing and other financial resources are in place or available within a specified time frame to support proposed or requested clinical privileges.

Section 6: Qualifications, Section and Functions of Medical Directors of Hospital-Based Services

a. Each Medical Director shall be appointed by the Chief Executive Officer after consultation with the Medical Executive Committee. The Medical Director shall be a member of the Medical Staff well qualified by training, experience, and ability to carry out the professional and administrative responsibilities for the hospital-based service. The Medical Director may serve as a member of the departmental committee. Each hospital-based service Medical Director shall be accountable to the Chief

Medical Officer and Chief Executive Officer for all professional, technical, and administrative activities within the hospital-based service.

Section 7: Functions of Departments

a. 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.

b. Each department shall have a committee responsible for conducting current and retrospective reviews of medical records of patients and other pertinent departmental sources of information for purposes of evaluating patient care and the performance of members of the department. The committee may select clinical information including cases for presentation at the regular meetings that will contribute to the continuing education of every practitioner and to the process of developing criteria to assure optimal patient care. Such reviews shall be conducted as needed and should include consideration of selected deaths, unimproved patients, patients with infections, complications, errors in diagnosis and treatment, and such other instances as are believed to be important, such as patients currently in the Health Center with unsolved clinical problems, or any case where there may be an opportunity for quality improvement.

c. In matters relating to medical care evaluation and medical records review, all Medical Staff members and other practitioners, and all appropriate Health Center personnel including members of the Board of Directors and Health Center management, shall be acting pursuant to the same rights, privileges, immunities, and authority as are provided for in Article VI of these Bylaws.

Section 8: Assignment to Departments

a. The Medical Executive Committee shall, based upon recommendations of the departments as transmitted through the Credentials Committee, recommend to the Board of Directors departmental assignments for all Medical Staff members.

Article XIII: The Medical Executive Committee

Section 1: Composition

a. The Medical Executive Committee shall be a standing committee and shall consist of the officers of the Medical Staff, the chairs of the clinical departments, the most immediately available past President of the Medical Staff who is not service as the chair or director of a department, and one other past President of the Medical Staff appointed by the President of the Medical Staff. The Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer, and Directors of Anesthesia, Emergency, Radiology, and Pathology Services and the chair of the Credentials Committee shall be ex-officio members without vote. Additional physicians, other licensed independent practitioners, members of Administration, Health Center staff and Board of Directors may be appointed or invited as guests by the President of the Medical Staff.

Section 2: Duties

a. The duties of the Medical Executive Committee shall be:

i. To represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws and to act on behalf of the Medical Staff between Medical Staff meetings;

ii. To coordinate the activities and general policies of the various departments;

iii. To receive and act upon committee reports;

iv. To develop, approve, and/or enforce administrative policies and procedures of the Medical Staff, including those determined necessary to clarify and implement provisions of the Medical Staff Bylaws, Rules and Regulations;

v. To provide liaison between Medical Staff and administration, and participate with administration in planning for the growth and development of the Medical Staff and the Health Center;

vi. To recommend action to the Chief Executive Officer and the Chief Medical Officer on matters of a medico-administrative nature;

vii. To make recommendations on Health Center management matters to the Board of Directors through the Chief Executive Officer and the Chief Medical Officer;

viii. To fulfill the Medical Staff's accountability to the Board of Directors for medical care rendered to the patients of the Health Center;

ix. To ensure that the Medical Staff is kept abreast of compliance with regulatory agencies and the accreditation program when appropriate, and informed of the accreditation status of the Health Center;

x. To provide for the preparation of programs for all Medical Staff meetings, either directly or through delegation to program chairs or other suitable agents;

xi. To review the credentials of all applicants and to make recommendations for Staff membership, assignments to department, and delineation of clinical privileges;

xii. To consider and recommend termination of Medical Staff membership in accordance with Medical Staff Bylaws, Rules and Regulations, policies or procedures;

xiii. To review periodically all information available regarding the performance and clinical competence of Medical Staff members and Allied Health Personnel, and as a result of such reviews, to make recommendations for reappointments and renewal or changes in clinical privileges.

xiv. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;

xv. To establish minimum levels for professional liability insurance coverage required for membership on the Medical Staff, with the approval of the Board of Directors.;

xvi. To establish standards for qualifications of physicians and any other health care profession as Qualified Medical Personnel for the Emergency Department, the Labor and Delivery Department, and other relevant areas of the Health Center, authorized to determine whether or not an emergency medical condition exists for the purposes of compliance with the Emergency Medical Treatment and Active Labor Act and to approve the designation of individuals as Qualified Medical Personnel who meet such standards.

xvii. To determine amount of and levy fines against members for significant medical records violations.

xviii. To ensure the Medical Staff shall have the independent right to utilize Medical Staff dues as appropriate for purposes of the Medical Staff, including for the retention of independent legal counsel to represent the Medical Staff.

Section 3: Meetings

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

Article XIV: Committees (Departmental, Joint Conference, Standing, and Special)

Section 1: Departmental Committee

a. Each department shall have a committee which shall consist of a minimum of five members from its respective department. The chair of the committee shall be the departmental chair. Each section chief and the hospital-based service representative from the respective department to which it is attached shall be appointed to the committee. The President of the Medical Staff in consultation with the departmental chair shall appoint the members of each committee annually and shall fill any vacancies that may occur. Each department committee shall meet regularly as needed on a date established by the chair, and each hospital-based service committee shall meet regularly as needed on a date established by the chair. Each hospital-based service shall report on its meetings, proceedings, and activities to its respective departmental committee. Each departmental committee shall maintain a permanent record of its proceedings and activities, and shall make a report thereof to the Medical Executive Committee. The chair may, with approval of the President of the Medical Staff, select a vice-chair.

Section 2: Joint Conference Committee

a. Composition

i. The Joint Conference Committee shall be composed of the President, Vice President or President-Elect, the immediate past President of the Medical Staff and three members of the Board of Directors. The Chief Executive Officer and the Chief Medical Officer shall be ex-officio members without voting privileges.

b. Duties

i. The Joint Conference Committee shall provide for medico-administrative liaison with the Board of Directors, the Chief Executive Officer and the Chief Medical Officer, and the Medical Staff relative to matters of Health Center policy and practice. Its primary function should be to serve as a forum for discussion of matters pertaining to efficient and effective patient care.

c. Meetings

i. The Joint Conference Committee shall meet as needed and shall transmit written reports of its activities to the Medical Executive Committee of both the Board of Directors and the Medical Staff.

Section 3: Standing Committees

a. The duties, composition, eligibility requirements of all standing committees shall be set forth in the Rules and Regulations adopted pursuant to Article XVII.

Section 4: Special Committees

a. The President, with approval of the Medical Executive Committee, shall appoint committees for special services and/or functions as may be necessary, as set forth in detail in the Rules and Regulations adopted pursuant to Article XVII.

Section 5: Ex-Officio Members

a. The President of the Medical Staff or designee, the Chief Executive Officer or designee, and the Chief Medical Officer shall be non-voting, ex-officio members of all committees to which they are not otherwise specifically appointed or designated.

Article XV: General Staff Meetings

Section 1: Regular General Staff Meetings

a. Regular meetings of the general Medical Staff shall be held at the discretion of the President of the Medical Staff on such day and hour as the President of the Medical Staff shall designate in the call and notice of the meeting.

b. The Medical Executive Committee may provide by resolution for the holding of additional regular meetings of the Medical Staff for the purpose of transacting such business as may come before the meeting.

Section 2: Special Meetings of the Medical Staff

a. The President of the Medical Staff, the Medical Executive Committee, or not less than one-fourth of the members of the Active Staff may at any time file a written request with the President that within 30 days of the fling of such request, a special meeting of the general Medical Staff may be called.

b. The Medical Executive Committee shall designate the time and place of any such special meeting.

c. Written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be delivered, either personally, by mail, or by e-mail to each member of the Active Staff not less than three nor more than 15 days before the date of such meeting, by or at the direction of the President or other persons authorized to call the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail, addressed to each member at their address as it appears on the records of the Health Center. If e-mailed, the notice of the meeting shall be deemed delivered on the date e-mailed to each member at his/her e-mail address as it appears on the records of the Health Center. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Section 3: Quorum and Manner of Action

a. The presence of fifty percent (50%) of the Active Staff eligible to vote at any regular or special meeting shall constitute a quorum for the purpose of adopting or amending the Bylaws or Rules and Regulations, or for the election or removal of Medical Staff Officers. The presence of twenty-five percent (25%) of such Members shall constitute a quorum for all other actions.

b. Except as otherwise specified, the action of a majority of the members present and voting at any meeting at which a quorum is present shall be the action of the group. Notwithstanding the departure of members, business may continue to be transacted at any meeting at which a quorum initially was present, as long as any action taken is approved by a majority of the required quorum for such meeting or such greater number as may be specifically required.

Article XVI: Committee and Department Meetings

Section 1: Regular Meetings

a. Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Clinical departments may discuss professional and administrative matters which relate to improvements in patient care.

Section 2: Special Meetings

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

Section 3: Notice of Meetings

a. Written, electronic, or oral notice, stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution, shall be given to each member of the committee or department not less than three days before the time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at their address as it appears on the records of the Health Center with postage thereon prepaid. If e-mailed, the notice of the meeting shall be deemed delivered on the date e-mailed to each member at his/her e-mail address as it appears on the records of the

Health Center. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

Section 4: Quorum

a. Twenty-five percent, but not less than two, of the voting members of a committee or department shall constitute a quorum at any meeting, unless otherwise stipulated in these Bylaws or specific meetings such as regular or special General Staff meetings.

Section 5: Manner of Action

a. Formal Action

   i. The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee or department.

b. Informal Action

   i. No action of a committee or department shall be valid unless taken at a meeting at which a quorum is present, except that any action may be taken without a meeting if a majority of the Committee members consent in writing (setting for the action so taken) via signature or e-mail transmission by each member entitled to vote thereat.

Section 6: Rights of Ex-Officio Members

a. Except as specified in Article XIII, Section 1, persons serving under these Bylaws as ex-officio committee members shall have all rights and privileges of regular members, except they shall not be counted in determining the existence of a quorum and shall have no voting rights.

Section 7: Minutes

a. Minutes of each regular and special meeting of a committee or department 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 presiding officer and/or administrative designee and a summary of the minutes shall be forwarded to the Medical Executive Committee. Each committee and department shall maintain a permanent file of the minutes of each meeting.

Section 8: Attendance Requirements

a. When a member whose patient's clinical course is scheduled for discussion at any medical staff or Health Center committee meeting, and the member's attendance at that meeting is deemed necessary by the President of the Medial Staff or the President's designee, the member shall be so notified and shall be required to attend such meeting. Whenever apparent or suspected deviation from standard clinical practice or repeated failures by a member to conform to or justify variations from accepted utilization norms is involved, the notice to the member shall so state, shall be given by special notice, and shall include a statement that the member's attendance at the meeting at which the alleged deviation is to be discussed is required.

b. Failure by a member to attend any meeting with respect to which they were given notice that attendance was mandatory unless excused by the Medical Executive Committee, upon a showing of

good cause, shall result in automatic suspension of all or such portion of the member's clinical privileges as the Medical Executive Committee may direct, and such suspension shall remain in effect until the matter is resolved through any mechanism that may be appropriate, including corrective action, if necessary. In all other cases, if the member shall make a timely request for postponement supported by an adequate showing that their absence will be unavoidable, such presentation may be postponed by the chair of their department, or by the Medical Executive Committee if the chair is the member involved, until not later than the next regular departmental committee meeting; otherwise, the pertinent clinical information shall be presented and discussed as scheduled.

Article XVII: Rules and Regulations

a. The Medical Staff shall adopt such general Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Board of Directors. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is required of each practitioner in the Health Center. Such general Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed as follows:

    i. The Medical Staff, by approval of these Bylaws, grants authority to the Medical Executive Committee to adopt or amend rules and regulations and/or policy on behalf of the organized Medical Staff, and to propose said adoptions or amendments to the Board of Directors as necessary. The Medical Executive Committee shall first communicate said adoption or amendment to the Medical Staff to allow for review and comment.

        1. The Medical Staff shall have up to 60 days from notification to review and comment on the proposed adoption or amendment.

        2. If 60 days after notification, the Medical Staff has not indicated in writing that it is in disagreement with the proposed adoption or amendment, the adoption or amendment shall be forwarded to the Board of Directors for approval.

        3. If within 60 days of notification, the Medical Staff indicates in writing that it is in disagreement with the proposed adoption or amendment, the matter shall be subjected to further review, and if necessary, the conflict resolution process noted here. In order for a written disagreement to be considered valid, it must be signed by at least twenty percent of the Active Staff.

    ii. Such changes shall become effective when approved by the Board of Directors.

b. Should there be an urgent need to adopt or amend rules and regulations and/or policy so as to comply with law or regulation, the Medical Executive Committee may provisionally make said adoption or amendment, and as necessary, the Board of Directors may provisionally approve said adoption or amendment without first communicating same to the organized Medical Staff.

    i. Should this occur, the Medical Executive Committee shall immediately notify the Medical Staff of the adoption or amendment. The Medical Staff shall have up to 60 days from notification to retrospectively review and comment on the provisional adoption or amendment.

ii. If 60 days after notification, the Medical Staff has not indicated in writing that it is in disagreement with the provisional adoption or amendment, the adoption or amendment shall be considered final.

iii. If within 60 days of notification, the Medical Staff indicates in writing that it is in disagreement with the provisional adoption or amendment, the matter shall be subjected to the conflict resolution process noted herein. In order for a disagreement to be considered valid, it must be signed by at least twenty percent of the Active Staff.

c. If the Active Staff proposed an adoption or amendment to the Rules and Regulations, and/or policy, the Medical Staff must first communicate the adoption or amendment to the Medical Executive Committee, who will have 90 days from date of receipt to review the adoption or amendment, and if in agreement, propose said adoption or amendment to the Board of Directors. If within 90 days of receipt the Medical Executive Committee is not in agreement with said adoption or amendment to Rules and Regulations and/or policy, the matter shall be subjected to the conflict resolution process noted herein. If after 90 days, the Medical Executive Committee has neither agreed nor disagreed on the adoption or amendment to the Rules and Regulations, and/or policy, the Medical Staff may proceed to propose said adoption or amendment directly to the Board of Directors.

d. Departmental rules and regulations and amendment thereto will be proposed by each departmental committee and submitted to the Medical Executive Committee and Board of Directors for approval.

e. Process for managing conflict between the Medical Executive Committee and the Medical Staff:

i. For the purposes of these Bylaws, the process for conflict management outlined in this section applies onto to conflict between the Medical Executive Committee and the Medical Staff regarding adoption or amendment of Medical Staff Rules and Regulations, and/or policy. Should there be disagreement between the Medical Executive Committee and the Medical Staff over the adoption or amendment of Medical Staff Rules and Regulations and/or policy, the following shall occur:

1. The Medical Executive Committee will inform the Board of Directors that either they or the Medical Staff has adopted or amended Medical Staff Rules and Regulations and/or policies, and that there is disagreement between the two bodies.

2. A special committee consisting of three individuals, one delegate from the Medical Executive Committee, one from the organized Medical Staff, and one from the Board of Directors. An individual who is neither a member of the Medical Executive Committee nor of the Medical Staff shall serve as Chair. Each delegate will be chosen by their respective group.

3. The special committee shall review the adoption or amendment as well as the Medical Executive Committees reason for disagreement. By majority decision, the special committee will make a recommendation to the Board of Directors to either allow the adoption or amendment to be proposed, or to decline receiving said proposal.

Article XVIII: Confidentiality, Immunity, and Releases

Section 1 Authorization and Conditions.

a. By applying for or exercising clinical privileges within the Health Center, the member releases from liability the Health Center, all of its representatives and its Medical Staff for their acts performed in good faith and without malice in connection with evaluation of the member's competence, ethics, character, and other qualifications for Medical Staff appointment and clinical privileges.

Section 2 Confidentiality of Information.

a. General

i. Medical Staff, department, section or committee minutes, files and records, including information regarding any member or applicant to the Medical Staff shall, to the fullest extent permitted by law, be confidential. Dissemination of such information and records shall only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff or, where no officially adopted policy exists, only with the express approval of the Medical Executive Committee.

b. Breach of Confidentiality

i. Effective peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions. Any breach of confidentiality of the discussions or deliberations of Medical Staff departments, sections or committees, except in conjunction with other hospitals professional societies or licensing authorities, is outside appropriate standards of conduct for members of the Medical Staff. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

Section 3 Immunity from Liability

a. For Action Taken

i. Each representative of the Medical Staff and Health Center shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made from the scope of member's duties as a representative of the Medical Staff or Health Center.

b. For Providing Information

i. Each representative of the Medical Staff and Health Center and all third parties shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief by reason of providing information, to a representative of the Medical Staff or Health Center concerning such persons who did, or do, exercise clinical privileges or provide services at the Health Center.

Section 4 Releases

a. Each applicant or member shall, upon request of the Medical Staff or Health Center, execute general and specific releases in accordance with the express provisions and general intent of this article. Execution of such releases shall not be deemed prerequisite to the effectiveness of this article.

Article XIX: Adoption, Amendments, and Review

a. Proposed amendments shall be referred to or may be initiated by the Bylaws and Accreditation Committee, who shall in turn submit the proposed amendments to the Medical Executive Committee. Adoption or amendment of the Medical Staff Bylaws resides with the organized Medical Staff and the Board of Directors, and cannot be delegated. The Medical Executive Committee approves proposed amendments which shall be published or mailed to each Active Staff member at least 30 days prior to the regular or special Staff meeting at which they are to be discussed. In the event that a proposed amendment is not approved by the Medical Executive Committee, it is still eligible or consideration in a manner equivalent to that of an approved proposed amendment if a petition in support of its consideration is executed by at least two percent of the members of the Active Staff and presented to the Medical Staff President. To be adopted, an amendment shall require approval by two-thirds vote of the Active Staff present at a meeting of the Active Staff at which a quorum has been reached, or by two-thirds of the votes received from a mailed balloting in which more than 25 percent of the Active Staff cast ballots. Amendments so made shall be effective when approved by the Board of Directors, which approval shall not be unreasonably withheld. Any non-substantive changes proposed by the Board of Directors to an amendment that has been adopted by the Active Staff may be approved by the Medical Executive Committee.

b. The Medical Staff shall have the ability to adopt Medical Staff Bylaws, Rules and Regulations, and/or policies, and/or amendments thereto, and propose them directly to the Board of Directors. The following criteria must be met in order for an adoption or amendment to be considered a valid action by the Medical Staff:

    i. The adoption or amendment must be in writing and signed by at least 51% of the Active Staff.

    ii. The adoption or amendment cannot contravene or be inconsistent with federal, state, or local law, regulation, or accreditation standards set forth by The Joint Commission.

c. Adoption of these Medical Staff Bylaws shall be by the same procedure as for amendments. Neither the Board of Directors nor the Medical Staff shall unilaterally adopt or amend the Bylaws. These Bylaws shall be reviewed at least triennially by a committee of the Medical Staff.

Article XX: Exceptions

a. The Medical Executive Committee is permitted to make exceptions to specific rules of these Bylaws, Rules and Regulations where good cause is demonstrated in the interest of good patient care, by a two-thirds vote of the voting members of the Medical Executive Committee.

Article XXI: Interpretation

Section 1 The Bylaws, Rules and Regulations:

a. The construction and the interpretation by the Medical Executive Committee shall be final and binding, subject to the approval of the Board of Directors.

Section 2 Parliamentary Procedure:

a. In the absence of specific rules, Robert's Rules of Order shall govern the deliberation of this organization.

Section 3 Conflict Resolution:

a. In the event of real or apparent conflict between provisions of the Medical Staff Bylaws, Rules and Regulations; Medical Staff Departmental Rules and Regulations; and administrative policies and procedures approved by the Medical Staff, absent the Medical Staff's ability to reconcile the conflict, the hierarchal order of precedence is the order listed above. Real or apparent conflicts between any of the preceding Medical Staff approved documents and Health Center bylaws or other policies or procedures that cannot be reconciled by the Medical Staff in consultation with the Chief Executive Officer or designee shall be referred to the Joint Conference Committee for resolution.

Article XXI: Disputes with the Board of Directors

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

    a. Invoking the Dispute Resolution Process

        i. The Medical Executive Committee may invoke formal dispute resolution, upon its own initiative, or upon written request of at least ten percent of the members of the Active Staff.

        ii. In the event the Medical Executive Committee declines to invoke formal dispute resolution, such process shall be involved upon written petition of at least 25 percent of the members of the Active Staff.

    b. Dispute Resolution Forum

        i. Ordinarily, the initial forum for dispute resolution shall be the Joint Conference Committee, which shall meet and confer as further described in these Bylaws.

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

    c. If the parties are unable to resolve the dispute, the Board of Directors shall make its final determination after considering the recommendations of the Medical Executive Committee.

Article XXIII: Exceptions

1. Neither the Medical Staff, its members, committees or department heads, the Board of Directors, its chief administrative officer or any other employee or agent of the Health Center or Medical Staff, shall discriminate or retaliate, in any manner, against any patient, Health Center employee, member of the Medical Staff or any other health care worker of the health facility because that person has done either of the following:

    a. Presented a grievance, complaint, or report to the facility, to an entity or agency responsible for accrediting or evaluating the facility, or the Medical Staff of the facility, or to any other governmental entity; or

    b. Has initiated, participated, or cooperated in an investigation or administrative proceeding related to the quality of care, services, or conditions at the facility that is carried out by an entity or agency responsible for accrediting or evaluating the facility or its Medical Staff, or governmental entity.

Medical Staff Rules and Regulations
of **the Medical Staff**
of

Saint John's Health Center

PROVIDENCE Health & Services

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Medical Staff Rules and Regulations

I. Admission and Discharge of Patients

1. A patient may be admitted to Saint John's Health Center only by a member of its Medical Staff who has admitting privileges. All practitioners shall be governed by the official admitting policy of the Health Center.

2. Each patient shall be the responsibility of a member of the Medical Staff. The member is responsible for the medical care and treatment, for the prompt completion and accurate of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient of the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

3. Every patient who is admitted as an inpatient or to observation status must have at least one admitting and/or attending physician who must be a member who is qualified and competent to complete a medical history and physical examination, and who is responsible for supervising the overall medical care of the patient. The admitting and/or attending physician must complete an examination of the patient and a documented plan of care within 12 hours of admission for all patients, except well newborns who must be examined by the physician within 24 hours Any member who cannot, or does not wish to, assume all of these responsibilities shall admit patients only with another member who can and will assume such responsibilities.

4. A member shall not admit nor provide direct professional care for any patient who is their spouse, parent, child or sibling, except during an emergency.

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

6. In any emergency case in which it appears the patient will have to be admitted to the Health Center, the member shall, when possible, first contact the admitting department to ascertain whether there is an available bed.

7. Members admitting emergency cases shall be prepared to justify to the Medical Executive Committee and the Administration of the Health Center that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient's being admitted on an emergency basis and must be recorded on the patient's chart as soon as possible after admission.

8. In the case of an emergency admission, a patient who does not have a private physician who is a member may have a choice of any available member in the department or service to which they need to be admitted, or may be assigned in rotation to a member of the active, associate or provisional staff on duty in the department or service to which the illness of the patient indicates assignment. The chair of the appropriate department shall adding members to provide care for patients in the latter case.

9. Each member who does not reside in the immediate vicinity or who is not immediately available shall arrange with another qualified member who is resident in the area and available, to attend the former member's patients in any emergency or until they arrive. In cases of failure to name such member the Chief Executive Officer of the Health Center, the Chief Medical Officer, the President of the Medical Staff, or the Chair of the Department shall have authority to call any member.

10. The admitting personnel admit patients on the basis of the following order of priorities:

    a. Emergency Admissions

       This category of patients includes those who have serious medical problems and who may be at risk of death or serious injury to their health if not admitted within four hours. Such patients have first priority for admission to the Health Center beds. (When requested by the Resource Management Committee, the admitting physician must furnish to that Committee, within 24 hours of the request, a signed, sufficiently complete documentation of the need for emergency admission. Failure to provide this information or evidence of willful or continued misutilization of this category of admission will be brought to the attention of the Medical Executive Committee.)

    b. Urgent Admissions

       This category includes patients with serious medical problems who may be at risk of substantial injury to their health if not admitted within 24 hours. Admissions so designated by the member shall be reviewed as necessary by the Chief Medical Officer to determine priority when all such admissions for a specific day are not possible.

    c. Pre-Operative Admissions

       This category includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the Chief Medical Officer may decide the urgency of any specific admission.

    d. Routing Admissions

       This category includes elective admissions involving all services.

11. Patient Transfers

    Patient priorities are as follows:

    a. Emergency Department to appropriate patient bed;

    b. From obstetric patient care area to general care area, when medically indicated;

    c. From a critical care unit to general care area;

    d. From temporary placement in an area designated as a clinical service area to the appropriate area for that patient.

12. The member shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever their patients might be a source of danger from any cause whatever.

13. For the protection of patients, the medical and nursing staff and the Health Center, certain principles are to be met in the care of the potentially suicidal patient, or the patient who is a threat to self or to others.

a. They shall be admitted, if possible, to other institutions where suitable facilities are available.

b. They must have consultation by a member of the psychiatric staff.

c. In the event that any patient is admitted to the general floors of the Health Center and is then or later known to be a threat to self or others, they shall be transferred as soon as medically appropriate to another institution where adequate facilities are available. As a temporary measure, until transfer can be arranged, or until the patient's psychiatric-emotional state is sufficiently corrected, special nurses or companions shall be required for such patient.

14. Admission to, transfer from and discharge from, Intensive, Coronary Care, and Post-Coronary Care Units

a. If any questions as to the appropriateness of admission to, transfer or discharge from the Intensive Care Unit should arise, that decision is to be made through consultation with the Medical Director of the Intensive Care Unit. In a similar circumstance concerning admission to, transfer from, or discharge from the Coronary Care Unit, or Post-Coronary Care Unit, the Medical Director of the Coronary Care – Post-Coronary Care Unit is to be consulted. Unresolved disputes regarding patient admission, transferability, or discharge from one of the aforementioned units that arise between the appropriate Medical Director and the attending physician shall be presented to the Chair of the attending physician's clinical department for resolution, and if necessary, the President of the Medical Staff for determination.

15. The member is required to document the need for continued hospitalization after specific periods of stay as identified by the Resource Management Committee of this Health Center. This statement must contain:

a. An adequate written record of the reason for continued hospitalization; a simple reconfirmation of the patient's diagnosis is not sufficient.

b. The estimated period of time the patient will need to remain in the Health Center.

c. Plans for post-hospital care.

16. Patients shall be discharged only on a written order of the attending member. Should a patient leave the Health Center against the advice of the attending member, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

17. On the day of discharge of a patient, it is the responsibility of the attending member to encourage and facilitate discharge of the patient by 11:00 AM. If the patient is to be discharged with continuing care such as to a Skilled Nursing Facility (SNF), or utilizing post discharge services such as Home Health, Hospice, Dialysis, Infusion, Durable Medical Equipment, etc., it is imperative that the patient's choice be followed. Physicians or the Health Center shall provide names of two or three providers. The physician will disclose to the patient or his/her family or decision maker any relationship the physician or one of his/her first degree relatives has with that provider (e.g., ownership interests, medical directorship, royalties, consultation fees, etc.). The physician shall sign, date and time a Health Center form evidencing that the patient's choice is followed. Failure by the physician to disclose on the form ownership or interest in the facility will result in referral for peer review.

18. In the event of a Health Center death, the deceased shall be pronounced dead by the attending physician or their designee or the house physician, within a reasonable time. The body shall not be

released until an entry has been made and signed in the medical record of the deceased by a physician member of the Medical Staff. Policies with respect to release of the deceased shall conform to local law.

19. It is the duty of all members to secure meaningful autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies shall be performed by the Health Center pathologist, or by a pathologist delegated this responsibility. Provisional anatomic diagnoses shall be recorded on the medical record by the pathologist immediately after completion of the autopsy and the complete protocol shall be made a part of the record within six weeks.

II. Medical Records

1. The attending member is responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. For inpatients and observation status patients, this record shall include identification data; complaints; history of present illness; past history; system failure; family history; physical examination; special reports, such as consultations, pathology, and radiology services, and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnoses; condition on discharge; summary or discharge notes; and autopsy report when performed,

2. Except as specified in Section 3 below, an appropriate note including the history and physical examination and/or admission history and physical examination shall be appropriately recorded. This report should include pertinent findings resulting from an assessment of the systems of the body specific to the patient's chief complaint, reason for admission, surgical procedure, and/or diagnosis. If a complete history and physical examination has been recorded and a physical examination was performed by the admitting member during the 30 days prior to the patient's admission to the Health Center, a reasonably durable, legible copy of these reports may be used in the patient's medical record in lieu of the admission history and report of the physical examination, provided these reports were recorded by a member. In such instances, an interval admission note that includes all significant additions to the history and any subsequent changes in the physical findings must always be recorded within 24 hours after admission.

3. Pre-Procedure Documentation Requirements

    a. When the history and physical examination are not recorded before an inpatient surgical procedure under general anesthesia, regional anesthesia or moderate sedation or any surgical or diagnosis procedure associated with significant risk to the patient as evidenced by the need for continuous, electronic physiological monitoring, the procedure shall be cancelled unless the attending member states in writing that such delay would be detrimental to the patient. For elective procedures, the history and physical examination must be recorded and transmitted to the Health Center at least two business days prior to the scheduled date of the planned procedure(s).

    b. Members who admit patients for approved outpatient surgery under general, regional or spinal / epidural anesthesia or for surgery which is associated with significant risks shall complete all medical records prior to performance of the procedure which are ordinarily require for inpatient surgery.

    c. Members who admit patients for approved minor outpatient surgery under local anesthesia shall complete at least a brief report prior to the performance of the procedure which includes

the pertinent and important medical history and physical findings, and also record the diagnosis, orders and a description of the operative procedure.

d. The member who admits a patient for an outpatient surgical or diagnostic procedure under moderate sedation or associated with significant risk to the patient as evidenced by the need for continuous, electronic physiologic monitoring shall complete at least a brief report prior to the performance of the procedure, which includes the pertinent and important medical history and physical findings, including heart and lung, and also record the diagnosis, orders, and a description of the operative procedure.

4. The attending member must verify that they have reviewed any reports submitted by a physician not on the medical staff. The attending member shall confirm or correct the contents of the history, physical examination, pre-operative note or other medical record entries when they have been recorded by a certified Physician Assistant, or a Nurse Practitioner. Certified Physician Assistants and Nurse Practitioners may only prepare records for their designated supervising physician(s). When records are prepared in the above manner the attending physician is required to record a pertinent and timely note in the medical record.

5. 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 clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily.

6. The member performing any surgical procedure under general or regional anesthesia or under moderate sedation or any surgical or diagnostic procedure associated with significant risk to the patient as evidenced by the need for continuous, electronic physiologic monitoring during or following the procedure must document the following in the medical record prior to the initiation of the planned procedure:

    a. Assessment and pertinent pre-procedure findings based on a history, physical examination, and diagnostic testing;

    b. Indication;

    c. Rationale, including the risks and benefits;

    d. Informed consent from the patient or authorized health care surrogate. The informed consent discussion between the member and the patient or surrogate should be sufficient to assure that the patient or surrogate receives known, relevant, applicable information necessary to make informed decisions about the contemplated care such as:

        i. Health stats, diagnosis, and progress;

        ii. The nature and purpose of the proposed procedure, anesthesia to be used (if applicable), short- and long- term risks and consequences and the probability that the proposed procedure will be successful;

        iii. An explanation of alternative methods of treatment (if any) and their associated risks and benefits;

iv. An explanation of the risks and prognosis if no treatment is rendered; and

v. An explanation of who will actually perform the procedure, who will administer the anesthesia (if applicable), and which other practitioners will perform important parts of the surgical procedure.

e. If not recorded, the surgery or procedure shall be postponed or canceled. In an emergency, the member shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery. For the purpose of this section, an "emergency" is defined as a condition in which serious, permanent harm might result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

7. Operative reports and other high risk procedure reports shall include a detailed account of the findings at surgery or at the procedure as well as the details of the surgical or procedural technique. Operative reports and procedural reports shall be dictated immediately following surgery or the procedure for outpatients as well as inpatients and the report signed by the surgeon and made a part of the patient's current medical record.

a. In addition to the dictated operative or other high-risk procedure report, a progress note shall be entered immediately into the patient's medical record after the operation or procedure and before the patient is transferred to the next level of care.

b. The operative or procedure report and the progress note must contain at least seven elements:

i. The name(s) of the primary surgeon(s) and assistant(s).

ii. The name of the procedure(s) performed.

iii. A description of each procedure.

iv. Findings.

v. Estimated blood loss.

vi. Specimens removed.

vii. Post-operative diagnosis.

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

9. The current obstetrical record shall include a complete perinatal record; it may be a legible copy of the attending practitioner's office record transferred to the Health Center before admission. In such instances, an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

10. All clinical entries in the patient's medical record shall be accurately dated, time, and authenticated. The authentication may be by a signature or electronic means.

11. Symbols and abbreviations may be used only when they have been approved by the Medical Executive Committee. An official record of approved abbreviations is kept on file in the Health Information Services Department.

12. Final diagnosis shall be recorded in full, without the use of unapproved symbols or abbreviations, and dated, timed, and signed by the responsible member at the time of discharge of all patients. The attending member has the responsibility to establish the final diagnosis.

13. A discharge clinical resume shall be written or dictated on all medical records of patients hospitalized over 48 hours, except for normal obstetrical deliveries, normal newborn infants and certain selected patients with problems of a minor nature. These latter exceptions shall be identified by the Medical Executive Committee, and for those, a final summation-type progress note shall be sufficient. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible member.

    a. An acceptable discharge summary shall contain the following items:

        i. Admission date
        ii. Discharge date
        iii. Admission diagnosis
        iv. Discharge diagnosis
        v. Hospital course
        vi. Operations, procedures
        vii. Medications upon discharge
        viii. Disposition of patient
        ix. Follow-up (who will follow up with patient and when / coordination with PCP)

14. Written consent of the patient or their authorized agent is required for release of medical information to persons not otherwise authorized to receive this information.

15. In case of readmission of a patient, all previous records shall be available for the use of the attending member. This shall apply whether the patient be attended by the same member or by another.

16. The Director of Health Information Services or designee may allow a member of the Medical Staff to review the medical record of any patient for whom the member is currently providing medical care.

17. Whenever information is urgently needed for the welfare of a patient who has been, but is not then a patient in this Health Center, the Director of Health Information Services or designee may release essential medical information by telephone to any physician who is currently providing care to this patient.

18. Records may be removed from the Health Center's jurisdiction and safekeeping only in accordance with court order, subpoena, or statute. All records are the property of the Health Center and shall not otherwise be taken away without permission of the Chief Executive Officer.

19. Free access to all medical records of all patients shall be afforded to members for bona fide study, consistent with preserving the confidentiality of personal information concerning the individual patients.

All such projects shall be approved by the Health Center Research Administration Office and may be subject to Institutional review Board approval before records can be studied. Subject to the discretion of the Chief Executive Officer, former members shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Health Center.

20. A medical record shall not be permanently filed until it is completed by all responsible practitioners or is ordered filed by the Medical Executive Committee.

21. A member's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, timed, and signed by the member.

22. Medical records must be completed promptly and authenticated or signed within two weeks following the patient's discharge. The Director of Health Information Services or designee notifies members whenever they have medical record deficiencies as defined in a written Medical Staff "procedure" and the member's clinical privileges are automatically suspended if records remain delinquent after the grace period established by the Medical Executive Committee in the written Medical Staff "procedure." The member's privileges shall remain suspended until the delinquencies which caused the suspension have been corrected

23. Cumulative suspensions of thirty days or more for medical records deficiencies within any 12 month period shall be sufficient cause for assessment of fines, additional dues obligations and/or demotion or termination of a member's appointment and privileges.

24. For good and sufficient reason, the Medical Executive Committee may grant excuses to practitioners for medical record deficiencies when, for example, prolonged absences or illness may prevent the timely completion of medical records.

25. Consultation reports; operative, procedure, and delivery reports; and discharge summaries must be dictated directly into the hospital transcription system.

III. General Conduct of Care

1. Informed consent procedures shall be kept current and approved by the Medical Executive Committee with the aid of legal counsel.

2. All orders for treatment shall be in writing. A telephone order shall be considered to be in writing if the member dictates the order to a registered nurse, licensed pharmacist, or to a duly authorized person functioning within their sphere of competence, and the order is then signed by the responsible member. All orders dictated over the telephone shall be signed by the appropriately authorized person to whom dictated and shall clearly identify the name of the member giving the order. The prescribing member, a covering or attending member, or another member responsible for the care of the patient, even if the order did not originate with the countersigning member, shall countersign, date and time such orders within 48 hours if those orders are within the scope of his/her privileges or competency. Telephone orders should be used infrequently and only when deemed necessary by the ordering member.

3. The member's order must be written clearly, legibly, and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse. The use of "renew," "repeat," and "continue orders" are not acceptable. The member's printed name, name stamp and/or dictation code number must accompany any member's signature that is not legible.

4. For categories of medications, including narcotics, antibiotics and anticoagulants, and at intervals recommended by the Pharmacy and Therapeutics Committee and approved by the Medical Executive Committee, the member must rewrite orders, by drug name, for medications that are ordered without specific limitation as to time or number of doses.

5. All previous orders are cancelled when a patient's surgery is completed.

6. All drugs and medications administered to patients shall be those listed in the latest edition of the United States Pharmacopoeia, National Formulary, American Hospital Formulary Services, or AMA Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration, and must be approved by the Health Center Research Administration Office and may be subject to Institutional Review Board approval, and dispensed by the Health Center pharmacy according to established procedures for handling investigational drugs.

7. All drugs and medications brought to the Health Center by patients will be turned over for safekeeping to the nurse in charge of the patient's care and may be administered to the patient only if clearly identified by the pharmacist and specifically ordered by the attending member.

8. All research undertaken by members or others which in any way involves the Health Center or patients of the Health Center, must be approved by the appropriate chair of department(s) or section(s), and must be approved by and conducted according to the rules and conditions formulated and adopted by the Health Center Research Administration Office.

9. A member may use or allow the use of the name of the Health Center in published works only with the written permission of the chair of the member's department and the Chief Medical Officer. However, they shall have the privilege of self-identification as a member within the limits of accepted professional ethics and practices.

10. It is the duty of the organized Medical Staff, through its departmental chairs and Medical Executive Committee, to see that those with clinical privileges do not fail in the matter of calling consultants as needed.

11. Any qualified member with clinical privileges in this Health Center can be called for consultation within their area of expertise and within the limits of clinical privileges for consultation which have been granted to him/her.

12. Except in an emergency, consultation is required for the following situations:

    a. In unusually complicated situations or where specific skills of other practitioners may be needed.

    b. In instances in which the medical or surgical patient exhibits severe psychiatric symptoms.

    c. When requested by the patient or their family.

13. Except in an emergency, any patient under the age of two years, undergoing surgery, must be attended by a member who has pediatric privileges.

14. The attending member is responsible for requesting consultation when indicated and for calling in a qualified consultant. This does not preclude request for consultation on any patient when the Medical Director of a service, Department Chair, or President of the Medical Staff determine that a patient will benefit from such consultation.

15. One member shall be designated as attending physician for each inpatient or observation status patient. The attending physician has overall responsibility for the medical care of their patient. When clinically appropriate, the attending physician may transfer responsibilities to another qualified physician member. The attending physician may also delegate specific aspects of the medical evaluation and treatment of a patient to another member. The attending physician documents the transfer or delegation of these responsibilities by written orders on the medical record.

16. Each member is required to successfully complete the appropriate general and specialty-specific proficiency training, including applicable proficiency tests on the use of Saint John's electronic health record prior to the hospital's installation or within 30 days of its installation. Each newly appointed member is required to successfully complete the above-noted requirements within 30 days of being appointed to the Medical Staff.

17. Members who hold surgical privileges are required to document successful completion of a Health Center-approved Operating Room Safety Course no later than December 1, 2012. Initial applicants requesting surgical privileges are required to document successful completion of a Health Center-approved Operating Room Safety Course for their application to be considered complete.

18. Duties and responsibilities for members with inpatient admitting privileges:

    a. Dictate history and physical within two hours of initial visit and request that a copy be sent to the referring and/or consultant physician(s).

    b. Initiate necessary consultations directly through physician to physician communication.

    c. Respond to all non-emergent Health Center pages / phone calls within 30 minutes; respond to urgent pages / phone calls commensurate with patient need.

    d. Complete a legible, hand-written progress note on admission, documenting the diagnostic impression and the treatment plan.

    e. Communicate with patient / family on admission regarding the treatment plan, discharge plan, advance directive status, and initiate end-of-life discussions as appropriate.

    f. Communicate as requested in a timely and professional manner with the case manager / discharge planner regarding the treatment plan and arrangements required for a safe discharge.

    g. Actively and directly communicate with specialists, physician to physician, throughout the course of care, including advising specialists when their services are no longer needed.

    h. Write clear, legible, and timely orders for changes in level of care.

    i. Limit the inpatient diagnostic work-up to testing medically necessary and appropriate to the current acute admission. Facilitates outpatient testing post-discharge, when indicated.

j. Document daily and legibly in the progress note the patient's treatment plan and discharge plan, as appropriate.

k. Cooperate with Medical Staff-approved Joint Commission "core measures" best practice interventions and documentation.

l. Complete rounds on all patients that are potential discharges that day by 11:00 AM and ensure consultant cooperation.

m. Ensure dictation of the discharge summary within 72 hours of discharge and request that a copy be sent to the referring and consultant physician(s).

n. Ensure that covering physician associates communicate in a timely and direct manner with the attending physician to inform of discharge, events of the hospitalization, and discuss the continuum of care.

o. Ensure that covering physician associates are informed and knowledgeable about patients and are empowered to make clinical and discharge / disposition decisions.

p. Reconcile the patient's previous and current medications at all changes in level of care; communicate the patient's medications to the next provider when a patient is referred or transferred; and provide the patient with a complete list of medications on discharge

q. On the day of discharge of a patient, it is the responsibility of the attending member to encourage and facilitate discharge of the patient by 11:00 AM. If the patient is to be discharged with continuing care such as to a Skilled Nursing Facility (SNF), or utilizing post discharge services such as Home Health, Hospice, Dialysis, Infusion, Durable Medical Equipment, etc., it is imperative that the patient's choice be followed. Physicians or the Health Center will provide names of two or three providers. The physician will disclose to the patient or his/her family or decision maker any relationship the physician or his/her first degree relatives have with that provider (e.g., ownership interests, medical directorship, royalties, consultation fees, etc.). The physician shall sign, date, and time a Health Center form evidencing that the patient's choice is followed. Failure by the physician to disclose on the form ownership or interest in the facility will result in referral for peer review.

r. If an Admitting Physician cannot admit appropriately, place orders timely, and respond within 30 minutes (per above), bridging orders will be entered for non-complex patients by the Emergency Medicine physician, and/or the patient will be automatically transferred to the current Hospitalist.

IV. General Rules Regarding Surgical Care

1. A patient admitted by a dentist for dental care, or a podiatrist for podiatric care, is a dual responsibility involving the dentist or podiatrist and a physician member.

   a. Dentists' or Podiatrists' Responsibilities

      i. The dentist or podiatrist shall arrange with a physician for medical coverage.

      ii. Provide a detailed dental or podiatric history justifying Health Center admission.

iii. Provide a detailed description of the dental or podiatric examination and an admitting pre-operative diagnosis.

iv. Complete the operative report, describing the findings and technique.

v. Enter progress notes as are pertinent to the dental or podiatric condition.

vi. Record a clinical resume (or summary statement).

vii. Perform and record the medical history and physical examination in the case of an oral – maxillofacial surgeon or podiatrist who has been granted those specific clinical privileges or to ensure performance by the collaborating physician member.

b. Physicians' Responsibilities

i. If not performed and recorded by a duly privileged oral – maxillofacial surgeon or podiatrist, complete medical history pertinent to the patient's general health.

ii. If not accomplished by a duly privileged oral – maxillofacial surgeon or podiatrist, perform and record results of a physical examination to determine the patient's condition prior to anesthesia and surgery.

iii. Supervise the patient's general medical care while hospitalized.

c. The discharge of the patient shall be on written order of the dentist or podiatrist member.

2. Written, signed, informed, surgical consent shall be obtained by the physician, dentist, or podiatrist prior to an operative procedure, except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies, involving a minor, unconscious or incompetent patient for whom consent to surgery cannot be immediately obtained from parents, guardian, conservator, or authorized agent, these circumstances should be fully explained on the patient's medical record. In such instances, if time permits, a consultation may be desirable before the emergency operative procedure is undertaken.

3. The anesthesiologist shall maintain a complete anesthesia record, to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition. The anesthesiologist must document in the medical record the nature of any anesthetic complications which are identified during the anesthetic or post-anesthetic evaluation of the patient.

4. Anesthetic induction for elective surgery will not begin until ordered by the attending surgeon or qualified assistant surgeon is prepared to start surgery when patient is fully induced.

5. All tissues, foreign bodies or devices removed at operation and which may have clinical or pathological implications shall be sent to the Health Center pathologist, who shall make such examination as necessary to establish their findings and/or arrive at a diagnosis. Their authenticated report shall be made part of the patient's medical record. Tissues such as prepuces removed at circumcision, placentas, excised scars, normal tissue removed in reconstructive procedures, eye lenses, and devices such as orthopaedic hardware which is not defective and removed in the normal course of treatment, need not be sent to the pathologist for examination.

6. Freshly cleaned surgical suits, facial masks, and caps or hoods approved by the Department of Surgery Committee, must be worn at all times, by all persons, in the operating rooms. If shoe covers, masks, caps or hoods are worn outside the boundaries of the surgical suite and recovery room, these items are not to be worn again in an operating room. Clean scrub suits may be worn in others areas of the Health Center if covered with an overgown. In such cases, if the scrub suit has been protected from contamination it may be worn again in the surgical suite.

7. Doors into individual operating rooms must be closed during the conduct of surgery.

8. Only members and Health Center staff are permitted in the operating rooms during surgery, unless prior permission has been obtained from the Chair of the Department of Surgery and/or the Chief Medical Officer.

9. The services of an appropriate assistant should be employed by the surgeon whenever the complexity or technological demands of the procedure require additional resources.

10. For every single surgical or invasive procedure, an attending surgeon is to be designated. The attending surgeon, who is identified as the primary surgeon in the operative record, is the member who must assume and will be held accountable for the following responsibilities:

    a. To ensure that informed consent for the planned procedure has been obtained, including but not limited to, explanation of the anticipated benefits, risks, and alternative therapies.

    b. To disclose the significant or material portion(s) of the planned procedure, if any, that may or will not be directly performed by the attending surgeon. In the event the attending surgeon will be involved with more than one operation on different patients at the same time through the aid of other qualified persons, the attending surgeon must inform each of those patients so affected that the attending surgeon may not be physically present at the patients operating table through the entire procedure. Representation that the patient has been so informed should be documented in the attending surgeon's preoperative note.

    c. To supervise and direct any person(s) authorized to act as surgical assistant(s) during the procedure.

    d. To order induction of anesthesia.

    e. To "scrub in," direct, and participate in substantial portions of the procedure, including those portions of the surgery that are critical to the outcome.

    f. To remain readily available to return to the Operating Room through the entire period the patient is present.

V. Emergency Services

1. The Medical Staff shall adopt a method of providing medical coverage in the Emergency Department. This shall be in accord with the Health Center's basic plan for the delivery of such services, including delineation of clinical privileges for all members who render emergency care. Members who have served on the Medical Staff for 25 years of more, or are 65 years of age or older, may request that their Department Committee excuse them from service on emergency department panels.

a. Per Medical Staff Bylaw Section 3, article h, “coverage of the Emergency Department on a rotational basis is an obligation which may be imposed by each of the Departments. Service in this coverage is at the discretion of the Health Center and is not a clinical privilege or right of membership on the Medical Staff.”

b. Service on an ED Call Panel for unassigned patients is an obligation of Staff Membership. No Medical Staff Member has a right to serve on any Call Panel. A decision to remove a Member from the Call Panel shall not construe a denial or restriction of Clinical Privileges and gives rise to only the hearing rights set forth in this rule.

c. Medical Staff Bylaw Section 3, article i states “Compliance with the Emergency Medical Treatment and Active Labor Act (‘EMTALA’) including, but not limited to, the requirement that physician who are providing on-call coverage for the Emergency Department must come to the Health Center, if so requested, within a reasonable time following initial contact by the Emergency Department and providing any necessary stabilizing treatment to patients regardless of the patient’s ability to pay.”

d. To ensure that the obligation for medical coverage of the Emergency Department is on a rotational basis, a designated Section leader / representative will create shift schedules in six-month increments, for each of the following ED Call Panels for unassigned patients:

   i. General Surgery

   ii. Hand / Plastics

   iii. Neurological Surgery

   iv. Oral / Maxillofacial Surgery

   v. Ophthalmology

   vi. Orthopaedic Surgery

   vii. Otolaryngology (Head and Neck Surgery)

   viii. Cardiovascular Surgery

   ix. Spine Surgery

   x. Thoracic Surgery

   xi. Urology

   xii. Vascular Surgery

   xiii. Cardiology

   xiv. Interventional Cardiology

xv. Gastroenterology

xvi. Neurology

xvii. Stroke (Acute, Hospitalist, and Sub-acute)

xviii. Internal Medicine / Family Practice

xix. Obstetrics and Gynecology

xx. Pediatrics

e. In cases where a patient's diagnosis is uncertain, or crosses specialty lines, the ED physician will have ultimate authority in deciding which specialty should respond in-person to examine the patient in the ED.

f. A Member may be denied participation on, or terminated from, an ED Call Panel for unassigned patients by the Department Chief to which the Member is assigned, the Medical Staff President, or the Emergency Department Medical Director.

i. The decision to deny or terminate participation will be final, subject only to review by the Medical Executive Committee or a subcommittee comprised of at least three members of the Medical Executive Committee (MEC), appointed by the MEC to conduct the review.

ii. Prior to a final adverse decision, the affected Member will be given a statement of the reasons for the proposed action and an opportunity to appear before the Medical Executive Committee, or an MEC subcommittee, to explain why the proposed action should not be imposed.

iii. The fact that the MEC denied a Member's request to serve, or terminated a Member's participation on the Call Panel shall not affect the Member's Medical Staff Privileges, nor shall it be used as evidence in any disciplinary action. However, the facts which the committee reviewed in reaching its decision may be used for any and all purposes.

g. Conduct of ED Call Panel Physicians

i. Members on call must respond promptly when requested to see a patient and at least call within 15 minutes after they are first called. The response time must be reasonable in view of the patient's clinical circumstances. Each ED Call Panel member must let the Health Center know how to reach him/her immediately and remain close enough to the Health Center to be able to arrive within 30 minutes.

ii. A participant who is unable to provide panel coverage during his/her scheduled time (including when he/she is detained due to another medical commitment) is responsible for arranging coverage by another current Panel Member. The participant will inform the Health Center of the back-up coverage.

iii. 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 that it is pertinent to medical care), physical or mental handicap, insurance status, economic status, or ability to pay.

iv. All transfers shall be carried out in accordance with Health Center policies and will require that the patient's Attending physician or the ED Call Panel member personally examine the patient prior to transfer and finds that the patient is stable. Patients who are not stable may be transferred only if the Member finds, within reasonable medical probability, that the expected medical benefits of the transfer outweigh the risks posed by the transfer, or the patient (or his/her authorized decision maker), requests transfer after the Member has explained the medical risks and benefits of transfer.

v. If a Member fails to respond to an ED Call Panel obligation, the ER physician shall call the appropriate Department Chair. A report of the incident shall be referred to the Professional Practices Committee.

vi. Members are expected to respond appropriately to calls for emergent issues within the Health Center that are not inside the Emergency Department.

vii. Members must display behavior that is professional, as a representative of the Medical Staff and Health Center. This will be reflected in their decorum, dress, and interactions with patients and caregivers.

viii. Members' fees must be reasonable and not higher than fees for comparable services in the community.

h. Members who are placed on a Focused Professional Practice Evaluation (FPPE) may not serve on an ED Call Panel for unassigned patients.

2. The duties and responsibilities of all personnel who service patients within the Emergency Department shall be defined in a procedure manual relating specifically to this outpatient facility.

3. An appropriate medical record shall be kept for every patient receiving service in the Emergency Department and shall be incorporated in the patient's Health Center record. The record shall include:

a. Adequate patient identification.

b. Information concerning the time of the patient's arrival, means of arrival, and by whom transported.

c. Pertinent history of the injury or illness, including details relative to first aid or emergency care given the patient prior to their arrival at the Health Center.

d. Description of significant clinical, laboratory, and imaging studies findings.

e. Diagnosis and treatment given

f. Condition of the patient on discharge or transfer.

g. Final disposition, including instructions given to the patient and/or family, relative to necessary follow-up care.

4. Each patient's medical record shall be signed by the member in attendance who is responsible for its clinical accuracy.

5. There shall be a monthly review of Emergency Department medical records by a physician, who shall report thereon to an appropriate committee of the Medical Staff.

6. There shall be a plan or the care of mass casualties at the time of any major disaster, based upon the Health Center's capabilities in conjunction with other emergency facilities in the community.

7. All patients presenting to the Emergency Department (ED) must be seen by an ED clinician in every case).

   a. Sending a patient to the ED to be seen by an attending, admitting, or consulting physician – and not by an ED clinician – is not allowed. Even in situations where the patient was seen in an outpatient office and is now being sent to the ED to wait for an available bed or procedure, the patient must be given a documented medical screening exam by an ED clinician.

   b. The reasons for this practice are as follows:

      i. Patients admitted without being seen by an ED clinician are at higher risk for not meeting core measures (as mandated by The Joint Commission and the Centers for Medicare and Medicaid Services), including those mandated for the management of pneumonia and sepsis.

      ii. Unstable patients may deteriorate while waiting for a physician to "meet them in the ED."

      iii. The patient's perception of customer service by the ED is negatively impacted.

      iv. ED metrics, such as turnover times, are negatively impacted.

      v. The risk for an EMTALA violation is increased.

      vi. ED clinicians are specifically trained to navigate a patient through the ED in an optimal manner.

8. The Medical Executive Committee designates Physician Assistants and Labor and Delivery Registered Nurses as Qualified Medical Personnel.

VI. Medical Staff Committees

1. The standing committees shall be the Credentials, Surgical Services Review, Medical Records, Resource Management, Pharmacy and Therapeutics, Infection Control, Cancer, Transfusion, Risk Management and Physicians' Health Committee. Each year the President shall appoint the Medical Staff members to these committees, shall select the chair of each, and shall fill any vacancies that may occur. These committees shall consist of members of the Staff selected on a basis that will insure representation of the major clinical specialties, the Health Center based specialties, and representatives of Health Center

management, and those paramedical services that affect the specific areas of a committee's responsibilities. Each Committee shall meet as needed on dates established by the chair, shall maintain a permanent record of its proceedings and activities, and shall report as directed by and to the Medical Executive Committee.

2. As Health Center interests and services expand, the Medical Staff shall develop appropriate committees to direct or monitor, and review and analyze these services on a regular basis. These may include, but are not limited to, committees of clinical sections and committees for the following: Bylaws and Accreditation, Nominating, Disaster, Emergency, Critical Care, Medical Education and Library, and Radiation Safety.

3. Composition: These committees shall be composed of a chair and members from the Medical Staff appointed each year by the President of the Medical Staff and appropriate members of the Health Center appointed by the Chief Executive Officer as required by law or regulations or for effective functioning.

    a. Credentials Committee

        i. The duties of the Credentials Committee shall be as follows:

            1. To review the credentials of all applicants and to make recommendations or membership and delineation of clinical privileges in compliance with Articles VI, VII, and VIII of these Bylaws, taking into consideration the current departmental, Health Center, and community needs for professional medical services;

            2. To review periodically all information available regarding the competence of staff members and as a result of such reviews to make recommendations for the granting of privileges, reappointments, and the assignment of practitioners to the various departments or services as provided in Articles VI, VII, and VIII of these Bylaws;

            3. To investigate any breech of ethics that is reported to it;

            4. To make a report to the Medical Executive Committee on each applicant for Medical Staff membership or clinical privileges, giving specific consideration to the recommendations from the departments in which such applicant requests privileges.

    b. Surgical Services Review Committee

        i. The Surgical Services Review Committee of the Medical Staff shall conduct a comprehensive review for justification of surgery performed, whether tissue was removed or not, and for the acceptability of the procedure chosen. Specific consideration shall be given to the agreement or disagreement of the preoperative and pathological diagnoses. The committee shall report to the Department of Surgery Committee or the Obstetrics and Gynecology Committee as appropriate.

    c. Medical Records Committee

        i. The duties of the Medical Records Committee shall be as follows:

1. The Medical Records Committee shall be responsible for assuring that all medical records meet the appropriate standards of patient care, usefulness, and of historical validity.

2. The Medical Staff representatives shall be specifically responsible for assuring that the medical records reflect realistic documentation of medical events.

3. The Committee shall conduct periodic reviews of currently maintained medical records to assure that they properly describe the condition and progress of the patient, the therapy provided, the results thereof, and the identification of responsibility for all actions taken, and that they are sufficiently complete at all times so as to meet the criterion of medical comprehension of the case in the event of transfer of the patient.

4. It shall also conduct a retrospective review of records of discharged patients to determine the promptness, pertinence, adequacy, and completeness thereof, and coordinate all medical care audits in order to evaluate the quality of medical care and to assure educational and/or corrective measures in response to audit findings.

5. The Medical Records Committee shall also be responsible for developing guidelines for the form, content, and evaluation of nursing audits. The responsibility for executing the nursing audits may be delegated to the nursing staff under the supervision of, and pursuant to, the guidelines developed by the Medical Records Committee.

6. The Committee shall review all nursing audits in order to evaluate the quality of nursing care and to initiate any necessary corrective measures.

d. Resource Management Committee

i. The duties of the Resource Management Committee, any and all of which may be assumed by or delegated by the Chair of the Committee to the Director of Resource Management in conjunction with other Medical Staff committees, shall be as follows:

1. Resource Management Studies

a. The Resource Management Committee shall review resource utilization studies designed to evaluate the appropriateness of admissions to the Health Center, lengths of stay, discharge practices, use of medical and Health Center services and all related factors which may contribute to the effective utilization of Health Center and physician services. Specifically, it shall analyze how under-utilization and over-utilization of each of the Health Center's services affects the quality of patient care provided at the Health Center, shall study patterns of care and obtain criteria relating to lengths of stay by specific disease categories, and shall evaluate systems of resource management employing such criteria. It shall also work toward the assurance of proper continuity of care upon discharge through, among other things, the accumulation of

appropriate data of the availability of other suitable health care facilities and services outside the Health Center. The Committee shall communicate the results of its studies and other pertinent data to the entire Medical Staff and shall make recommendations for the optimum utilization of Health Center resources and facilities commensurate with the quality of patient care and safety. Whenever this Committee or a designated subcommittee thereof determines that the utilization patterns of a practitioner appear to be substantially at variance with other ordinary practice, the Committee shall require that practitioner to appear in order to explain such variance. Repeated failure by a practitioner to conform or to justify variation(s) from accepted utilization norms may be grounds for correction action as defined in Article IX of these Bylaws.

2. Written Resource Utilization Plan

   a. It shall also assist in the formation of a written resource utilization plan for the Health Center. Such plan, as approved by the Medical Staff and the Board of Directors must be in effect at all times and must include all of the following elements: the organization and composition of committee(s) which will be responsible for the utilization review function; frequency of meetings; the types of records to be kept; the methods to be used in selecting cases on a sample or other basis; the definition of what constitutes the period of extended duration; the relationship of the resource utilization plan to claims administration by a third party; arrangements for committee reports and their dissemination; and responsibilities of the Health Center's administrative staff in support of utilization review.

3. Extended Duration Evaluations

   a. The Committee shall evaluate the medical necessity for continued Health Center services for particular patients, where appropriate. In making such evaluations, the committee shall be guided by the following criteria: no physician shall have review responsibility for extended stay cases in which they were professionally involved; all decisions that further inpatient stay is not medically necessary shall be made by physician members of the committee and only after opportunity for consultation has been given the attending physician by the committee and full consideration has been given to the availability of out-of-Health Center facilities and services; and all decisions that further inpatient stay is not medically necessary shall be given by written notice to the Medical Executive Committee, to the chair of the appropriate department, to the Chief Executive Officer, to the attending physician, and to the patient, for such action, if any, as may be warranted.

4. Should the Health Center enter into agreements with any outside professional utilization review organizations, the functions of the Resource Management Committee may be modified and findings of the Resource Management

Committee and Medical Records Committee may be submitted to and utilized by the outside review agencies as provided for in the agreements. Whenever such agreements are in force, the Chair of the Resource Management Committee shall, upon direction of the Medical Executive Committee, undertake whatever functions and studies which may be required by the outside review agency and authorized by the terms of the agreement between the Health Center and the agency, without further amendment of these Bylaws.

e. Pharmacy and Therapeutics Committee

i. The duties of the Pharmacy and Therapeutics Committee shall be as follows:

1. The Committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to therapeutic diet and drugs in the Health Center. It shall also perform the following specific functions:

a. serve as an advisory group to the Medical Staff and chief pharmacist on matters pertaining to the choice of available drugs and therapeutic dietary matters;

b. make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

c. develop and review periodically a formulary or drug list or use in the Health Center;

d. prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;

e. evaluate clinical data concerning new drugs or preparations requested for use in the Heath Center; and

f. assist in the formulation of broad professional policies regarding the evaluation, appraisal, selections, procurement, storage, distribution, use, safety procedures, adverse drug reactions, and all other matters relating to drugs.

2. The Health Center and its Medical Staff will be engaged in the centralized Providence Health and Services (PH&S) formulary determination process, which ensures patients of Providence and its affiliates are provided with safe, high-quality, and affordable medications through the continuum of care.

3. The committee accepts and adheres to the outcomes of the centralized PH&S formulary process.

4. 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.

5. The committee, or an individual Member of the Medical Staff, provider in coordination with a committee lead 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, and cost) is on those who advocate the alternative.

6. The Health Center and the Medical Staff delegate 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.

f. Infection Control Committee

i. The duties of the Infection Control Committee shall be as follows:

1. The Infection Control Committee shall be responsible for the surveillance of inadvertent Health Center infection risks, the review and analysis of actual infections, the promotion of a preventive and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the Health Center's activities, including:

a. operating rooms, delivery rooms, nursery rooms, special care units;

b. sterilization procedures by heat, chemicals, or otherwise;

c. isolation procedures

d. prevention of cross-infection by anesthesia apparatus or respiratory therapy equipment;

e. testing of Health Center personnel for carrier suits;

f. disposal of infectious material; and

g. other situations as requested by the Medical Executive Committee.

g. Cancer Committee

i. Composition

1. The Cancer Committee is a multidisciplinary committee which includes physician representation from the diagnostic and therapeutic specialties as well as Allied Health Professionals involved in the care of cancer patients. Physician members must include but are not limited to representatives of the major sites of cancer,

surgery, medical oncology, radiation oncology, diagnostic radiology, pathology, and the cancer liaison physician. Membership composition is to be consistent with that recommended by the American College of Surgeons' Commission on Cancer. Non-physician members may include Administration, Nursing, Social Services, Cancer Registry, Pharmacy, and Quality Improvement.

ii. The duties of the Cancer Committee shall be as follows:

1. develop and evaluate the annual goals and objectives for the clinical and educational activities related to cancer, thereby promoting a coordination of multiple approaches to clinical treatment;

2. recommend policies and procedures concerning care of cancer patients;

3. promote the participation of Medical Staff and patients in research programs designed to further knowledge and quality of care of cancer patients;

4. plan and participate in the conduct of a quality management program;

5. maintain liaison with the Registry Service, recommend procedures for its functioning, review its findings and assist in developing policies to assure accurate and timely reporting of cancer data;

6. inform the Medical Staff of pertinent information derived from the Registry Service; and

7. plan and present educational and consultative "Cancer Conferences" for members of the Medical Staff, thereby promoting a multidisciplinary approach to cancer treatment.

h. Transfusion Committee

i. The duties of the Transfusion Committee include:

1. at least quarterly review of transfusion statistics and practices and of blood donor and special transfusion programs, i.e., autologous, frozen plasma, pheresis;

2. review of transfusions of blood components flagged as "at variance from criteria for use"; and

3. review of all transfusion reactions and complications or problems.

i. Risk Management Committee

i. The duties of the Risk Management Committee shall include:

1. review and evaluation of incidents reported to the Risk Manager;

2. review of follow-up reports to corrective actions;

3. review of reports of status of claims and suits; and

4. periodic review of applicable policies and procedures.

j. Physicians' Health Committee

i. The Physicians' Health Committee is comprised of members with special interest and/or expertise in physician wellness concerns who have been appointed by the President of the Medical Staff. The Committee meets and reports to the Medical Executive Committee, as needed. It does not keep minutes of its proceedings. The Physicians' Health Committee is consultative in nature and chartered to develop programs to provide education and support for physician health and wellbeing, address prevention of physical, psychiatric or emotional illness and facilitate confidential diagnosis, treatment, and rehabilitation of members who suffer from potentially impairing conditions. These programs encompass:

1. Educating the Medical Staff and Health Center staff about prevention and recognition of illness and impairment issues to include education of specific conditions as deemed relevant.

2. Disseminating information for contacting the Committee for timely help, for self-referrals, referral by other Medical Staff or Health Center employees.

3. Reminding the Medical Staff of the Committee's function, availability, and membership.

4. Providing forums as needed to provide timely topics and promote collegiality and interaction with members of the Committee.

5. Responding to special incidents that affect the emotional welfare of Medical Staff members with consultation as appropriate.

6. Providing such advice, counseling, or referrals to appropriate professional resources for diagnosis and/or treatment of the condition or concern.

7. Evaluating the credibility of a complaint, allegation or concern, including such investigation as reasonably deemed necessary.

8. Monitoring the affected member and the safety of patients until the rehabilitation or any corrective action process is complete; and in the event the member fails to complete a required rehabilitation program, informing the Medical Executive Committee so the need for other appropriate actions may be assessed.

9. Enduring appropriate confidentiality with respect to the affected practitioner; however, if the Committee receives information that indicates that the health status of a member may pose a risk of harm to Health Center patients (or prospective patients), that information shall be referred to the President of the Medical Staff who will determine whether corrective action is necessary.

10. Recommending to the Medical Executive Committee education or outreach programs benefitting the Medical Staff.

k. Postgraduate Training Oversight Committee

i. Purpose

1. The Postgraduate Training Oversight Committee (PTOC) coordinates and reviews all aspects of training programs that operate within Providence Saint John's Health Center (PSJHC) licensed facilities.

ii. Duties

1. Develop policies and procedures to ensure appropriate supervision and oversight for trainees rotating at PSJHC.

2. Provide a formal mechanism for trainees to participate in the development, review, and evaluation of trainee patient care responsibilities and functions.

3. Advise the Credentials Committee regarding credentialing of trainees.

4. Review training programs proposed by Medical Staff Members.

5. Evaluate existing training programs on an annual basis.

iii. Composition

1. The PTOC shall include at least two Active Staff Members.

iv. Meeting Frequency

1. The PTOC shall meet as often as necessary, at least annually.

v. Reporting

1. The PTOC will report to the Medical Executive Committee at least annually.

Department Rules and Regulations
of **the Medical Staff**
of

Saint John's Health Center

PROVIDENCE Health & Services

Table of Contents

Department Rules and Regulations

Department of Medicine

Composition

1. The Department of Medicine shall be composed of the following specialties:

    a. Adult Congenital Heart Disease
    b. Allergy and Immunology
    c. Cardiovascular Disease
    d. Clinical Cardiac Electrophysiology
    e. Dermatology
    f. Emergency Medicine
    g. Endocrinology, Diabetes, and Metabolism
    h. Family Medicine
    i. Gastroenterology
    j. Hematology / Medical Oncology
    k. Hospital Medicine (Hospitalist)
    l. Infectious Disease
    m. Internal Medicine (including Hospice and Palliative Medicine)
    n. Interventional Cardiology
    o. Nephrology
    p. Neurology (including Tele-Neurology)
    q. Physical Medicine and Rehabilitation
    r. Psychiatry (including Tele-Psychiatry)
    s. Pulmonary Disease (including Critical Care Medicine)
    t. Rheumatology

Sections

1. The Department of Medicine shall be organized into the following sections:

    a. Cardiology
    b. Emergency Medicine
    c. Gastroenterology
    d. Hospital Medicine
    e. Internal Medicine

Cardiology

1. Cardiac catheterization and angiography procedures are defined as surgical procedures and the Medical Staff rules and regulations relating to surgery are application in such cases (e.g., General Rules regarding Surgical Care, No's 1, 3, 8, 9, and 10; Medical Records Rules No's 3, 6).

2. Clinical privileges for cardiac catheterization and angiography are ordinarily granted initially on a probationary basis. A member of the Medical Staff who has probationary privileges may perform such procedures under the supervision of another member of the Medical Staff who has unrestricted privileges for performing the procedure.

Hematology / Medical Oncology

1. All patients with stem cell disorders, hematologic malignancies or cancer (hereafter referred to as neoplasms) who are on active treatment for their neoplasm or currently receiving care for complications of their neoplasm by a hematologist/medical oncologist on the Medical Staff of Saint John's Health Center will be required to have their hematologist/medical oncologist either dictate or submit a transcribed or electronic document within 24 hours that includes the following:

    a. reason for hospitalization;
    b. underlying hematology or oncology diagnosis;
    c. history of diagnosis and stage;
    d. initial treatment;
    e. current ECOG performance status;
    f. history of recurrence if any with treatment;
    g. goal of current treatment;
    h. code status and advanced directive;
    i. major comorbidities;
    j. past history;
    k. family history;
    l. social history;
    m. review of systems;
    n. physical examination;
    o. results of outside imaging;
    p. pertinent laboratory data including outside laboratory results and pathology reports;
    q. provisional admitting diagnoses;
    r. plans for inpatient diagnostic evaluation and treatment; and
    s. physicians to be consulted

2. All such patients will be seen daily by a hematologist/oncologist with clearly written progress notes per Rules and Regulations of the Medical Staff, II. Medical Records, Section 5 which outline the patient's progress, significant issues leading to continued hospitalization and plans to address the medical issues and the plan for transition of care to the outpatient setting.

3. All inpatient who receive biologic, immunologic, or chemotherapeutic drugs for a neoplasm as an inpatient will be required to have an informed consent on the chart.

4. Patients with a neoplasm on active medical treatment must have a staff hematologist/medical oncologist manage the medical illnesses that are secondary to the disease or its treatment. This does not preclude use of specialists to manage or co-manage morbidity, e.g., surgeon, cardiologist, but a hospitalist or other subspecialist

is not to primarily manage the side-effects of the medical treatment of the neoplasm or to be the primary manager of the medical manifestations of neoplasms.

5. If a patient with a neoplasm on active treatment by a hematologist / medical oncologist, or with medical complications of the neoplasm managed by their hematologist / medical oncologist, requires hospitalization and their primary hematologist / medical oncologist is not on the Medical Staff at Saint John's Health Center, then the admitting physician should whenever possible consult a Saint John's Health Center staff member for subspecialty care.

6. At discharge, the hematologist/medical oncologist must document in either the discharge summary or in a progress note, the plan for ongoing care.

Department of Obstetrics and Gynecology

1. The prenatal records must be available when a patient is admitted in labor and an admitting note must be written by the attending physician describing any historical changes, unusual problems, and currently significant physical findings.

2. On admission, blood will be drawn for determination of blood group and type if this is not recorded on an available medical record, on all women in labor or with incomplete, threatened or missed abortion, and a blood sample will be held in the Pathology Department for cross-match with the Rho Immune Globulin, should this be necessary.

3. A dictated note describing the labor and delivery for all deliveries including operative vaginal and cesarean section is required.

4. Delivery records and post-partum orders are to be completed immediately after delivery and the patient shall not be transferred from the Obstetrical Recovery Room until this has been done.

5. Cord blood will be drawn on all newborns in the delivery room for such laboratory studies as may be required.

6. Babies shall be isolated from mothers who have known communicable diseases or undiagnosed fevers.

7. Mothers with known communicable diseases will be transferred from the maternity area.

8. General or regional anesthesia is to be administered by members of the Anesthesiology Section, or by those approved by that section. The obstetrician should only administer such anesthetics in an emergency. The anesthesiologist shall be responsible to monitor the vital signs of the patient while she is in the Labor or Delivery Room, and they will assist with newborn resuscitation, if necessary. Pudendal, local or para-cervical anesthesia nay be given by the obstetrician in the delivery area. Epidural anesthesia may be administered to a patient in labor at the obstetrician's order as long as the obstetrician is readily available.

9. Oxytocic Agents

    a. Oxytocic agents shall be used during labor only if the attending physician or registered nurse gives evidence of having examined the patient on the day of induction and the physician gives orders for induction.

    b. Intravenous oxytocic agents shall be used during labor only if a qualified observer can stay with the patient or if a physician qualified to conduct the labor and delivery and to deal with any complications

that may result from the use of the oxytocic agent is readily available. Oxytocic intravenous drips will be given only through microdrip devices or controlled measuring devices.

10. If a physician does not order the administration of Rho Immune Globulin to parturients or aborters when indicated by laboratory studies, they shall record the circumstances and reasons on the patient's medical record.

11. The physician who delivers a newborn shall be responsible for the care of the infant until the services of an attending pediatrician or physician with pediatric privileges have been assured.

12. Consultation is required in the following conditions for all practitioners except those who have been granted consultation privileges in the Department of Obstetrics and Gynecology:

    a. Prior to any obstetrical operation including cesarean section, with the exception of episiotomy or prophylactic use of low forceps or vacuum extraction;

    b. The use of antepartum oxytocic agents;

    c. In cases in which the patient has been in active labor without normal progress, or in which the patient has not delivered within 24 hours after rupture of placental membranes;

    d. In all cases of toxemia;

    e. When a patient shows evidence of abnormal bleeding before, during or after parturition;

    f. In abnormal presentations, including breech;

    g. In post-partum obstetrical complications;

    h. Prolapse of umbilical cord during labor or delivery;

    i. Persistent signs of fetal distress during labor; or

    j. Vaginal deliveries planned for patient who has had a previous cesarean section.

13. Members of the Family Medicine Section, who have privileges for obstetrical primary care only, must obtain consultation and assure on-site or ready availability of an obstetrician, who has consulting privileges, prior to the use of oxytocic agents for the induction of labor and prior to the use of general or regional anesthesia for any obstetrical procedure.

14. If the results of a hepatitis B surface antigen test are not documented on an obstetrical patient's prenatal record when the patient is admitted, the test will be performed at the time of admission.

15. For labor patients presenting for vaginal delivery, the patient's prenatal record may be used for an admission H&P but the physician must write an interval note.

Department of Pediatrics

1. Consultation by a pediatrician and/or an appropriate specialist is required for pediatric patients in the following situations: An obscure diagnosis, a critical illness, when there is a question about the appropriateness of therapy, and in all cases of severe or unusual hemorrhage, whatever the cause.

2. A physical examination by a physician with pediatric privileges is required for all elective surgical patients of less than two years of age.

3. The obstetrician must designate a staff physician with pediatric privileges as attending physician to supervise the care of each newborn.

4. Consultation and/or supervision by a physician with newborn intensive care privileges is required for newborns in the following situations: for a hypoglycemic infant (less than 30 mg %), for infants of low birth weight (5 pounds or less), or of less than 37 or greater than 41 weeks gestation, for an infant with significant jaundice (serum bilirubin 10 mg % during the first 24 hours, 12 mg % during the second 24 hours, 15 mg % during the third 24 hours), and for any infant who is "not doing well."

5. The attending physician who is caring for an infant who becomes icteric in the first 24 hours of life must evaluate the patient within six hours of being notified of the infant's jaundice.

Department of Surgery

Composition

1. The Department of Surgery shall be composed of the following specialties:

    a. Acupuncture
    b. Anesthesiology
    c. Colon and Rectal Surgery
    d. Complex General Surgical Oncology
    e. Congenital Cardiac Surgery
    f. Dentistry (including Orthodontics)
    g. Neurointerventional Radiology
    h. Neurological Surgery
    i. Neurological Spine Surgery
    j. Neurotology
    k. Nuclear Medicine
    l. Ophthalmology
    m. Oral and Maxillofacial Surgery
    n. Orthopaedic Surgery
    o. Orthopaedic Spine Surgery
    p. Orthopaedic Sports Medicine
    q. Otolaryngology
    r. Pain Medicine
    s. Pathology
    t. Plastic Surgery
    u. Podiatry
    v. Radiation Oncology

w. Radiology
x. Surgery
y. Surgery of the Hand
z. Thoracic and Cardiac Surgery
aa. Urology
ab. Vascular Surgery

Sections

1. The Department of Surgery shall be organized into the following sections:

a. Anesthesiology
b. General Surgery
c. Neurological Surgery
d. Ophthalmology
e. Oral and Maxillofacial Surgery
f. Orthopaedic and Spine Surgery
g. Otolaryngology
h. Pathology
i. Plastic Surgery
j. Podiatry
k. Radiation Oncology
l. Radiology (including Neurointerventional Radiology)
m. Robotic Surgery
n. Spine Surgery
o. Thoracic and Cardiac Surgery
p. Urology
q. Vascular Surgery

1. Outpatient Surgery

a. Physicians who admit patients for approved surgery under general, regional, or spinal / epidural anesthesia, or for surgery which is associated with significant risks (Category I) shall complete all medical records prior to performance of the procedure which are ordinarily required for inpatient surgery.

b. The physician who admits a patient for approved minor surgery under local anesthesia (Category II) shall complete a brief report to the performance of the procedure, of the pertinent and important medical history and physical findings, and also record the diagnosis, orders, and a description of the operative procedure.

c. The attending physician shall be responsible for completing informed consents for surgery for all patients prior to outpatient surgery, as required for inpatient surgery.

d. Any consultation required for an inpatient shall be required for a Category I surgery outpatient (pediatric consultation, etc.).

e. An anesthesiologist shall perform and record pre- and post-operative evaluations for each outpatient who has a general, regional, or spinal / epidural anesthetic (Category I) and, when indicated, for those who have minor procedures under local anesthetics (Category II).

2. Anesthesiology Section

a. Prior to commencing surgery, the anesthesiologist, or the surgeon if an anesthesiologist is not in attendance, shall verify the patient's identity, the site and side of the body to be operated on, and ascertain that a record of the following appears in the patient's medical record:

1. An interval medical history and physical examination performed and recorded within the previous 24 hours.

2. Appropriate screening tests, based on the needs of the patient, accomplished and recorded within 72 hours prior to surgery.

3. An informed consent, in writing, for contemplated surgical procedure.

b. In all cases, except emergency cases in which this is not possible, prior to the induction of anesthesia, the anesthesiologist shall valuate the patient, explain the anesthetic choices to the patient, and establish and discuss the anesthesia plan with the patient; then, document this information on the patient's medical record prior to the induction of anesthesia.

c. During the conduct of surgery and anesthesia, the patient's anesthesiologist is responsible for the safe and proper administration of anesthetic agents, the maintenance of airway and respiration, the monitoring of vital functions, and the administration of blood products and parenteral fluids.

d. The anesthesiologist shall record, in the medical record, all significant events taking place during the induction of, maintenance of, and emergence from anesthesia, including the vital signs and amount and duration of all anesthetic agents, intravenous fluids, and blood or blood products.

e. An anesthesiologist within 48 hours after anesthesia end time shall document in the medical record their findings and the presence or absence of anesthesia-related complications.

f. The Medical Director of Anesthesiology Services, or a member of the Anesthesiology Section designated by the Medical Director, assigns anesthesiologists to surgical cases and to the obstetrical service, considering the special qualifications of the anesthesiologists and the most efficient and effective use of personnel and facilities.

g. A limited supply of narcotics and dangerous drugs for emergency use may be issued to an anesthesiologist. The anesthesiologist must account for the use of all such drugs, and they are responsible for their security; they must be under their immediate surveillance or in an appropriate locked container. Narcotics and dangerous drugs shall not be left unattended on an anesthetic cart or tray or in unlocked drawers or containers.

h. The anesthesiologist shall maintain anesthesia equipment so that it is clean and safe, and they shall check the readiness, availability and cleanliness of all anesthetic equipment and supplies prior to the administration of anesthetic agents.

i. Anesthesiologists shall have their anesthesia machines inspected by a competent serviceman at least annually, and on each occasion shall submit a written report of inspection and correction of any deficiencies to the supervisor of Surgery.

j. No items, except those required for safe and effective patient care, shall be kept in or on an anesthesia machine or introduced into an operating room by an anesthesiologist.

k. The anesthesiologist monitors each patient who is receiving general anesthesia with a pulse oximeter.

4. Pediatric Surgery

a. Surgical procedures for infants (those under the age of three years), may be performed in the surgical suites if the following conditions are met:

1. When the patient is younger than one month of age, a neonatologist must be present in the operating suite;

2. The surgical procedure must not require postoperative intensive care services beyond those available in the Neonatal Intensive Care Unit (NICU).

5. Call Panel

a. All practitioners are obligated to participate in their Section's general call panel.

b. Surgeons may be excused if they can document that they have solely subspecialized their practice during the past five years, or for other reasons that the Department of Surgery deems acceptable. Examples would include orthopaedic surgeons who have restricted their practice to spine surgery, or general surgeons who have limited their practice to breast or other general surgery subspecialties.

c. Plastic Surgery Call Panel

i. Plastic Surgeons who are Board Certified in *Surgery of the Hand* by the American Board of Plastic Surgery will automatically qualify for hand surgery privileges and are required to participate in the Hand Call Panel for 10 years after board certification.

ii. Surgery of the Hand – certified Plastic Surgeons who were board certified greater than 10 years ago are not obligated to participate in the Hand Call Panel.

iii. Proctoring

1. Plastic and/or Hand Surgeons may participate on the Call Panel prior to completion of proctoring, for consultation and evaluation purposes only. Concurrent proctoring is required for surgical care.