Children's Hospital & Research Center Oakland

Medical Staff Bylaws

October 16, 2025

Contents

P R E A M B L E

WHEREAS, Children's Hospital & Research Center at Oakland dba UCSF Benioff Children's Hospital Oakland is a nonprofit public benefit corporation organized in accordance with the laws of the State of California; and

WHEREAS, its purpose is to serve as a children's medical center providing patient care, community service, education and research; and

WHEREAS, it is recognized that one of the aims and goals of the Staff is to attain and maintain quality patient care in the Hospital and that in this regard the cooperative efforts of the Medical Staff, Management and the Governing Body are necessary to fulfill this goal; and

WHEREAS, it is recognized that these Bylaws are a necessary framework to govern the conduct of Medical Staff functions, supportive of these purposes and goals;

THEREFORE, the physicians, dentists, podiatrists and clinical psychologists practicing in this Hospital hereby organize themselves into a Medical Staff for the purpose of self-governance in conformity with these Bylaws.

ARTICLE 1

NAME

The name of this organization shall be the Medical Staff of Children's Hospital & Research Center Oakland. Alternatively, the organization can be referred to as the Medical Staff of UCSF Benioff Children's Hospital Oakland.

ARTICLE 2

PURPOSES AND RESPONSIBILITIES

2.1 Purposes

The purposes of this organization shall be:

2.1-1 To strive toward quality patient care for all patients admitted to or treated in any of the facilities, departments or services of the Hospital;

2.1-2 To preserve quality medical care through the monitoring of the professional performance of all Practitioners authorized to practice in the Hospital through the appropriate delineation of Clinical Privileges, and through a periodic review and evaluation of their performance;

2.1-3 To participate in the organizational performance improvement activities in accordance with the Hospital and Medical Staff's Performance Improvement Plan;

2.1-4 To provide an educational setting that will assist in maintaining patient care standards and that will lead to continuous advancement in professional knowledge and skill;

2.1-5 To provide a research setting that will assist in maintaining patient care standards that will lead to continuous advancement in professional knowledge and skill;

2.1-6 To support the provision of medical education programs, including programs in undergraduate and postgraduate medical education at the Hospital;

2.1-7 To foster a harmonious relationship between community and hospital-based Practitioners;

2.1-8 To initiate and maintain rules and regulations for self-governance of the Staff; and

2.1-9 To provide a means whereby issues concerning the Staff and Hospital may be discussed by the Staff with the Governing Body and the Chief Executive Officer.

2.2 Responsibilities

The responsibilities of the Medical Staff shall be:

2.2-1 To participate in activities to measure, assess and improve organizational performance in accordance with the provisions set forth in the Hospital and Medical Staff's Performance Improvement Plan and recommend to the Governing Body programs for the establishment, maintenance, continuing improvement and enforcement of professional standards in the delivery of health care within the Hospital;

2.2-2 To maintain a credentials program, including mechanisms for appointment and reappointment and the ongoing matching of Clinical Privileges to be exercised with the verified credentials and current demonstrated performance of the applicant and Staff member;

The Medical Staff may enter into arrangements with the Medical Staffs of affiliated Hospitals to coordinate and/or assist in credentialing activities. This may include, but is not limited to, utilizing a shared application, relaying on an affiliated Hospital's medical Staff resources to process or assist in processing applications for appointment or reappointment, or otherwise coordinating functions with the affiliated Hospital's medical Staff to review and evaluate applications for appointment and reappointment.

2.2-3 To assure that all patients admitted or treated within any of the hospital's service receive a uniform standard of quality patient care, consistent with generally accepted standards attainable in the hospital's means and circumstances;

2.2-4 To support programs at the Hospital involved in medical research;

2.2-5 To support the Hospital's medical education programs, including undergraduate and postgraduate education programs;

2.2-6 To maintain a continuing education program fashioned, at least in part, on the needs demonstrated through the Performance Improvement Plan;

2.2-7 To recommend to the Governing Body action with respect to appointments, reappointments, Staff category and department assignments, Clinical Privileges and corrective action;

2.2-8 To develop, administer and recommend amendments to and compliance with these Bylaws, the Rules and Regulations and policies of the Staff and Hospital;

2.2-9 To assist in identifying community health needs and in setting appropriate instructional goals and in implementing programs to meet those needs; and

2.2-10 To exercise the authority granted by these Bylaws as necessary to fulfill the foregoing responsibilities.

2.3 Distributions and Dissolution

2.3-1 This organization is organized and shall be operated exclusively to receive, administer, and expend funds to promote and represent the common interests of the organization's members, consistent with the purposes set forth in Article 2 Sections 1 and 2 above, and consistent with the meaning of §501(c)(6) of the Internal Revenue Code of 1986, as amended, or corresponding provisions of any subsequent tax laws.

Notwithstanding any other provision of these Bylaws, the organization shall not conduct or carry on any activities not permitted to be conducted or carried on by an organization exempt under §501(c)(6) of the Internal Revenue Code of 1986, as amended, or corresponding provisions of any subsequent federal tax laws. The organization is authorized and empowered to make distributions to organizations that qualify as exempt organizations described under Section 501(c)(3) or 501(c)(6) of the Internal Revenue Code, or corresponding section of any future federal tax code, so long as those distributions are consistent with the expressed purposes of the organization as set forth in Article 2 Sections 1 and 2 above.

No part of the net income of the organization shall inure to the benefit of or be distributable to its directors, officers, or other private persons, except that the organization shall be authorized and empowered to pay reasonable compensation for services actually rendered and to make payments and distributions in furtherance of the purposes and objects set forth in Article 2 Sections 1 and 2.

2.3-2 Upon the dissolution of this organization or the winding up of its affairs, all assets shall be distributed exclusively for the common interests of its members or to organizations which are exempt from Federal income tax under §501(c)(6) of the Internal Revenue Code of 1986, as amended, or corresponding provisions of any subsequent federal tax laws, or shall be donated to Children's Hospital & Research Center Foundation (dba UCSF Benioff Children's Hospitals Foundation) (the surviving corporation into which Children's Hospital Oakland Research Institute (CHORI) was merged), a tax exempt organization within the meaning of Section 501(c)(3) of the Internal Revenue Code, and designated to Children's Hospital and Research Center Foundation as an educational fund for junior physicians, students and residents participating in research so that they may travel and attend meetings and/or participate in worthwhile health initiatives. Any such assets not disposed of shall be disposed of by a court of competent jurisdiction in the county in which the principal office of the organization is then located, exclusively for such purposes or to such organization or organizations, as the Court shall determine, and which are organized and operated exclusively for such purposes.

2.4 Affiliation

The Hospital is affiliated with UCSF, which is the sole corporate member of the Hospital. To maintain high professional standards and provide efficient patient care and support services, the Hospital and Medical Staff are authorized to work cooperatively with the Medical Staff of Medical Staff of UCSF Medical Center to develop processes, policies, or agreements for cooperation in fulfilling the Medical Staff's responsibilities to Children's Hospital & Research Center Oakland, including those involving committees, credentialing, quality and patient safety, and peer review. In developing these processes, policies, or agreements, the Hospital and Medical Staff shall ensure that cooperation does not infringe on the Medical Staff's right to self-governance or in any way limit the Medical Staff's ability to meet its own legal and accreditation requirements.

2.5 Joint Peer Review Initiatives

To maintain high professional standards and provide efficient patient care and support services, the Medical Staff may work with the Medical Staffs of affiliated hospitals to develop cooperative processes, policies, or agreements to fulfill the Medical Staff's responsibilities for carrying out credentialing, quality and patient safety, and/or peer review functions. This may include participation in combined or joint medical Staff

committee meetings with Staff members from affiliated hospitals if an agreement has been executed with the affiliated hospital's medical Staff to allow for the sharing of peer review information and appropriate protocols are developed to ensure the following: that Medical Staff members have consented to the sharing of peer review information with other peer review bodies (whether by operation of the Medical Staff's Governing Documents or by a separate agreement); that confidential Medical Staff information and patient information is not inappropriately disclosed; that such cooperative efforts do not infringe on the Medical Staff's right to self-governance and that this Medical Staff (BCHO) retains appropriate decision-making authority regarding its Medical Staff members; that the Medical Staff's ability to meet its own legal obligations or accreditation requirements are not limited by these combined or joint efforts; and that this Medical Staff (through its authorized representative(s)) maintains access to, and approval authority of, all minutes prepared at such meetings.

ARTICLE 3

MEDICAL STAFF MEMBERSHIP

3.1 Nature of Membership

Membership on the Medical Staff or the exercise of temporary privileges shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Medical Staff membership shall confer the prerogatives as have been granted under these Bylaws. Only Practitioners who are appointed to the Medical Staff may exercise Medical Staff membership rights and responsibilities, and only to the extent and in the manner described in these Bylaws for the staff status the Practitioner holds. Only Practitioners who are granted privileges to do so under the processes detailed in these Bylaws may admit or provide services in this Hospital.

No applicant shall be denied Membership or clinical privileges on the basis of any protected class as defined by federal, state, or municipal law, including but not limited to race, color, ethnicity, national origin, citizenship, sex, age, disability, religion, creed, military or veteran status, marital status, sexual orientation, gender identity, or gender expression, or other criterion unrelated to the delivery of quality and safe patient care or to professional competence or conduct. Medical Staff membership or privileges shall not be denied on the basis of any physical or mental disability if the applicant meets the standards set forth in the Governing Documents with or without reasonable accommodation.

Members must maintain adequate professional liability insurance, the amount of which will be fixed from time to time by the Medical Executive Committee (referred to herein as "MEC"). Further specifics of the requirement may be contained in the Rules and Regulations.

3.2 Basic Qualifications for Membership

3.2-1 Except where otherwise indicated in the Governing Documents, a Practitioner must demonstrate continuous compliance with each of the following Basic Qualifications set forth in this Section to have an application for Medical Staff Membership and/or Clinical Privileges accepted for review, and to maintain Medical Staff Membership and/or Clinical Privileges:

a. Hold a current unrestricted license to practice medicine, dentistry, podiatry or clinical psychology in the State of California;

b. Possess a current Federal Drug Enforcement Agency (DEA) certificate, if practicing medicine, dentistry, or podiatry and the requested clinical privileges contemplate prescribing controlled substances. Members of the Medical Staff who are never responsible for ordering controlled substances may have the requirement for DEA registration waived at the discretion of the Credentials Committee;

c. Demonstrate proof of graduation from an appropriately accredited professional school and completion of an Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), American Dental Association (ADA), or American Podiatric Medical Association (APMA) approved residency program, or other training or educational program acceptable to the Medical Executive Committee and the Governing Body;

d. Have and continuously maintain professional liability insurance coverage that meets the criteria set forth in Medical Staff Rules and Regulations;

e. Not have been convicted of, or entered a plea of guilty or no contest to any misdemeanor or felony involving (a) insurance or health care fraud or abuse, (b) violence, physical abuse or exploitation directed at a person; or (c) violation of law pertaining to controlled substances;

f. Be eligible to participation in Medicare and Medi-Cal programs;

g. Participate in any vaccination, screening, or personal protective equipment requirements in accordance with Hospital licensure requirements, CMS requirements, accreditation standards, and Hospital policy based on the above requirements or standards approved by the Governing Body. Practitioners who limit their practice to telemedicine and do not provide services on-site at the Hospital may request an exemption from this requirement;

h. Meet any clinical activity requirements specified by the Department as necessary to demonstrate current competence for the privileges requested;

i. If requesting privileges in departments operated under an exclusive contract, be a member, employee, or subcontractor of the group or person that holds the contract;

j. To the extent required by law or accreditation of the Hospital, provide evidence of compliance with any continuing education and cardiopulmonary resuscitation requirements;

k. Agree in writing to abide by all Governing Documents;

l. Provide and maintain a valid physical address, email address, and cell phone number that will be used as a primary method of communication; and

m. For membership in a category with clinical privileges, meet one of the board certification criteria described in Section 3.2-2(a)(b) or have been granted an exception pursuant to Section 3.2-2(c).

3.2-2 Membership in Staff categories with Clinical Privileges shall be limited to Practitioners who meet the criteria described in sub-section (a) or (b) or have been granted an exception as described in sub-section (c). Practitioners applying for privileges must also meet any additional, specific specialty board requirements indicated in the privilege request form that have been developed by their department or division, and approved by the MEC and Governing Body. Deeming an applicant ineligible to apply for Membership and/or Clinical Privileges, or the non-renewal of a Practitioner's Privileges and Membership because of a failure to continuously meet the criteria, shall not entitle the Practitioner to the procedural hearing and appellate review rights provided for in the Article 8.

a. Current Board certification, by a Specialty Board (as defined in the Definitions Section of these Bylaws). If the applicant has attained initial certification, the applicant must be deemed, by the Specialty Board or Sub- Board for that specialty or subspecialty, to be meeting its requirements for Maintenance of Certification (MOC), as described below.

1. Practitioners who request privileges in multiple clinical services must hold and maintain certification in all areas in which they are requesting privileges. (For example, a pediatric cardiologist who also has a general pediatric clinic must maintain certification by a Specialty Board in both Cardiology and General Pediatrics.)

2. Practitioners who hold initial Specialty Board certification in multiple specialties are only required to meet requirements for MOC for specialties in which they hold privileges. (For example, a physician who is Board certified in pulmonology, cardiology, and critical care but has privileges in only the Pulmonology Service, is only required to maintain certification in that subspecialty.)

3. Subspecialists who hold privileges only in their subspecialty need not maintain privileges nor participate in MOC in their primary specialty.

4. Practitioners who hold permanent (Lifetime) certificates are encouraged but not required to fulfill requirements for MOC in their specialty or subspecialty.

b. Currently Board Eligible with a Specialty Board and actively pursuing Board Certification. Practitioners who meet this criteria must achieve Board certification within the timeframes imposed by their Specialty Board. Thereafter, they must meet the Specialty Board Certification and meet the MOC requirements specified in sub-section (a). Practitioners who fail to achieve initial Board certification within the time limit following completion of training imposed by their Specialty Board (i.e., are no longer Board Eligible), will not be granted initial or renewed privileges or Membership, unless the provider meets one of the exceptions in sub-section c.

c. Exceptions

1. Practitioners who are current members and have privileges as of the adoption of this amendment, who have completed their training before 2010, and were never Board certified, will not be required to become Board certified or to meet the requirements of MOC to maintain their current privileges, as long as they continue to meet the other specific competency criteria for the privileges they are requesting, and all other Medical Staff Membership criteria.

2. An equivalent foreign certification deemed acceptable by the Credentials Committee, Medical Executive Committee, and Governing Body may be accepted in lieu of the requirement for initial Board certification and MOC.

3. Dentists and Psychologists are currently exempted from the Board certification and Board eligibility requirements because of the absence of widely accepted Specialty Boards in these professions.

4. Applicants with time-limited certification who have obtained initial board certification, but who are not currently meeting requirements for MOC, as

defined by the relevant Specialty Board, may appeal to the Credentials Committee for an extension of privileges for a limited period while remedying this deficiency. The time limit will generally be less than 1 year but will be reviewed on a case-by-case basis with full consideration of the timing and logistics of the actions necessary to remedy the deficiency and fulfill the requirements mandated by the relevant Specialty Board or Sub-Board.

5. Persons not fulfilling the Board certification, board eligibility, or MOC requirements, may request special consideration and a waiver of the requirement via the process described in Bylaws Section 3.4, and must demonstrate that their education, training, experience, demonstrated ability, judgment, and medical skills are equivalent to or greater than the level of proficiency evidenced by the eligibility criteria listed above.

3.2-3 The Practitioner shall have the burden of producing adequate information for a proper evaluation of the Practitioner's qualifications as set forth in Section 3.2-1 above and for resolving any reasonable doubts about any of these qualifications and any additional qualifications required with respect to specific Clinical Privileges and Staff category requested, and of satisfying any reasonable requests for information or clarification made by appropriate authorities on the Staff or Governing Body.

3.2-4 Membership on the Medical Staff requires documentation of a current and valid California license to practice, a current and valid DEA registration when applicable, compliance with the professional liability insurance requirements set forth in Medical Staff Rules and Regulations and, to the extent required by law or accreditation of the Hospital, evidence of compliance with any continuing education and cardiopulmonary resuscitation requirements. Members of the Medical Staff who are never responsible for ordering controlled substances may have the requirement for DEA registration waived at the discretion of the Credentials Committee.

3.3 Qualifications for Membership

3.3-1 In addition to the Basic Qualifications for Membership under Section 3.2, the Practitioner must:

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

b. Be determined (i) to adhere to the lawful ethics of the Practitioner's profession; (ii) to be capable of consistently working in a professional and cooperative manner with others in a hospital setting and refraining from harassment of others so as not to adversely affect patient care or Hospital operations; and (iii) to be willing to participate in and properly discharge Medical Staff responsibilities.

3.4 Standards of Professional Conduct

Members shall abide by the Medical Staff Standards of Professional Conduct as set forth in the Medical Staff Rules and Regulations.

3.5 Waiver of Qualification

3.5-1 Insofar as is consistent with applicable laws and accreditation standards, the Governing Body has the discretion to deem a Practitioner to have satisfied a qualification, upon recommendation of the Medical Executive Committee, if it determines that the Practitioner has demonstrated he or she has substantially comparable qualifications and that this waiver is necessary to serve the best interests of the patients and of the Hospital. There is no obligation to grant any such waiver, and Practitioners have no right to have a waiver considered and/or granted. A Practitioner who is denied a waiver or consideration of a waiver shall not be entitled to any procedural hearing and appellate review rights provided for in Article 8.

3.6 Responsibilities of Medical Staff Membership

Each Medical Staff Member shall continuously meet the following responsibilities:

3.6-1 Abide by the Governing Documents of the Medical Staff;

3.6-2 Abide by all applicable laws and regulations of governmental agencies and comply with applicable standards of The Joint Commission and other accreditation entities;

3.6-3 Abide by the ethical principles of the member's profession;

3.6-4 Refrain from fee splitting or unlawful inducements relating to patient referrals;

3.6-5 Have knowledge of and comply with the Hospital's Corporate Compliance Plan as it is appropriately applied to members of the Medical Staff;

3.6-6 Discharge such Medical Staff, Department, Division, Committee and other Medical Staff functions for which the member is responsible by appointment, election or otherwise;

3.6-7 Exercise only such Clinical Privileges as have been granted by the Medical Staff and Governing Body in accordance with these Bylaws;

3.6-8 Prepare and complete in a timely manner the medical and other required records for all patients to whom the member provides services at the Hospital;

3.6-9 Seek consultation whenever warranted by the patient's condition or when required by the Governing Documents, and furnish specialty consultations within the Practitioner's specialty when reasonably requested;

3.6-10 Participate in Call Panels as allowed and as required under the Governing Documents, the Hospital EMTALA Policy, and applicable laws, regulations and policies;

3.6-11 Cooperate in peer review processes and refrain from retaliation against any person who is a witness or otherwise participates in these processes;

3.6-12 Retain responsibility within the member's area of professional competence for the continuing care and supervision of each patient in the Hospital for whom the member has assumed professional responsibility or arrange for a suitable alternate for such care and supervision;

3.6-13 Pay dues, assessments and an application processing fee in the amounts set annually by the MEC in accordance with Section 4.7;

3.6-14 Provide patients with the quality of care which meets the professional standards of the Medical Staff.

3.6-15 Report to the Medical Staff Office within five (5) business days any and all information that would otherwise correct, change, modify or add any information already provided by the member on the most recent application for initial or renewed Membership, or otherwise change the answer to any question on the most recent application for initial or renewed Membership , when such correction, change, modification or addition has the possibility to affect or reflect adversely on current qualifications for Membership or privileges.

This reporting obligation includes, but shall not be limited to:

a. any formal investigation or filing for possible criminal charges or discipline by a state licensing board, California Department of Justice, federal Drug Enforcement Agency, Office of Inspector General, or any other state or federal agency;

b. any arrest, conviction or plea bargain of any kind, whether involving a federal or state agency, or a felony or misdemeanor;

c. any formal investigation, formal charges, disciplinary action, or proceeding (hearing or appeal) initiated by any hospital medical staff or other peer review body where the member has privileges or Membership,

d. Any report made about the member to the state licensing board (i.e., an 805, 805.01 or 805.08 Report) or the National Practitioner Data Bank;

e. any loss or lapse of board certification for any reason, or expiration of board admissibility without obtaining board certification, unless excepted in accordance with Section 3.2-2(c);

f. any claim for professional liability made against the member, and any settlement, payment or other remuneration paid by the member or the member's professional liability carrier resulting from an allegation of professional malpractice or unprofessional conduct; and

g. Any change to the Member's contact information that will be used as the primary methods of communication.

3.7 Effect of Other Affiliations

No Practitioner shall be entitled to Membership on the Medical Staff merely because that Practitioner holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, Staff Membership or privileges at another health care facility. Medical Staff Membership or Clinical Privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, IPA, PPO, HMO, PHO, hospital-sponsored foundation or other organization or in contracts with a third party which contracts with this hospital. Lawful affiliation with or other pursuit of business interests by members cannot adversely affect Medical Staff Membership or granting or exercise of any Clinical Privileges. Affiliation with the hospital by contract or otherwise does not exempt the member from the application of the disciplinary or any other provisions of the Medical Staff Bylaws, Rules and Regulations, and policies.

3.8 Membership Term

3.8-1 The final decision on Medical Staff Membership shall be made by the Governing Body. Except as otherwise provided by California Business and Professions Code section 809.05, the Governing Body shall act on Membership actions only after there has been a recommendation from the Medical Staff as provided in these Bylaws.

3.8-2 Medical Staff Membership shall be for a period of not more than 2 years.

3.9 Period of Observation for New Members

3.9-1 Assignment to Provisional Staff Category

a. New Medical Staff members who have applied for either Active Staff or Courtesy Staff will be assigned to the Provisional category. Provisional members will be subject to a period of observation (referred to by the Joint Commission as a Focused Professional Practice Evaluation) by the relevant Department Chair/Division Chief(s) or the member's appointed proctor(s) to determine the member's eligibility for continued Staff Membership and for exercising those Clinical Privileges granted without supervision.

b. A Provisional member must complete the period of observation before being authorized to exercise privileges without supervision, except as otherwise specified herein. The observation shall include review of data customarily obtained through a focused professional practice evaluation of a Practitioner's performance, including but not limited to:

1. Concurrent and/or retrospective chart review;

2. Proctoring of cases, i.e. real-time and in-person visual observation of procedures or patient encounters as appropriate;

3. Other patient care activities as specified by the departments

4. Adherence to the Medical Staff Bylaws, Rules & Regulations, and other policies of the Medical Staff;

5. The quality of care and outcomes delivered by the member as determined by Medical Staff peer review processes; and

6. Any other relevant information and data.

c. The departments and divisions shall develop privilege request forms regarding observation of new members which must be reviewed and approved by the MEC and the Governing Body. The privilege request forms will include specific observation and proctoring requirements for the department and for divisions within that department.

d. It is required that:

1. Proctors prepare a detailed written critique of each case proctored on a form approved by the MEC;

2. The member shall not practice any Clinical Privileges unsupervised in the hospital until all proctoring is completed according to the proctoring requirements and is submitted on the approved proctor forms, reviewed and approved by the division chief and department chair; and

3. That the Department Chair approve a final report for the Credentials Committee at the completion of the proctoring process summarizing the member's level of skill and competence in the matters observed and proctored.

e. If the Practitioner's low rate of hospital use makes it impractical to observe the Practitioner's hospital practice at this Hospital, the relevant division/department chief(s) may rely upon satisfactory evidence of current competence in the privileges and procedures sought which is obtained from another accredited hospital, in lieu of having some of the Practitioner's practice observed and/or proctored at this Hospital. Any Practitioner falling under this provision shall not practice Clinical Privileges unsupervised in the hospital without:

1. The first procedure and/or patient encounter, as appropriate, must be proctored in the Hospital

2. Review by the department chair of the evidence of current competence obtained from the other hospital, and the chair's approval for the member to practice unsupervised in the hospital for the relevant privilege(s) requested; and

3. A detailed written analysis by the department chair of the reasons why the evidence from the other hospital, along with all other data available, justifies the chairs decision to approve the member's right to practice the privilege(s) without supervision.

f. In the event the new member is appointed to head a division, the appropriate department chairperson shall be responsible for appointment of the proctor(s).

g. In the event the new member is appointed to head a department, the President of the Medical Staff shall be responsible for appointment of the proctor(s).

3.9-2 Completion of Observation and Credentials Committee Recommendations.

a. Except as specified elsewhere in these Bylaws, Provisional members are subject to a period of observation, including proctoring, not to exceed twenty-four (24) months. The MEC shall not extend this period of observation without good cause.

b. For those who become members of the Provisional Staff after adoption of this subsection (b.)*

1. The member shall be subject to a period of observation not to exceed twenty-four (24) months, and proctoring not to exceed three(3) months after the members appointment. Either period may be extended by the MEC for good cause and for a specified amount of time; and

2. The member may seek advancement to Active Staff any time after twelve months of observation if the department chair determines the member has satisfactorily completed all proctoring requirements and the member otherwise qualifies for Active Staff Status.

c. As soon as feasible after the new member completes, or seeks to advance out of, the period of observation, the division/department chief/chairperson or designee shall report to the Credentials Committee in writing whether the Practitioner has satisfactorily demonstrated ability to exercise without supervision the Clinical

Privileges initially granted, and has otherwise met all qualifications and responsibilities of the Staff category for which the member has applied.

* This subsection became effective on March 7, 2018

d. The Credentials Committee shall make one of the following recommendations to the MEC:

1. Removal of observation for all Clinical Privileges and advancement to Active or Courtesy Staff, as applied for or

2. Removal of observation for certain specified privileges but continuation of observation for certain other privileges for a specified period of time; or

3. Termination of one or more privileges or termination of Membership, Or

4. In the case of members' requesting additional privileges, denial of any or all of the requested privileges.

3.9-3 MEC Action:

a. The MEC shall consider the Credentials Committee's recommendation, and shall thereafter recommend to the Governing Body what action it finds appropriate, within the options listed in Section 3.8-2.d, or as otherwise appropriate. If the MEC recommends that the Board take action of a type described in Section 3.8-2(d)(3) above, due to medical disciplinary cause or reason, the Practitioner shall be notified of such recommendation by SPECIAL NOTICE and shall be afforded the procedural rights set forth in Article 8.

b. In the event the MEC Determines that observation should be continued as to certain specified privileges (see Section 3.8-2(d)(2), the division/department chief/chairperson shall review the matter at least monthly, and shall thereupon recommend to the Credentials Committee whether to

1. Lift all or some of the remaining observation procedures;

2. Deny all or some or all of the privileges for which observation procedures are not recommended to be lifted.

3. Continue observation for some or all of the remaining procedures subject to observation. A recommendation to the MEC from the Credentials Committee for continued observation shall only be appropriate if the MEC finds good cause, e.g., that there is insufficient information about the Practitioner's competency to either grant or deny the privileges without continued observation.

c. In the event the recommendation is to deny one or more requested privileges due to disciplinary cause or reason, the Practitioner shall be afforded the procedural rights set forth in Article 8. The Practitioner shall be notified of any recommendation to deny such privileges by SPECIAL NOTICE.

d. If the member fails to complete, without good cause, the required number of patient consultations and/or cases to be proctored in the time specified herein, or in the time period as otherwise extended by the MEC as applicable, the member's

Membership and privileges shall automatically terminate. Under this circumstance, the member shall not be entitled to the rights set forth under Article 8.

3.10 Monitor or Proctor: Agent of the Medical Staff Committee

Any Practitioner acting as a monitor or proctor is serving as an agent of the MEC. For this reason, any forms, reports, or communications to the appropriate committee concerning the matters observed shall be subject to the fullest protections provided by law. In addition, such monitor or proctor shall enjoy the fullest immunities provided by law for any actions undertaken or communications made during the course of performing duties as a proctor or monitor.

3.11 Leave of Absence

3.11-1 A member of the Medical Staff who intends to be absent from practice at the Hospital for a period of six (6) months but no longer than twenty-four (24) months shall make a request in writing to the MEC for a leave of absence. The MEC may place reasonable conditions on the granting of such leaves of absence.

3.11-2

a. Upon return from the leave of absence and no later than the period of the leave of absence granted, the Medical Staff member shall request, in writing, reinstatement to the Staff category the member held prior to the leave of absence. Such Medical Staff member requesting reinstatement shall meet the criteria required of a Practitioner requesting reappointment as specified in Section 6.4 and Section 6.5.

b. This request shall be reviewed by the appropriate division(s)/department(s) (of which said Staff member is requesting privileges and said division(s)/department(s) shall make recommendations to the Credentials Committee. After considering the request, the Credentials Committee shall make a recommendation to the MEC.

c. Such privileges shall be in effect upon approval of the Governing Body after recommendation by the MEC. A negative recommendation by the MEC or Governing Body shall entitle the Staff member to a hearing pursuant to Article 8 of these Bylaws.

3.11-3 Failure to request reinstatement as provided in Section 3.10s-2 shall be deemed a resignation from the Medical Staff.

3.11-4 Medical Staff members on leave of absence shall be excused from dues and Medical Staff duties and meeting requirements for the duration of the leave.

3.12 Conflicts of Interest

3.12-1 Generally, a conflict of interest arises when there is a divergence between an individual's private interests and his/her/their professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by those private interests. A conflict of interest depends on the situation and not on the character of the individual.

3.12-2 Officers, department chairs, division chiefs, medical Staff representatives, and those medical Staff members selected for committees represent the interests of the medical Staff in improving patient care. To meet this obligation to the medical Staff and to enable discerning decision-making, every medical Staff leader and candidate, and all medical Staff members appointed to committees disclose potential conflicts of interest as relevant to the

position held and the circumstances. Membership and privileges shall not be affected by any conflict of interest or the declaration of any potential conflict of interest.

3.12-3 The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness.

3.12-4 The processes, circumstances and requirements to make disclosures, declare potential conflicts of interest, evaluate and take action on such conflicts shall be set forth in the Rules & Regulations.

3.12-5 The disclosed information is shared only with those who need the information to make an informed decision. Consequently, those with a vote in an election obtain disclosure from candidates; peer review committee members obtain information from other committee members and reviewers; leaders obtain information from those who may be appointed to serve in a peer review or other decision-making capacity. Failure to disclose upon reasonable request disqualifies the member from the position at issue; repeated refusal to disclose may be considered at Membership renewal.

3.12-6 The Rules & Regulations shall prescribe other requirements and procedures pertaining to Conflicts of Interest which shall not be inconsistent with these Bylaws.

ARTICLE 4

CATEGORIES OF THE MEDICAL STAFF

4.1 Categories

The Medical Staff shall consist of the following categories: Active, Courtesy, Provisional, Corresponding, Emeritus, and Telemedicine. Except for those appointed to the Corresponding, Emeritus, or Telemedicine Staff, each applicant granted membership will first be assigned to the Provisional Staff category.

4.2 Active Staff

4.2-1 Qualifications

The Active Staff shall consist of Practitioners, each of whom:

a. Meets the requirements for Medical Staff Membership contained in these Bylaws;

b. Has completed the initial FPPE requirements for initial privileges set forth in the governing documents; and

c. Is regularly involved in caring for patients, is substantially involved in medical staff activities, and shows a genuine concern and interest in the Hospital, as demonstrated by:

1. Admitting or consulting on at least 20 inpatients or outpatients within each two year reappointment; and

2. Attending at least 40% of the Member’s Department meetings.

4.2-2 Prerogatives

The prerogatives of an Active Staff member shall be to:

a. provide care to patients within the scope of the Clinical Privileges granted;

b. hold Staff, division or department office to which the member may be elected or appointed;

c. attend Medical Staff and Hospital educational programs;

d. attend and vote at general and special meetings of the Medical Staff;

e. attend and vote at meetings of the member's division and department;

f. serve as a voting member on any Medical Staff committee to which the member has been appointed; and

g. exercise such other rights as may be granted in the Governing Documents,

4.2-3 Responsibilities

Each member of the Active Staff shall:

a. abide by the Governing Documents;

b. serve as an evaluator for FPPE when requested by the division and department;

c. pay dues and assessments in a timely manner; and

d. discharge such other functions as established in Governing Documents of the Medical Staff as may be required.

4.2-4 Transfer of Active Staff Member

If a member fails to satisfy the requirements for Active Staff Membership, the member may be transferred to the Courtesy Staff at the time of the member's reappointment. Such transfer shall be without any recourse to an appeal.

4.3 Courtesy Staff

4.3-1 Qualifications

The Courtesy Staff shall consist of Practitioners, each of whom meets the requirements for Medical Staff Membership contained in these Bylaws but not the criteria for Active Staff status, and:

a. Admit or consult on at least six (6) patients at time of bi-annual reappointment; OR

b. Provide satisfactory evidence of current equivalent clinical performance at a JCAHO accredited hospital.

4.3-2 Prerogatives

The prerogatives of a Courtesy Staff member shall be to:

a. provide care to patients within the scope of the Clinical Privileges granted;

b. attend Medical Staff and Hospital educational programs;

c. attend (but not vote at) general and special meetings of the Medical Staff;

d. attend (but not vote at) meetings of the member's department and division;

e. serve as a voting member on any Medical Staff committee to which the member has been appointed; and

f. exercise such other rights as may be granted in these Bylaws, the Rules and Regulations or policies of the Medical Staff.

4.3-3 Responsibilities

Each member of the Courtesy Staff shall:

a. abide by the Bylaws, Rules and Regulations and policies of the Medical Staff;

b. pay dues and assessments in a timely manner; and

c. discharge such other functions as established in these Bylaws, the Rules and Regulations and policies of the Medical Staff as may be required.

4.4 Provisional Staff

4.4-1 Qualifications

The provisional Staff shall consist of Practitioners, each of whom:

a. Meet the general medical Staff Membership qualifications set forth in Article 3 Medical Staff Membership; and

b. Immediately prior to their application and appointment were not members or were no longer members in good standing of this medical Staff

4.4-2 Prerogatives

The Provisional Staff member shall be entitled to:

a. Provide care to patients within the scope of the Clinical Privileges granted to the member;

b. Attend Medical Staff and Hospital educational programs;

c. Attend (but not vote at) general and special meetings of the Medical Staff;

d. Attend (but not vote at) meetings of the member's department and division;

e. Serve as a voting member on any Medical Staff committee to which the member has been appointed;

f. Exercise such other rights as may be granted in these Bylaws, the Rules and Regulations or policies of the Medical Staff.

4.4-3 Responsibilities

Each member of the Provisional Staff shall:

a. abide by the Bylaws, Rules and Regulations and policies of the Medical Staff;

b. pay dues and assessments in a timely manner; and

c. discharge such other functions as established in these Bylaws, the Rules and Regulations and policies of the Medical Staff as may be required.

4.4-4 Observation of Provisional Staff Member:

Each provisional Staff member shall undergo a period of observation by designated monitors as described in Article 3.7. The purpose of observation shall be to evaluate the member's (1) proficiency in the exercise of Clinical Privileges initially granted and (2) overall eligibility for continued Staff Membership and advancement within Staff categories. Observation of provisional Staff members shall follow whatever frequency and format each department deems appropriate in order to adequately evaluate the provisional Staff member including, but not limited to, concurrent or retrospective chart review, mandatory consultation and/or direct observation. Appropriate records shall be maintained. The results of the observation shall be communicated by the department chair to the credentials committee, see Medical Staff Proctoring Policy and Procedure.

4.4-5 Term of Provisional Staff Status

A member shall remain in the provisional Staff for a period of 12 months (but not less than 3 months), unless that status is extended by the MEC for an additional period of up to 12 months upon a determination of good cause, which determination shall not be subject to review pursuant to Article 3.7-2 Period of Observation for New Members.

4.4-6 Action at Conclusion of Provisional Staff Status

a. If the provisional Staff member has satisfactorily demonstrated the ability to exercise the Clinical Privileges initially granted and otherwise appears qualified for continued Medical Staff Membership, the member shall be eligible for placement in the active or courtesy Staff as appropriate, upon recommendation of the MEC; and

b. In all other cases the appropriate department shall advise the credentials committee which shall make its report to the MEC regarding a modification or termination of Clinical Privileges or termination of Medical Staff Membership.

4.5 Corresponding Staff

4.5-1 Qualifications

The Corresponding Staff shall consist of Practitioners, each of whom:

a. possesses a clinical or research expertise, which allows the member to make important contributions to the Hospital; and

b. Desires to be informed of Hospital and Medical Staff activities; but is unable or unwilling to assume responsibilities of other categories of Membership.

4.5-2 Prerogatives The prerogatives of a Corresponding Staff member shall be limited to attending meetings of the Medical Staff and the member's division and department.

4.5-3 Responsibilities Each member of the Corresponding Staff shall:

a. pay an application processing fee and dues (at a reduced level in accordance with Section 4.6) and assessments in a timely manner; and

b. Abide by the Bylaws and the Rules and Regulations and policies of the Medical Staff.

4.6 Emeritus Staff

4.6-1 Qualifications

The Emeritus Medical Staff shall consist of Practitioners, each of whom:

a. has passed the age of sixty (60) years; and

b. has served more than ten (10) years on the Active Staff; and

4.6-2 Prerogatives The prerogatives of an Emeritus Staff member shall be limited to:

a. serving as a voting member on any Medical Staff committee to which the member has been appointed;

b. attending (but not voting at) general and special meetings of the Medical Staff and the member's division/department.

4.6-3 Responsibilities

Members shall have no specific responsibilities and shall not be required to pay dues. They shall be required to abide by these Bylaws, the Rules and Regulations and policies of the Medical Staff, as they may apply.

4.7 Telemedicine Staff

4.7-1 Qualifications

The Telemedicine Staff shall consist of Practitioners, each of whom meets the requirements for Medical Staff Membership contained in these Bylaws (except that Members with teleradiology privileges shall not be required to maintain DEA certification) and:

a. provide diagnostic (including, but not limited to, radiologic interpretations) or treatment services to Hospital patients via Telehealth devices (i.e., interactive involving real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information) audio, video, or data communications (but not to include telephone or electronic mail communication);

b. Provide satisfactory evidence of current equivalent clinical performance at a Joint Commission accredited hospital or telemedicine entity.

4.7-2 Prerogatives

a. Telehealth Staff Members may not admit patients to the Hospital or exercise Clinical Privileges in the Hospital. Members of this Staff category may only provide patient care services from a Distant Site (a site where the Member who provides health care services is located while providing these services via a telecommunications system).

b. Telehealth Staff Members may attend meetings of the Medical Staff and of the department/division(s) to which the Telehealth Staff Member is assigned (including general committee meetings and educational programs), but shall have no right to vote at such meetings. A Telemedicine Staff Member may attend meetings of committees to which the Member is assigned, but shall have no right to serve as Chair of the committee or to vote at committee meetings.

c. Telehealth Staff Members shall not be eligible to hold office in the Medical Staff organization, and once approved, will be appointed directly to the Telemedicine category.

4.7-3 Responsibilities

Each member of the Telemedicine Staff shall:

a. abide by the Bylaws, Rules and Regulations and policies of the Medical Staff; and

b. pay dues and assessments in a timely manner;

4.8 Dues and Application Fees

4.8-1 Dues and the initial application fee will be fixed by the MEC at the start of the Medical Staff year and will be collected in a manner to be determined by the MEC. A late fee may be assessed for delinquent dues.

4.8-2 New members receiving their appointment after October 1 shall have their dues for that year reduced by one-half (1/2).

4.8-3 Emeritus Staff members shall not be required to pay dues.

Notice of delinquency shall be sent by SPECIAL NOTICE to any member who has not paid his/her/their dues three (3) months after the initial bill was sent. A state of delinquency shall be considered an automatic voluntary resignation from Membership if dues are not received within one (1) month after said SPECIAL NOTICE was sent to the delinquent member. A member thusly resigning shall not be entitled to request a hearing, but shall be required, if the member desires to continue his/her/their Membership, to apply as a new member.

ARTICLE 5

CLINICAL PRIVILEGES

5.1 Clinical Privileges

5.1-1 Every Practitioner practicing at the Hospital 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 Governing Body, except as otherwise provided in this Article 5. Privileges are granted for a period not to exceed two years.

5.1-2 The granting of specific Clinical Privileges shall be based upon the applicant's:

- education;
- training;

- experience;
- demonstrated competence;
- ability to exercise Clinical Privileges requested with reasonable safety and efficiency
- references; and
- other relevant information, including training and proficiency in the use of the Electronic Medical Record including an appraisal by the Division Chief/Department Chair in which such privileges are sought. This appraisal shall include an assessment of the resources needed for each requested privilege, including space, equipment, Staffing and financial resources. The basis for the determination of privileges shall include observed clinical performance, the documented results of appropriate performance review and evaluation of activities conducted at the Hospital and required by these Bylaws.

The determination of privileges also shall be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where the applicant exercises or has exercised Clinical Privileges. The applicant shall have the burden of establishing the applicant's qualifications and competency in the Clinical Privileges requested.

5.1-3 In instances where there is cause for concern regarding the member's or applicant's mental or physical health which may adversely affect the exercise of the member's or applicant's Clinical Privileges, the MEC shall have the authority to require a physical and/or psychiatric examination or consultation and the submission of a report to it for its review and consideration as a condition to the granting of privileges.

5.1-4 Members shall be expected to practice at the Hospital with sufficient regularity to permit the member's division/department to assess periodically the member's continuing qualifications for the Clinical Privileges granted or requested.

If the member has practiced insufficiently at the Hospital during the appointment term to assess the member's continuing qualifications for the privileges requested, then, if made available, the division/department chief may consider evidence of comparable work performed at another Joint Commission accredited hospital. Such comparable work, if deemed adequate to confirm the member's qualifications, shall be accepted in lieu of work performed at the Hospital.

5.1-5 As a condition for the continuing exercise of Clinical Privileges, each member shall be expected to retain responsibility within the member's competence for the continuing care and supervision of each patient in the Hospital for whom the member has assumed professional responsibility, or arrange for a suitable alternate for such care and supervision.

5.2 Privileges for Doctors of Dental Surgery

5.2-1 Surgical privileges performed by doctors of dental surgery shall be under the overall supervision of the Chairperson of the Department of Surgery and doctors of dental surgery shall be assigned to the Department of Surgery, Division of Dentistry.

The scope and extent of their privileges shall be defined and granted in the same manner as all other surgical privileges. Doctors of dental surgery may write orders and prescribe medications within the limits of their license and of the Medical Staff Bylaws and Rules and Regulations.

5.2-2 Doctors of dental surgery may initiate the admission of a patient; however, the admitting dentist is responsible for arranging for a physician member of the Staff with appropriate Privileges to assume overall responsibility for the medical care of such patient unless the doctor of dental surgery also is a medical doctor and has the appropriate privileges to oversee the patient's medical care. The admitting doctor of dental surgery is responsible for that part of the history and physical examination that is related to dentistry.

Patients admitted to the Hospital for dental care shall receive the same basic medical appraisal as patients admitted for other services.

5.3 Privileges for Doctors of Podiatric Surgery

5.3-1 Surgical privileges performed by doctors of podiatric surgery shall be under the overall supervision of the Chairperson of the Department of Surgery and doctors of podiatric surgery shall be assigned to the Department of Surgery.

The scope and extent of their privileges shall be defined and granted in the same manner as all other surgical privileges. Doctors of podiatric surgery may write orders and prescribe medications within the limits of their license and of the Medical Staff Bylaws and Rules and Regulations.

5.3-2 Doctors of podiatric surgery may initiate the admission of a patient; however, the admitting doctor of podiatric surgery is responsible for arranging for a physician member of the Staff with appropriate privileges to assume overall responsibility for the care of such patient. The admitting doctor of podiatric surgery is responsible for that part of the history and physical examination that is related to podiatry.

Patients admitted to the Hospital for podiatric care shall receive the same basic medical appraisal as patients admitted for other services.

5.4 Privileges for Clinical Psychologists

5.4-1 In the exercise of privileges granted, licensed clinical psychologists shall be under the overall supervision of the Chief of the Division of Mental Health & Child Development within the Department of Medicine.

The scope and extent of their privileges shall be defined and granted in the same manner as all other Clinical Privileges. Clinical psychologists may write orders within the limits of their license and of the Medical Staff Bylaws and Rules and Regulations.

5.4-2 Every Hospital inpatient treated by a clinical psychologist shall be admitted by a physician member of the Medical Staff, who shall maintain primary responsibility for the overall care of the patient at the Hospital.

5.5 Temporary Privileges

5.5-1 When Granted

a. Temporary privileges are granted to meet an important patient care need, or for new applicants for Membership to the medical Staff while awaiting review and approval of the application.

b. Temporary privileges may be granted to a non-Staff Practitioner by the Chief Executive Officer or designee upon recommendation of the President of the Medical Staff or, as the President designates, any of the following:

1. The division chief or designee, or the department chairperson, from the division or department in which a Practitioner will be exercising the privileges; or

2. The Credentials Committee chair or designee.

5.5-2 Temporary Privileges for New Applicants for Medical Staff Membership Temporary privileges for new applicants shall be granted upon request of the applicant only when the verified information available reasonably supports a favorable determination regarding the requesting applicant's qualifications, licensure, ability and judgment to exercise the privileges requested.

Temporary privileges for new applicants may be granted for a period no longer than 120 days, or for the duration of time required to process the application to completion, whichever is shorter. A new applicant's temporary privileges shall automatically terminate if the applicant's initial Membership application is withdrawn.

The following must be verified and evaluated before a recommendation is made to the Chief Executive Officer or designee for the granting of temporary privileges for a new applicant:

a. An unrestricted license to practice medicine, surgery, dentistry, podiatry or clinical psychology in California;

b. No current or previously successful challenge to licensure or DEA registration;

c. Relevant training and experience; including training and proficiency in the use of the Electronic Medical Record

d. Current overall competence, and the ability to perform the privileges requested, as determined by the Division Chief or Department Chair;

e. A query to the National Practitioner Data Bank and favorable evaluation of the information received in response;

f. A complete application;

g. That the applicant for temporary privileges possesses current unrestricted privileges in an - accredited hospital which are comparable to those requested. An exception may be made if the applicant, who is otherwise qualified by the conditions set forth in these Bylaws, has recently completed residency or fellowship training, or if the applicant is serving in the military or has recently satisfied military or other federal/state obligations.

h. The applicant is not subject to involuntary limitation, reduction, denial or loss of Clinical Privileges at any other institution;

i. Compliance with the professional liability insurance requirements as recommended by the MEC and approved by the Governing body;

j. Compliance with Medical Staff requirements for documented evidence of testing and/or immunization for communicable diseases as may be required by the Medical Staff Rules & Regulations;

k. The applicant's agreement to abide by the Medical Staff Bylaws, Rules and Regulations, and policies.

5.5-3 Temporary Privileges to satisfy an important patient care need

a. Temporary privileges to satisfy an important patient care need may be granted for no longer than 120 days, or only for the duration reasonably necessary to satisfy the patient care need, which ever period is shorter. Current licensure and current competence are verified before temporary privileges are granted. If the important patient care need cannot be satisfied by a grant of temporary privileges lasting 120 days or less, the period of temporary privileges may be extended by the Chief Executive Officer only upon recommendation of the MEC and only for a specified period of days up to 120 days.

b. If a reappointment application has been submitted in accordance with the Rules and Regulations, but not been acted upon prior to the appointment expiration date through no fault of the renewal applicant, an important patient care need may be curtailed or unmet if the renewal applicant's privileges expire. If it is found that an important patient care need must be met under such circumstances, temporary privileges may be granted to that renewal applicant by the Chief Executive Officer or designee upon recommendation by the President of the Medical Staff or delegate authorized by the President. The temporary privileges granted under this subsection shall not exceed the reasonable time period necessary to complete the renewal application process, and in no case shall last for more than 60 days.

5.5-4 The performance of the Practitioner granted temporary privileges shall be the responsibility of the division/department chief/chairperson or designee. Special requirements of supervision, proctoring, and reporting shall be imposed by the division chief on any Practitioner granted temporary privileges as may be appropriate under the circumstances.

5.5-5 The Chief Executive Officer or designee may at any time, upon the recommendation of the division/department chief(s)/chairperson concerned, or the President of the Medical Staff, terminate a Practitioner's temporary privileges. If the Practitioner has one (1) or more patients in the Hospital at the time of such termination, the appropriate division/department chief/chairperson or, in his/her/their absence, the President of the Medical Staff, shall assign a member of the Medical Staff to assume responsibility for the care of such terminated Practitioner's patient(s) until the patient(s) are discharged from the Hospital. The wishes of the patient shall be considered where feasible in the selection of such substitute Practitioner.

5.5-6 A Practitioner shall not be entitled to the procedural rights afforded by Article 8 because the Practitioner's request for temporary privileges is refused or because all or any portion of the Practitioner's temporary privileges are terminated or suspended; except that, insofar as any denial, withdrawal or termination of temporary privileges is for a "medical disciplinary cause or reason," as defined in Section 805 of the Business and Professions Code, such action shall entitle the affected Practitioner to the procedural rights in Article 8, but only to the extent required by California law.

5.6 Additional Privileges

In order to obtain additional privileges, any member of the Medical Staff shall make written application on the prescribed form which shall state the privileges desired, previous training and experience, and, if requested, a resume of cases.

The burden shall be on the member to demonstrate qualification to exercise the privileges sought. Application shall be processed in a manner analogous to an application for Membership as provided in Section 5.1. Such privileges may be granted subject to proctoring.

5.7 Emergency Privileges

For the purpose of this section, an emergency is defined as a condition in which serious or permanent harm will 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. In the case of such an emergency, any physician, dentist, podiatrist or clinical psychologist with Clinical Privileges, to the degree permitted by his/her/their license and, regardless of department/division or Medical Staff status or Clinical Privileges, shall be automatically deemed to have emergency privileges within the scope of the member's license to handle the emergency, and shall be permitted to do, and shall be assisted by the Hospital personnel in doing, everything possible to save the patient from serious harm.

As soon as another Practitioner who has appropriate Clinical Privileges to treat the patient is available to assume the patient's care, care should be transferred to such Practitioner. When the emergency situation no longer exists, emergency privileges of such physician, dentist, podiatrist or clinical psychologist shall automatically expire, and the Practitioner may not continue to treat the patient without requesting and obtaining appropriate privileges. In the event such privileges are either not requested or are denied, the patient shall be assigned to an appropriate member of the Medical Staff.

5.8 Disaster Privileges

Licensed independent Practitioners who do not possess medical Staff privileges at Children's Hospital and Research Center at Oakland may be granted disaster privileges only when the emergency management plan has been activated and the hospital is unable to meet immediate patient needs placed upon it by the disaster. Such disaster privileges may be granted by the Chief Executive Officer or the Chief Executive Officer's designee(s), or the Hospital Incident Commander, or designee(s). The decision to grant disaster privileges is made on a case-by-case basis at the sole discretion of the person authorized to grant such privileges, in accordance with the needs of the hospital and patients during the disaster, and the qualifications of the volunteer Practitioners seeking disaster privileges, as set forth in this section.

5.8-1 In order for a volunteer to be eligible to act as a licensed independent Practitioner in a disaster, the volunteer must provide the medical Staff representative responsible for handling requests for disaster privileges a valid photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least any one of the following:

a. A current picture hospital identification card that clearly identifies professional designation;

b. A current license to practice

c. Primary source verification of the license.

d. Photo identification indicating that the Practitioner is a member of a disaster medical assistance team (DMAT), or Medical Reserve Corp (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups appropriately and relevant to disaster preparedness and training;

e. Identification indicating that the individual has been granted authority by a federal, state or municipal authority to render patient care, treatment, and services in disaster circumstances;

f. Identification by current hospital personnel or medical Staff member(s) with personal knowledge regarding the volunteer's ability to act as a licensed independent Practitioner during a disaster.

5.8-2 Upon presentation of the information required under section 5.8-1 disaster privileges may be granted by the Chief Executive Officer or designee(s) subject to (1) subsequent verification of the volunteer Practitioner's licensure and (2) ongoing oversight of the care, treatment and services provided by the Practitioner with disaster privileges. Primary source verification of licensure shall be conducted by the Medical Staff Office as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer Practitioner present to the organization. A record of this information will be retained in the Medical Staff Office.

5.8-3 The hospital shall issue an identification badge, or other form of identification, to Practitioners granted disaster privileges which shall be worn by each such Practitioner while on duty on hospital premises. The identification so worn shall permit hospital personnel and medical Staff members to readily identify the Practitioner's name and the fact that the Practitioner has been granted disaster privileges.

5.8-4 The medical Staff shall oversee the professional practice of Practitioners with disaster privileges.

The Practitioner will be assigned to a currently credentialed member and should act only under the supervision of a medical Staff member.

5.8-5 Regardless of whether the volunteer Practitioner's license is verified within 72 hours, an initial grant of disaster privileges shall be reviewed within 72 hours by a person authorized to grant disaster privileges to determine whether the disaster privileges should be continued. Such determination shall be based on information obtained from ongoing oversight of the care, treatment and services provided by the Practitioner.

5.8-6 The medical Staff shall 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 Section 5.5-3 of these Bylaws, relating to temporary privileges to fulfill an important patient care need.

5.8-7 The Practitioner's disaster privileges will be immediately terminated in the event that any information received through the verification process indicates any adverse information indicating the person may not be capable of rendering services in an emergency in a safe and competent manner.

5.8-8 The Practitioner's privileges will be for the period needed during the disaster only. Disaster privileges shall be cancelled by the Chief Executive officer or designee when it is determined that a Practitioner's services required due to the disaster are no longer necessary.

5.8-9 Medical Staff coordination is accomplished through the mechanism specified in the Disaster Plan.

5.9 Lapse of Application

If a Medical Staff member requesting a modification of Clinical Privileges or department assignment fails to furnish the information necessary within 60 days to evaluate the request, the application shall automatically lapse and the applicant shall not be entitled to a hearing as set forth in Article 8.

5.10 Telemedicine Privileges

a. The MEC shall make recommendations to the Board regarding which clinical services are appropriately delivered via telehealth, and the scope of such services. Clinical services offered through this means shall be provided consistent with commonly accepted quality standards. For approved telemedicine services, licensed independent Practitioners at the distant site may be granted telemedicine privileges upon application and favorable recommendation of the MEC and approval by the Board, if (1) the distant site is currently Joint Commission-accredited and the Practitioner is privileged there to provide the same services provided at the Hospital; or(2) the Practitioner qualifies for privileges for the service provided at the Hospital and is a member.

b. When the Hospital is a party to a written agreement with a distant site hospital or telemedicine entity containing all of the requirements of the CMS Hospital Conditions of Participation and Joint Commission standards related to telemedicine credentialing and privileging, the Medical Staff may rely upon the telemedicine physician's credentialing and privileging information from the distant-site hospital or telemedicine entity. However, the Medical Staff will remain responsible for ensuring the applicant meets the qualifications for Membership and Clinical Privileges and for performing a query of the National Practitioner Data Bank and any other non-delegable queries.

c. When the Hospital is not a party to a written agreement with a hospital or telemedicine entity containing all of the requirements of the CMS Hospital Conditions of Participation and Joint Commission standards related to distant-site telemedicine credentialing, the telemedicine physician must be credentialed and privileged through the Medical Staff pursuant to the general credentialing and privileging procedures described in these Medical Staff Bylaws. In order to assist in this credentialing and privileging process, the Hospital may request information from the telemedicine physician's primary practice site to assist in evaluation of current competency. The Hospital may also accept primary source verification of credentialing information from the physician's primary practice site or the telemedicine entity to supplement its own primary source verification.

5.11 Medical History and Physical Examination Privileges

Only those granted privileges to do so conduct a medical history and physical examination or update histories and physicals. Privileges to conduct a medical history and physical examination or an update to a medical history and physical examination are granted only to physicians and oral surgeons, or other qualified licensed individuals in accordance with state law and hospital policy and as set forth in the Rules & Regulations. All medical history and physical examinations are completed and documented in accordance with state law and Medical Staff policy.

ARTICLE 6

PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

6.1 Application for Initial Appointment

6.1-1 All applications for appointment to the Medical Staff must complete an application in the format approved by the MEC and the Governing Body.

The application shall, as a minimum, require detailed information concerning the applicant's professional qualifications, shall include the names of at least three (3) persons

who have recently worked with the applicant, directly observed the applicant's professional performance over a reasonable period of time and who can and will provide reliable information regarding the applicant's current professional competence, ethical character, and ability to work with others. The application shall also include information as to whether any of the following has ever been revoked, suspended, reduced, not renewed, denied, voluntarily or involuntarily relinquished under any circumstances:

a. Staff Membership status or Clinical Privileges at any hospital, health care institution, or other health care entity (including an IPA, HMO, health plan, or private payor);

b. Membership/fellowship in local, state or national professional organizations;

c. Specialty board certification/eligibility;

d. License to practice any profession in any jurisdiction; and

e. Drug Enforcement Agency (DEA) registration

f. Participation in any government insurance program

6.1-2 The application form shall include the statement that the applicant has read the Bylaws, Rules and Regulations of the Medical Staff and agrees to be bound by the terms thereof if granted Membership and/or Clinical Privileges and to be bound by the terms thereof in all matters relating to consideration of the applicant's application without regard to whether or not the applicant is granted Membership and/or Clinical Privileges.

6.1-3 The application form shall require that the applicant furnish complete information regarding any and all professional liability actions in which the applicant has been named as a defendant and known claims which have been asserted against the applicant, including information in such actions. The applicant shall be required to provide information about the professional liability carrier and insurance coverage limits.

6.1-4 The applicant shall state the department(s)/division(s) and Clinical Privileges for which the applicant wishes to be considered.

6.1-5 The applicant shall provide an email address, which shall be used as the main correspondence during the application process. The applicant must agree to check this address regularly, and to provide an updated address, if the address changes.

6.2 Effect of Application

By applying for appointment to the Medical Staff, each applicant:

6.2-1 Signifies the candidate's willingness to appear for interviews in regard to the application;

6.2-2 Authorizes the Hospital and Medical Staff representatives to consult with others who have been associated with the candidate and/or who may have information bearing on the applicant's professional competence and qualifications;

6.2-3 Consents to Hospital and Medical Staff representatives inspecting all records and documents that may be material to an evaluation of the applicant's professional qualifications and physical and mental health to carry out the Clinical Privileges requested;

6.2-4 Releases from any liability to the fullest extent permitted by law all Hospital and Medical Staff representatives for their acts performed in connection with evaluating the applicant and the related credentials;

6.2-5 Releases from any liability to the fullest extent permitted by law all individuals and organizations who provide information, including organizations who provide information, including otherwise privileged or confidential information, to Hospital and Medical Staff representatives concerning the applicant's competence, professional ethics, character, physical and mental health relative to his/her/their performance of the Clinical Privileges requested, emotional stability and other qualifications for Staff appointment and Clinical Privileges; and

6.2-6 Authorizes and consents to Hospital and Medical Staff representatives providing other hospitals, medical associations, licensing boards and other organizations concerned with evaluating the performance and the quality and efficiency of patient care with any information relevant to such matters that the Hospital and Medical Staff may have concerning the applicant, and releases the Hospital and Medical Staff representatives from liability for so doing.

6.2-7 Acknowledges and agrees that the processing and verifications of the information submitted may be completed by the Oakland Medical Staff Office personnel or an approved credentialing verification service, such as a Credentials Verification Organization.

6.3 Appointment Process for New Applicants

6.3-1 The applicant shall submit a completed application, together with all required accompanying document. The references, licensure and other similar information needed to complete the file, as defined in the Rules and Regulations, Section 5, shall be verified promptly. The resulting information shall be organized and routed to the Division Chief, if applicable, the Department Chair, and the Credentials Committee upon approval of each reviewer. The Credentials files shall be an electronic or paper file.

If problems are encountered in completing the file, the applicant shall be notified of the nature of these problems, and it shall be the applicant's obligation to obtain the required information. Only when the necessary collection and verification is accomplished shall the application and all supporting materials be transported for further review and evaluation. All significant issues identified during the verification phase shall be clearly communicated to the reviewers.

6.3-2 Within sixty (60) days after receipt of (1) the completed application for Membership and (2) the completed application(s) for privileges, the Medical Staff Office, Credentials Coordinator shall make the applications available in the Medical Staff office, or electronically via a secure portal, for review by the appropriate division/department chiefs in which the Practitioner has requested Clinical Privileges, except when further time is necessary for good cause. Within sixty (60) days, the appropriate division/department (for diagnostic imaging and pathology) chief(s)/chairperson(s) shall review the applications, which may include a personal interview with the applicant, and make recommendations to the Credentials Committee. If appointment is recommended to the Credentials Committee, the report shall recommend Staff category, department/division affiliation(s), Clinical Privileges to be granted, and any special conditions to be attached to the appointment.

6.3-3 At the next regular meeting following receipt of the recommendations from the appropriate division/department chief(s)/chairperson(s), the Credentials Committee shall then review the appraisal of division/department chief(s)/chairperson(s), and it shall examine all of the evidence material to whether the Practitioner has established that the Practitioner meets all of the necessary qualifications for Membership on this Medical Staff, including any

special qualifications attendant to the category of Staff Membership requested, and for the Clinical Privileges requested.

6.3-4 Credentials Committee Consideration: In all instances where the Credentials Committee contemplates an adverse recommendation with respect to Membership or privileges, the applicant shall be invited to a meeting with the Credentials Committee. Such invitation shall be sent by SPECIAL NOTICE and shall specify the adverse recommendation being considered. At such meeting, the reasons for the contemplated adverse recommendation shall be discussed with the applicant and the applicant shall be given an opportunity to respond. This meeting shall not constitute a hearing and none of the procedural rights provided in these Bylaws with respect to the hearing or appeals shall apply. Failure by the applicant to attend this meeting shall constitute a voluntary withdrawal of the application for Membership or privileges under consideration and no further action by the Credentials Committee shall be taken. Following such meeting, the Credentials Committee shall take action on the application. The action shall be either to defer a recommendation (in the event it decides that further information is needed before a recommendation), recommend the applicant for Membership and for the privileges requested, or recommend adversely with respect to the privileges requested or Membership. In the event the action is to defer a recommendation, it shall be followed up within ninety (90) days with a recommendation to the MEC.

Where the recommendation is favorable to the Practitioner, the recommendation shall include the Staff category, division/department (for diagnostic imaging and pathology) affiliation(s) and the Clinical Privileges to be granted which may be qualified by conditions relating to such Clinical Privileges.

Where the recommendation is adverse, the reasons therefore shall be included with the recommendation in the Credentials Committee's report on the applicant.

6.3-5 MEC Consideration:

a. At its next regular meeting after receipt of the application and the report and recommendation of the Credentials Committee, the MEC shall either defer the application for further investigation or make a recommendation to the Governing Body. The MEC shall only defer action in the event it finds that additional investigation is warranted. In such instance, the MEC may return the matter to the Credentials Committee or conduct such further investigation itself. When the action of the MEC is to defer the application for further consideration, it must be followed up within ninety (90) days or longer with the applicant's consent, but not to exceed one hundred eighty (180) days with a recommendation to the Governing Body to accept or reject the application as described below.

b. Delegation of Authority A sub-committee of the MEC is authorized to review and approve appointments under this section 6.3, and reappointments under section 6.4 of this Article, and other actions recommended by the Credentials Committee during those months in which the full MEC does not meet. The sub-committee shall consist of President, Past-President, or President-Elect as Chairperson, and at least three (3) other Medical Staff Members of the MEC to be selected by the Chairperson. Only appointments that have been approved by the Credentials Committee without reservation and are approved unanimously by this sub-committee would be submitted to the Governing Body for action. The minutes of any meeting of the sub-committee would be presented at the next meeting of the MEC.

c. When the MEC is in a position to make a recommendation to the Governing Body, the recommendation shall be either to:

1. Accept the application for Membership and for the privileges requested (in which instance the application will be processed as provided in Section 6.3-6 below); or

2. Reject the application for one or more of the privileges requested, reject the application for Membership, or both (in which instance the application shall be processed as provided in Section 6.3-7 below).

d. The MEC shall review the application and make its recommendation to the Governing Body within sixty (60) days after receiving the Credentials Committee report. A MEC's recommendation to the Governing Body under section 6.3-5.c.i. of this Article shall be forwarded to the MEC of the Governing Body for review and decision on the recommendation at its next regularly scheduled monthly meeting. If such subcommittee does not meet before the next meeting of the Governing Body as a whole, the MEC's recommendation shall instead be forwarded to the Governing Body. The MEC shall certify that the recommendation concerning the appointment of the Medical Staff member, and the Clinical Privileges to be granted upon appointment are based upon the factors specified in Sections 5.1 and 6.5.

e. The MEC recommendation shall be forwarded to the Governing Body, and in no event shall be forwarded to the MEC of the Governing Body, if any of the following are found:

1. The applicant has submitted an incomplete application;

2. The MEC has made an adverse recommendation regarding Membership or privileges as described in section 6.3-5.c.ii;

3. There is a current challenge or a previously successful challenge by a state or federal agency to the applicant's licensure or DEA registration;

4. The applicant has received an involuntary termination of medical Staff Membership at another organization;

5. The applicant has received involuntary limitation, reduction, denial, or loss of Clinical Privileges; or

6. There has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment(s) against the applicant.

6.3-6 Governing Body Consideration Following an Affirmative MEC Recommendation

6.3-7 The MEC's recommendation shall be promptly forwarded, together with the minutes of the Credentials Committee, to either the MEC of the Governing Body or the Governing Body itself, as set forth in section 6.3-5(d) and (e). The MEC's recommendation shall specifically recommend Staff category, department/division affiliation(s), and, if applicable, the Clinical Privileges to be granted, with any applicable conditions relating to such Clinical Privileges. At its next regular meeting, the MEC of the Governing Body, or the Governing Body if it meets as a whole before the MEC of the Governing Body, shall, in whole or in part, adopt or reject the favorable recommendation of the MEC, or refer the recommendation back to the MEC for further consideration, stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made.

a. If the action is to accept the application for Membership and the privileges requested, the applicant shall be duly notified by letter from the Chief Executive Officer which shall be copied to the credentials file.

b. If the proposed action is to reject either one or more of the privileges requested, the application for Membership, or both, the matter shall be referred to the Joint Conference Committee for review and recommendation and the Governing Body shall consider such recommendation before making its final decision. If the proposed action is still adverse to the applicant, the Chief Executive Officer shall promptly inform the applicant by Special Notice and the applicant shall be entitled to a hearing in accordance with Section 6.3-5(d).

c. If the action is adverse to the applicant, the Chief Executive Officer shall promptly inform the applicant by SPECIAL NOTICE and the applicant shall be entitled to a hearing in accordance with this Section. The action of the Governing Body shall be held in abeyance until the applicant has requested and exhausted or waived his/her/their right to a hearing. Such hearing shall be before the Governing Body or a committee of the Governing Body. The procedures governing such hearing shall be adopted by action of the Governing Body. The decision following the hearing shall be the final decision of the Governing Body. The Practitioner shall be duly notified by letter of the nature of such final action from the Chief Executive Officer which shall be copied to the MEC, and to the applicable division chief or chairperson.

6.3-8 Governing Body Consideration Following an Adverse Recommendation of the MEC

An adverse recommendation by the MEC, either with respect to one or more of the privileges requested, the Membership application, or both, shall not be immediately forwarded to the Governing Body. Instead, the Chief Executive Officer shall promptly notify the Practitioner by SPECIAL NOTICE of the adverse recommendation and of the Practitioner's right to a hearing pursuant to ARTICLE 8 of these Bylaws.

a. In the event the Practitioner does not request a hearing within the time limit allowed, the applications for Membership and privileges, together with the adverse recommendation from the MEC, shall be forwarded to the Governing Body for action. The Governing Body may defer the matter for further investigation or consideration, accept, modify or reject the adverse recommendation. If the proposed action of the Governing Body is to reject or modify the recommendation of the MEC, that proposed action shall be held in abeyance, pending referral of the matter to the Joint Conference Committee. The Joint Conference Committee shall review the matter and make a recommendation to the Governing Body. When the Governing Body is in a position to make a final decision on the application for Membership and privileges, it shall promptly take such action and notify the Practitioner by letter from the Chief Executive Officer, which shall be copied to the MEC and applicable division chief or chairperson. Such action shall constitute the final action of the hospital.

b. In the event the Practitioner requests a hearing within the time frame allowed, the Governing Body shall be informed of the fact at its next regular meeting after the hearing has been requested. It may be asked to take actions with respect to matters pertaining to the hearing (such as appointment of a hearing officer); however, it shall take no action on the applications of the Practitioner, pending the conclusion of the hearing process. (The hearing process consists of a formal hearing before a special committee, called the Judicial Review Committee, and an optional appeal before the Governing Body. The procedures governing such hearing and appeal are set forth in Article 8.)

c. In the event the hearing decision by the Judicial Review Committee is not appealed, either by the Practitioner or the MEC, the action of the Judicial Review Committee shall be considered the final action of the hospital and shall be reported to the Governing Body at its next regular meeting following such decision. The Practitioner shall be duly notified by the Chief Executive Officer of the final nature of the decision by letter, which shall be copied to the MEC and applicable division/department chief/chairperson.

d. In the event the hearing decision is appealed, the Governing Body shall decide the matter in accordance with the appeal procedures set forth in Section 8.3.

6.3-9 A decision and notice to appoint shall include:

a. The Staff category to which the applicant is appointed;

b. The department(s)/division(s) to which the Practitioner is assigned;

c. The Clinical Privileges the Practitioner may exercise; and

d. Any special conditions attached to the appointment.

6.3-10 An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of twelve (12) months of such decision taking effect. Exceptions to this waiting period may be made by the MEC and the Governing Body upon proper application for good cause. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as the Staff or the Governing Body may require to demonstrate that the applicant now meets the requirements for appointment to the Medical Staff.

6.4 Reappointment Process

The Credentials Coordinator, as the Credentials Committee's agent, shall,

6.4-1 at least one hundred twenty (120) days prior to the expiration of each Staff member's appointment, mail the Staff member the necessary forms to apply for reappointment to the Medical Staff and, if appropriate, patient care privileges; or email instructions for electronically completing the reappointment process through the credentialing portal. The forms, as approved by the MEC and Governing Body, shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 6.1.

6.4-2 The Staff member must reapply in the prescribed format and with all requested documentation or information no later than ninety (90) days before the expiration of the Staff member's appointment. In the event the Member fails to submit a complete application for reappointment within the prescribed time, the Credentials Coordinator shall notify the member of the member's failure. If the member thereafter fails to submit a complete an application for reappointment within thirty days of receipt of said notice, the Member shall be deemed to have resigned at the end of their current appointment period, and none of the hearing and appellate procedures in Article 8 shall apply.

Such Practitioner shall be permitted to reapply at any time upon expiration of the present Staff appointment, but such applicant shall be considered a new applicant.

Notwithstanding the foregoing, a Practitioner who fails to submit a complete application for reappointment in a timely manner may, if circumstances justify, be deemed exempt from

the requirement that he or she complete an application form for new applicants and may be treated as an applicant for reappointment so long as the application for reappointment is submitted within 60 days after the deemed resignation.

6.4-3 The Credentials Coordinator shall seek to verify the information submitted by the Staff Member seeking reappointment, as described in the Medical Staff Rules and Regulations, including, any requirements of the Medical Board of California or conditions of Hospital accreditation, certification, or licensure renewal.

Additionally, information shall be requested from the Practitioner's state licensure agency relative to disciplinary actions by such agency or by other peer review bodies. Any adverse information indicated in the National Practitioner Data Bank continuous query since the last reappointment shall also be submitted for review by the Credentials Committee.

The Credentialing Coordinator shall promptly notify the Staff Member of any problems in obtaining the information required and it shall be the Practitioner's obligation to obtain and submit the required information.

6.4-4 At such time as the applications for reappointment and privileges are considered to be complete, the Credentialing Coordinator shall notify the appropriate division/department chief(s). In the event the application is from a division chief, the applicable department chairperson shall fulfill the duties of division chief outlined in this Article. If a Department Chairperson is the applicant, the application will be reviewed by the President of the Medical Staff, or designee who will fulfill the duties outlined in this Article. Within ten (10) days after receipt of such notification, the division/department chief(s) shall review the application(s) and recommend reappointments and those privileges to be granted or denied. Where nonreappointment or a reduction or denial of privileges is recommended, the reasons for such recommendation shall be stated and documented.

6.4-5 When the above information is received by the Credentialing Coordinator, the reapplication form, together with all accompanying documentation, shall be forwarded to the Credentials Committee. The Credentials Committee shall, at least thirty (30) days prior to the expiration of the member's appointment, review said information and any other relevant information available to it and transmit to the MEC its report and recommendation that appointment either be renewed, modified, or terminated. The committee also may recommend that the MEC defer action. Where non-reappointment or a change in Clinical Privileges is recommended, the reason for each recommendation shall be stated and documented.

6.4-6 At least ten days prior to the expiration of a member's appointment, the MEC shall review the reapplication. In the event the application raises concerns regarding physical or mental health, the MEC may require that any member under consideration for reappointment be subject to a physical and/or mental health evaluation. The Staff Member shall execute all necessary authorizations and releases to allow the MEC or its representatives to communicate with the health care professional(s) conducting the evaluation and to allow the health care professional(s) to communicate with the requesting individual or committee about the results of the evaluation. The member shall be responsible for the cost of the evaluation.

6.4-7 When the MEC is in a position to make a recommendation to the Governing Body, the recommendation shall be either to:

a. Accept the application for Membership and for the privileges requested (in which instance the application will be processed as provided in Section 6.3-6 above); or

b. Reject the application for one or more of the privileges requested, reject the application for Membership, or both (in which instance the application shall be processed as provided in Section 6.3-7 above).

When the MEC makes a recommendation under subparagraph (a) of this section, it shall follow the expedited renewal procedures outlined in section 6.4-9 of this Article.

6.4-8 Each recommendation concerning the reappointment of a Medical Staff member and the Clinical Privileges to be granted upon reappointment shall be based upon the factors specified in Sections 5.1 and 6.5.

6.4-9 Expedited Renewal of Membership & Privileges

a. A MEC's recommendation to the Governing Body under section 6.4-7(a) of this Article shall be forwarded to the MEC of the Governing Body for review and decision on the recommendation at its next regularly scheduled monthly meeting. If such subcommittee does not meet before the next meeting of the Governing Body as a whole, the MEC's recommendation shall instead be forwarded to the Governing Body. The MEC shall certify that the recommendation concerning the appointment of the Medical Staff member, and the Clinical Privileges to be granted upon appointment are based upon the factors specified in Sections 5.1 and 6.5.

b. The MEC recommendation shall be forwarded to the Governing Body, and in no event shall be forwarded to the MEC of the Governing Body, if any of the following are found:

1. The applicant has submitted an incomplete application;

2. The MEC has made an adverse recommendation regarding Membership or privileges as described in section 6.3-5(c)(2);

3. There is a current challenge or a previously successful challenge by a state or federal agency to the applicant's licensure or DEA registration;

4. The applicant has received an involuntary termination of medical Staff Membership at another organization;

5. The applicant has received involuntary limitation, reduction, denial, or loss of Clinical Privileges; or

6. There has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment(s) against the applicant.

6.4-10 A Staff Member may, either in connection with reappointment or any other time, request modification of the Member's Staff category, department assignment, or Clinical Privileges by submitting a written application to the Medical Staff Office Credentials Coordinator, on the prescribed form, or via an email or written request. Such application shall be processed in substantially the same manner as provided in this Section.

6.5 Basis for Reappointment

Each recommendation concerning the reappointment of a Staff member and the Clinical Privileges to be granted upon appointment shall be based upon the following:

6.5-1 Those factors specified in these Bylaws and Rules and Regulations regarding qualifications for and conditions for initial appointment and Staff Membership;

6.5-2 Any special requirements imposed on the member's Staff category;

6.5-3 An evaluation of the member's exercise of any granted Clinical Privileges pursuant to those factors listed in Section 5.1;

6.5-4 The member's compliance with these Bylaws, the Rules and Regulations, and policies of the Medical Staff;

6.5-5 The member's cooperation with other members of the Staff, Hospital professionals and employees, to the extent required by consideration of quality patient care; and

6.5-6 With respect to any Clinical Privileges granted, other matters reasonably bearing on the demonstrated ability and willingness to contribute to quality patient care, as determined by the standards of this Medical Staff.

6.6 Terms of Appointment and Reappointment

Appointments, reappointments, and the grant of Clinical Privileges shall be up to a maximum of two years. No Practitioner has the right to a two-year appointment, and appointments may be for periods of less than two years.

6.7 Time Limits

The time limits contained herein are to guide the Medical Staff committees in accomplishing their tasks. Such time limits are not intended to grant to an applicant or member any vested right to have an application or reapplication processed within a particular period of time.

6.8 Duration of Appointment

No reappointment for Medical Staff Membership shall go beyond two years.

ARTICLE 7

CORRECTIVE ACTION, INVESTIGATION AND SUSPENSION

7.1 Corrective Action

7.1-1 Criteria for Initiation An investigation may be requested by any committee of the Medical Staff, the Medical Director, the chief of any division, the chairperson of any department, the Chief Executive Officer, or any officer of the Medical Staff whenever he/she/they become aware of information which indicates that a Medical Staff member is engaged in conduct either inside or outside of the Hospital which is, or is reasonably likely to be:

a. detrimental to patient safety or to the delivery of quality patient care;

b. disruptive to Hospital operations;

c. unethical; or

d. in violation of these Bylaws and Rules and Regulations of the Medical Staff, Medical Staff policies, or policies of the Hospital.

7.1-2 Requests and Notification

The Medical Executive Committee may initiate an investigation upon receiving information suggesting that grounds for an investigation exists. The Medical Executive Committee will determine which body will conduct an investigation, which may be the Medical Executive Committee as a whole, designated members of the Medical Executive Committee, or an ad hoc committee of Medical Staff Members which may include non-Medical Executive Committee members.

Nothing precludes the MEC from assigning one or more of its own members, or any other physician(s) on the medical Staff, to investigate a matter or complaint and report back to the MEC so it may determine if an ad hoc committee investigation is warranted and/or determine if the matter or complaint may warrant action that is not reportable to the Medical Board of California.

In accordance with Section 12.1-10 of these Bylaws, the MEC in its discretion may appoint Practitioners who are not members of the Medical Staff to serve as consultants to the ad hoc committee. All communications and records of such consultants, written and oral, shall be deemed part of the records and proceedings of the applicable committee and shall be viewed strictest confidence, and disclosed only as authorized in written policies governing the confidentiality of Medical Staff committee records and files.

7.1-3 Investigation After conducting a preliminary investigation, the ad hoc committee shall invite the Medical Staff member whose act or conduct is in question to appear before the committee. At such interview, the Medical Staff member shall be informed of the general nature of the charges against the Medical Staff member and shall be invited to discuss, explain or refute them. This appearance shall not constitute a hearing, shall be investigatory and exploratory in nature, and none of the procedural rights provided in these Bylaws with respect to hearings or appeals shall apply.

Neither the Practitioner nor the ad hoc committee may have legal counsel present during the interview. The ad hoc committee shall maintain a written record of the Practitioner's interview.

The committee shall maintain a file of its investigation. Such file shall include all of the minutes of the committee's meetings, the committee's report to the MEC, any notes made by any members and consultants to the committee, and other documents prepared by the committee or received by the committee. Members of the committee should not maintain notes and files regarding the matter separate from the committee's file on the matter. The committee file shall be maintained as a confidential medical Staff committee file and shall be maintained separate from the Practitioner's credentials file.

7.1-4 Findings and Recommendations of the Ad Hoc Committee At the conclusion of the committee's investigation, it shall deliver a report to the MEC which shall include findings and recommendations:

a. Findings: The committee's findings shall consist of a listing of the results of the investigation.

b. Recommendations: The committee's recommendations may include any of the following:

1. Formal corrective action.

Any action which grants the Practitioner hearing rights under Article 8, including, any one or more of the following actions:

1. Suspension of Medical Staff Membership or privileges;

2. Expulsion from the Medical Staff;

3. Reduction in Clinical Privileges;

4. Termination of all Clinical Privileges;

5. Requirement of consultation;

6. A Letter of Censure;

7. Termination of a contract between the Hospital and Practitioner for a medical Staff disciplinary cause or reason as defined in Business and Professions Code, Section 805 or its successor statute.

2. No formal corrective action.

This is appropriate when the committee finds that there was no unacceptable conduct.

3. Formal Corrective action not required. This is appropriate when the committee finds that, although some inappropriate conduct may have occurred, the particular conduct was not so grave or serious as to warrant formal corrective action. The committee's report should include appropriate recommendations as to what lesser forms of corrective action (such as a letter of warning, or a special form of continuing education) are advisable

7.1-5 Review by the MEC

The MEC will review the findings and recommendations of the ad hoc committee. The MEC may invite the Medical Staff member whose conduct is in question to appear before it prior to taking action. The appearance shall not constitute a hearing and shall be investigatory and exploratory in nature and none of the procedural rules provided in these Bylaws with respect to hearings and appeals shall apply. Neither the Practitioner nor the MEC may have legal counsel present during the interview. The MEC shall make a record of all such appearances before it.

7.1-6 Recommendation/Action by the MEC/Governing Body

The MEC may take any of the following actions or recommendations: (1) it may recommend to the Governing Body corrective action which grants the Practitioner hearing rights under Article 8; (2) it may decide on a lesser form of corrective action which does not grant the Practitioner hearing rights; or (3) it may decide to take no corrective action.

a. Recommendation Granting Hearing Rights

If the MEC's recommendation grants the Practitioner hearing rights under Article 8, the MEC, shall promptly notify, by SPECIAL NOTICE , the concerned Medical Staff member of his/her/their right to request a hearing under ARTICLE 8. The

recommendation of the MEC shall be held in abeyance pending exhaustion or a waiver of rights under ARTICLE 8.

The recommendation of the MEC shall not be immediately forwarded to the Governing Body. Instead, the Chief Executive Officer shall promptly notify the Practitioner by SPECIAL NOTICE of the adverse recommendation and of the Practitioner's right to a hearing under ARTICLE 8

1. In the event the Practitioner does not request a hearing within the time limit allowed, the recommendation of the MEC shall be forwarded to the Governing Body for action. The Governing Body may defer the matter for further investigation or consideration, accept, modify or reject the adverse recommendation. If the proposed action of the Governing Body is to reject or modify the recommendation of the MEC, that proposed action shall be held in abeyance, pending referral of the proposed action to the Joint Conference Committee. The Joint Conference Committee shall review the matter and make a recommendation to the Governing Body. When the Governing Body is in a position to make a final decision on the matter, it shall promptly take such action and notify the Practitioner by letter from the Chief Executive Officer, which shall be copied to the MEC and the applicable division/departmental chief. Such action shall constitute the final action of the hospital.

2. In the event the hearing decision of the Judicial Review Committee is not appealed, either by the Practitioner or the MEC, the action of the Judicial Review Committee shall be considered the final action of the hospital and shall be reported to the Governing Body at its next regular meeting following such decision. The Practitioner shall be duly notified by the Chief Executive Officer of the final nature of the decision by letter, which shall be copied to the MEC and applicable division/department chief.

3. In the event the decision is appealed, the Governing Body shall decide the matter in accordance with the appeal procedures set forth in Section 8.3

b. Action Not Granting Hearing Rights If the MEC's action does not grant the Practitioner hearing rights under Article 8 (whether because it is a lesser form of corrective action not entitling the Practitioner to a hearing or because it involves taking no corrective action), it shall notify the Practitioner of its decision. In these instances, the MEC's decision shall conclude the investigation with respect to such matter.

c. Informing the Ad Hoc Investigative Committee In its sole discretion, the MEC may inform the members of the ad hoc committee who conducted the investigation of its decision and the reasons therefore.

7.2 Suspension and Deliberation

7.2-1 Summary Suspension

a. Criteria for Initiation

A Medical Staff member's medical Staff Membership or Clinical Privileges may be summarily suspended or restricted, based on concurrent or retrospective information, whenever the failure to take such action may result in an imminent danger to the health, life or safety of any individual. The following persons or

committees are authorized to take such summary action: the President of the Medical Staff, the responsible department/division chief or the MEC.

Immediately upon imposition of the summary suspension or restriction, the President of the Medical Staff or responsible department/division chief shall have the authority to provide for appropriate medical coverage for the patients of the suspended Medical Staff member at the Hospital affected by the suspension or restriction. The patient's wishes shall be considered in the selection of an alternate Practitioner.

b. Written Notice of Summary Suspension

Such summary suspension or restriction shall be effective immediately upon imposition and the President of the Medical Staff (or Vice President if the President is unavailable) shall promptly notify the Practitioner by SPECIAL NOTICE of confirmation of the suspension or restriction. A summary suspension or restriction may be limited in duration in order to permit the MEC, where deemed appropriate, the authority to conduct an investigation under Section 7.1. Where the duration of the suspension or restriction is temporary, the Medical Staff member shall be notified of its temporary nature.

When no such person or committee is available to impose a summary suspension or restriction, the Governing Body may take such action if a failure to do so would be likely to result in an imminent danger to the health, life or safety of any individual. Prior to exercising this authority, the Governing Body must make a reasonable attempt to contact the President of the Medical Staff or his/her/their designee as the representative of the Medical Staff. Summary action by the Governing Body which has not been ratified by the President of the Medical Staff within two (2) working days, excluding weekends and holidays, after the suspension shall terminate automatically without prejudice to further summary action as warranted by the circumstances.

c. The Medical Staff member whose Clinical Privileges have been summarily suspended or restricted shall be invited to attend a meeting with the MEC to be held within fifteen (15) days after the imposition of the summary suspension.

The attendance of the Medical Staff member at such a meeting shall be mandatory and shall be a prerequisite to the Medical Staff member's ultimate exercise of hearing rights under Article 8. None of the procedural rules provided in these Bylaws with respect to hearings and appeals under Article 8 shall apply. Neither the Practitioner nor the MEC may have legal counsel present during the meeting. The MEC shall make a record of the Practitioner's appearance.

Following the meeting, the MEC may vote to affirm, remove or modify the summary suspension or restriction. The Medical Staff member shall be notified by SPECIAL NOTICE of the MEC's decision. The summary suspension or restriction shall remain in effect pending the outcome of any hearing and appeal initiated by the Medical Staff member pursuant to ARTICLE 8.

7.2-2 Automatic Suspension

Suspensions under this Section shall not entitle the Practitioner to the procedural rights in Article 8. Whenever any action is taken against a Medical Staff member as described in Sections 7.2-2(a)(1) through 7.2-2(a)(5) or Sections 7.2-2(b)(1) through 7.2-2(b)(3), such Medical Staff member shall notify the President of the Medical Staff and the Chief

Executive Officer immediately after such member learns of such action. Failure to so notify shall be grounds for further corrective action under Article 7.

a. License:

1. Revocation:

Whenever a Medical Staff member's license, certificate or other legal credential authorizing practice in this State is revoked, Medical Staff Membership and Clinical Privileges shall be immediately and automatically revoked.

2. Restriction:

Whenever a Medical Staff member's license, certificate or other legal credential is limited or restricted by the applicable licensing or certifying authority, those Clinical Privileges which have been granted and which are within the scope of or directly affected by said limitation or restriction, shall be immediately and automatically suspended. Further action on the matter shall proceed pursuant to Section 7.2-2(d).

3. Suspension:

Whenever a Medical Staff member's license, certificate or other legal credential is suspended, Medical Staff Membership and Clinical Privileges or specified services shall be automatically suspended. Further action on the matter shall proceed pursuant to Section 7.2-2(d).

4. Probation:

Whenever a Medical Staff member is placed on probation by the applicable licensing or certifying authority, the Medical Staff members voting and office holding prerogatives shall be automatically suspended effective upon and for at least the term of probation. Further action on the matter shall proceed pursuant to Section 7.2-2(d).

5. Expiration:

Whenever a Medical Staff member's license, certificate or other legal credential has expired and has not been renewed and there is no evidence to support that the renewal is in progress, those Clinical Privileges or specified services which have been granted to the Medical Staff member shall be automatically suspended. The suspension shall remain in effect until the Practitioner provides evidence of renewal. If, after six (6) months, there is no evidence of renewal, the member's Membership and Clinical Privileges shall be automatically terminated. A Practitioner, whose Medical Staff Membership is terminated pursuant to this section, shall have no right to a hearing under.

b. Controlled Substance Privileges :

1. Suspension:

Whenever the Drug Enforcement Agency (DEA) suspends a Medical Staff member's privileges to prescribe controlled substances, the Medical Staff

member shall be divested of the right to prescribe such medication for the term of the suspension. Further action on the matter shall proceed pursuant to Section 7.2-2(d).

2. Revocation:

Whenever the DEA revokes a Medical Staff member's privileges to prescribe controlled substances, the Medical Staff member shall immediately and automatically be divested of the right to prescribe such substances. Further action on the matter shall proceed pursuant to Section 7.2-2(d).

3. Probation:

Whenever a Medical Staff member is placed on probation insofar as the privilege of prescribing controlled substances under the DEA is concerned, action on the matter shall proceed pursuant to Section 7.2-2(d).

4. Expiration:

Whenever a Medical Staff member's DEA certificate expires, the Medical Staff member shall automatically and immediately be divested of the right to prescribe controlled substances.

c. Unauthorized Removal of Patient Charts

The unauthorized removal of patient charts from the Hospital shall result in the automatic suspension of the privilege to admit patients to the Hospital. Further action on the matter shall proceed in accordance with Section 7.2-2(d).

d. Department Deliberation

As soon as practically possible after action is taken in the above subsections (a)(2), (a)(3), or (a)(4), or subsections (b)(1), (b)(2) or (b)(3), or (c), the appropriate department or a committee thereof shall be convened to review and consider the facts under which such action was taken. The department may then recommend to the MEC such further action as is appropriate.

e. Medical Records

Members of the Medical Staff are required to complete medical records as specified in the Rules and Regulations of the Medical Staff. Members who fail to comply may have their privileges suspended, as provided in the Rules and Regulations, until such records are completed.

f. Professional Liability Insurance

Failure to maintain professional liability insurance, as required in Section 3.1, shall be grounds for automatic suspension of a member's Clinical Privileges. If, within three (3) months after written warnings of the delinquency, the member does not provide evidence of required professional liability insurance, the Practitioner's Clinical Privileges and Membership shall be automatically terminated.

ARTICLE 8

HEARING AND APPELLATE REVIEW PROCEDURES

8.1 Request for Hearing

8.1-1 Notice of Decision

Whenever as hereinafter set forth in Section 8.1-2, the subject applicant or Medical Staff member, as the case may be, shall promptly be given Special Notice. This notice shall include:

a. A description of the action or recommendation;

b. That the applicant or member has the right to request a hearing within thirty (30) days after receipt of Special Notice as defined herein;

c. A summary of the applicant's or member's rights in the hearing;

d. A concise statement of the reasons for the action or recommendation (when deemed necessary and in the event a hearing is requested, a more detailed Notice of the Reasons or Charges may be provided subsequently);

e. In the event the adverse action or recommendation is the type of action which will be reportable to the Medical Board of California pursuant to Section 805 of the Business and Professions Code, if adopted or implemented, an explanation that the action, if adopted or implemented, will be reportable to the California Medical Board pursuant to Business and Professions Code 805; and

f. In the event the adverse action or recommendation is the type of action which, if adopted, will be reportable to the National Practitioner Data Bank, the notice shall indicate that fact.

g. Such applicant or member shall have thirty (30) days following the date of the receipt of such notice within which to request a hearing by the Judicial Review Committee hereinafter referred to. Said request shall be by written notice to the President of the Medical Staff.

h. In the event the applicant or member does not request a hearing within the time and in the manner hereinabove set forth, the matter shall be forwarded to the Governing Body for final action.

8.1-2 Grounds for Hearing

Any one or more of the following actions or recommended actions taken for a medical disciplinary cause or reason, as defined in Section 805 of the California Business and Professions Code, shall constitute grounds for a hearing if such actions or recommendations would require the Medical Staff to file a report to the Practitioner's licensing board pursuant to California Business and Professions Code Section 805 or to the National Practitioner Data Bank ("NPDB") if the action becomes final:

a. denial of initial appointment or reappointment to the Medical Staff;

b. denial of requested Clinical Privileges;

c. termination of Medical Staff membership and/or any Clinical Privileges;

d. restrictions imposed on Medical Staff Membership and/or Clinical Privileges (e.g., involuntary imposition of significant consultation, proctoring, or monitoring requirements which restrict the exercise of Clinical Privileges) for a cumulative total of 30 days or more in a 12-month period;

e. suspension of Clinical Privileges or Medical Staff Membership which takes immediate effect and remains in effect for more than 14 consecutive days; or

f. any other action or recommendation which requires a report to be made to the Practitioner's licensing board under the provisions of Section 805 of the California Business and Professions Code or to the NPDB.

No other recommendation or action will entitle a Practitioner to a hearing detailed in this Article. Voluntary restrictions, leaves of absence, and resignations are not disciplinary actions or recommendations, and do not entitle a Practitioner to a hearing under these Bylaws, regardless of whether or not they must be reported to the licensing board or the NPDB.

8.1-3 Time and Place for Hearing

Upon receipt of a request for a hearing, the President of the Medical Staff shall deliver such request to the MEC. The MEC shall, within thirty (30) days after receipt of such request, schedule and arrange for a hearing.

At least thirty (30) days before the commencement of the hearing, the President of the Medical Staff shall give notice to the applicant or member of the time, place and date of the hearing. The date of the commencement of the hearing shall be not less than thirty (30) days from the date of the notice nor more than sixty (60) days from the date of receipt of the request by the MEC for a hearing; provided, however, that when the request is received from a member who is protesting a summary suspension, the hearing shall be held as soon as the arrangements may be reasonably made, but not to exceed thirty (30) days from the date of receipt of the request for a hearing by the MEC.

8.1-4 Notice of Charges

To the extent considered necessary, the MEC may supplement the reasons or the action provided in the Notice of Decision by including, as part of the Notice of Hearing, a statement of the acts or omissions with which the Medical Staff member is charged or the reasons for the action or recommendation upon which it intends to rely at the hearing providing, when appropriate, a list of the charts under question.

The Notice of Hearing shall include a list of the names of the individuals, so far as then reasonably known or anticipated, who are expected to give testimony or evidence in support of the MEC at the hearing. This list shall be updated as necessary and appropriate at least ten (10) days prior to the commencement of the hearing.

8.1-5 Judicial Review Committee

When a hearing is requested, the MEC shall appoint a Judicial Review Committee which shall be composed of not less than three (3) members of the Active Medical Staff. In addition, two (2) alternates shall be appointed from the Active Staff, who shall attend the hearing and shall be available to assume the responsibilities of a member of the Judicial Review Committee should a member be unable complete his/her/their responsibilities.

Such appointments shall include designation of the chairperson. Where feasible, it shall include an individual practicing in the same specialty as the person who requested the hearing.

The members shall not have acted as accusers, investigators, fact finders or initial decision makers in connection with the same matter, shall gain no direct financial benefit from the outcome, and shall not be in direct economic competition with the person who requested the hearing. Knowledge of the matter involved shall not preclude a member of the Active Medical Staff from serving as a member of the Judicial Review Committee.

In the event that it is not possible to appoint a Judicial Review Committee which satisfies the above requirements, the MEC may appoint qualified Practitioners from other Medical Staff categories or Practitioners from outside of the Medical Staff.

8.1-6 Failure to Appear

Failure without good cause of the person requesting the hearing to appear and proceed at such hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions involved which shall be come final and effective immediately.

8.1-7 Postponements and Extension

Postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by anyone, but shall be permitted by the Judicial Review Committee or its chairperson acting upon its behalf on a showing of good cause or on the agreement of the parties.

8.2 Hearing Procedures

8.2-1 Representation

The hearings provided for in these Bylaws are for the purpose of intraprofessional resolution of matters bearing on conduct or professional competency. The person who requested the hearing shall have the right to be represented at the hearing by legal counsel only if he/she/they notify the MEC of the person's intention to be represented by counsel in the person's written request for a hearing. In such event, the MEC shall also be entitled to be represented by legal counsel. In no event will the MEC be represented by legal counsel unless the person who requested the hearing is also represented at the hearing by legal counsel.

The foregoing shall not be deemed to deprive either party of its right to the assistance of an attorney for the purpose of preparing for the hearing. An attorney for purposes of this Section shall include any person with legal training from any law school, regardless of whether the person is admitted to the Bar of the State of California and regardless of whether person has graduated from law school. If not represented by an attorney, the applicant or member shall be entitled to be accompanied by and represented at the hearing by a Practitioner who is not an attorney and who preferably is a member in good standing of the Medical Staff. The MEC shall appoint a representative from the Medical Staff to present its recommendation in support thereof and to examine witnesses.

8.2-2 The Hearing Officer

The Governing Body shall appoint an attorney-at-law to act as a hearing officer to preside at the hearing. Such hearing officer may not be legal counsel to the Hospital, the medical Staff or the subject of the hearing, or be in partnership or other relationship with those who

are. The hearing officer may not be in economic competition with the subject of the hearing nor gain any direct financial benefit from the outcome and must not act as a prosecuting officer, as an advocate for the Hospital, Governing Body or MEC, or body whose action prompted the hearing. The hearing officer shall act to insure that all participants in the hearing have a reasonable opportunity to be heard, to present all oral and documentary evidence in an efficient and expeditious manner, and that decorum is maintained. The hearing officer shall be entitled to determine the order of procedure during the hearing and shall have the authority and discretion, in accordance with these Bylaws, to make all rulings and questions which pertain to matters of law and to admissibility of evidence. If requested by the Judicial Review Committee, the hearing officer may participate in the deliberation of such body and be a legal advisor to it, but shall not be entitled to vote.

8.2-3 Voir Dire

The person who requested the hearing shall have the right to a reasonable opportunity to voir dire the Judicial Review Committee members and the hearing officer, if any, and the right to challenge the appointment of any member or the hearing officer.

The hearing officer shall establish a procedure by which this right may be exercised. This procedure may include requirements that voir dire questions be proposed in writing in advance of the hearing and that the questions to the members be posed through the hearing officer. The hearing officer shall rule on any challenges in accordance with applicable legal principles defining standards of impartiality for hearing panels and hearing officers in proceedings of this type.

8.2-4 Prehearing Exchange of Information and Discovery

The person who requested the hearing shall have the right to inspect and copy at his/her/their expense any documentary information relevant to the charges which the MEC has in its possession or under its control, as soon as practicable after the receipt of the applicant's or member's request for hearing.

The MEC shall have the right to inspect and copy at its expense any documentary information relevant to the charges which the person who requested the hearing has in his/her/their possession or control as soon as practicable after receipt of the MEC's request.

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

The hearing officer shall consider and rule upon any dispute or controversy concerning a request for access to information, and may impose any safeguards the protection of the peer review process and justice requires. When ruling upon requests for access to information and determining the relevancy thereof, the hearing officer shall consider, among other factors, the following:

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

b. The exculpatory or inculpatory nature of the information sought, if any, e.g., whether there is a reasonable probability that the result of the hearing would be influenced significantly by the information it received into evidence

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

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

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

In addition to the discovery of documents as provided above, each party shall be entitled to request a list of the other's anticipated witnesses and a copy of all documents anticipated to be introduced at the hearing. Failure of a party to produce these materials, or to update them as necessary and appropriate at least ten (10) days before the commencement of the hearing, after being given a reasonable opportunity to do so, shall constitute good cause for a continuance. The member and the MEC shall have the right to receive all evidence which will be made available to the Judicial Review Committee.

8.2-5 Record of Hearing

The Judicial Review Committee shall maintain a record of the hearing by having a certified court reporter present to make a record of the hearing. The Judicial Review Committee may, but shall not be required to, order that evidence be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in the State of California. In the event of an appeal, the appellant shall bear the cost of preparing the original reporter's transcript.

8.2-6 Rights of Both Sides

At a hearing, both parties shall have the following rights:

a. To be provided with all of the information made available to the Judicial Review Committee;

b. To have a record made of the proceedings, copies of which may be obtained by the requesting party upon payment of any reasonable charges associated with its preparation;

c. To call and examine witnesses;

d. To introduce exhibits;

e. To cross-examine any witness on any matter relevant to the issues;

f. To impeach any witness;

g. To rebut any evidence; and

h. To submit a written statement at the close of the hearing If the applicant or member of the Medical Staff does not testify on his/her/their own behalf, he/she/they may be called and examined as if under cross-examination.

8.2-7 Admissibility of Evidence

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

Each party shall have the right to submit a memorandum of points and authorities and the Judicial Review Committee may request such a memorandum to be filed following the close of the hearing.

The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems it appropriate.

8.2-8 Burdens of Presenting Evidence and Proof

a. In all cases, it shall be incumbent on the body or committee whose recommendation prompted the hearing to come forward initially with evidence in support of its action or decision. Thereafter, the person who requested the hearing shall come forward with evidence in his/her/their support.

b. Applicants and reapplicants for Medical Staff Membership or for new Clinical Privileges shall bear the burden of persuading the Judicial Review Committee by a preponderance of the evidence of their qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning their current qualifications for Medical Staff Membership or Clinical Privileges. Applicants and reapplicants shall not be permitted to introduce information not produced upon request of the MEC during the application process unless they establish that the information could not have been produced previously in the exercise of reasonable diligence.

c. Except as provided above in paragraph (b), the MEC 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, which burden shall be made if it was the action or one of the actions which the MEC could reasonably have recommended given the facts as presented at the hearing.

8.2-9 Basis of Decision

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

a. Oral testimony of witnesses;

b. Briefs or memoranda of points and authorities presented in connection with the hearing;

c. Any material contained in the Medical Staff's personnel files regarding the person who requested the hearing;

d. Any and all applications, references and accompanying documents; and

e. Any other admissible evidence.

8.2-10 Adjournment, Conclusion and Decision

The presiding officer may adjourn the hearing and reconvene the same at the convenience of the participants without Special Notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed and finally adjourned.

Within ten (10) days of the final adjournment of the hearing, the Judicial Review Committee shall render a written decision and report. The decision and report shall include findings of fact regarding each charge and decision, and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached.

If the final proposed action adversely affects the Clinical Privileges of a physician, dentist, podiatrist or clinical psychologist for a period longer than thirty (30) days and is based on competence or professional conduct, the decision shall state that the action, if adopted, will be reported to the National Practitioner Data Bank, and shall state the text of the report as agreed upon by the committee.

The decision and report shall include an explanation of the procedure that is available for requesting and pursuing an appeal. The decision and report shall be delivered to (1) the body whose decision prompted the hearing; and (2) the applicant or member by Special Notice. After the period for filing an appeal has either passed or at such time as the notice of appeal is filed, the Governing Body shall receive a copy of the decision and report. If an appeal has been requested, the Governing Body shall take no action until the appeal has been heard.

8.2-11 The Appeal

The decision of the Judicial Review Committee shall be considered final, subject only to the right of appeal as provided in Section 8.3.

8.3 Appeal to the Governing Body

8.3-1 Time for Appeal

Within thirty (30) days after receipt of the decision and report of the Judicial Review Committee, either party may request an appellate review by the Governing Body. Said request shall be given to the Chief Executive Officer in writing and shall be delivered either in person or by Special Notice. A copy of said request shall be sent concurrently to the other party.

If such appellate review is not requested within such period, both sides shall be deemed to have accepted the action involved and it shall thereupon become final and shall be effective immediately upon the end of such thirty (30) day period. The written request of appeal also shall include a brief statement as to the reasons for appeal.

8.3-2 Grounds for Appeal

The grounds for appeal from the hearing shall be:

a. Substantial failure of the Judicial Review Committee, the MEC or the Governing Body to comply with the procedures required by these Bylaws in the conduct of hearings and decisions upon hearings so as to deny due process and a fair hearing;

or

b. Action taken arbitrarily, capriciously or with prejudice.

8.3-3 Time, Place and Notice

In the event of any appeal to the Governing Body as set forth in the preceding subsections, the Governing Body shall, within thirty (30) days after receipt of such notice of appeal, schedule an appellate review.

The appellate review shall be before the full Governing Body or a designated committee thereof (referred to herein also as the "Governing Body") which shall have been granted full authority to act on behalf of the Governing Body.

The Governing Body shall cause the applicant or member to be given notice of the time, place and date of the appellate review. The date of appellate review shall not be less than thirty (30) days or more than sixty (60) days from the date of receipt of the request for appellate review; provided, however, that when a request for appellate review is from a member who is protesting a summary suspension, the appellate review shall be held as soon as the arrangements may reasonable be made and not to exceed thirty (30) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Chairperson of the Governing Body for good cause.

8.3-4 Nature of Appellate Review

The proceedings by the Governing Body shall be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Review Committee, provided that the Governing Body may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Judicial Review Committee hearing.

Each party shall have the right to present a written statement in support of the party's position on appeal. If the appealing party chooses to submit a written statement, it shall be submitted at least ten (10) days prior to the date set for appellate review, and in its sole discretion, the Governing Body shall allow each party or representative, who may be an attorney, to appear personally and make oral argument. The Governing Body may place reasonable limits on such oral argument as to time and issues.

At the conclusion of oral argument, if allowed, the Governing Body may thereupon at a time convenient to itself, conduct deliberations outside the presence of the appellant and respondent and their representatives. The Governing Body may affirm, modify or reverse the decision of the Judicial Review Committee, or, in its discretion, refer the matter for further review and recommendation.

8.3-5 Final Decision

Within ten (10) days after the conclusion of the proceedings before the Governing Body, the Governing Body shall render a final decision in writing, which shall specify the reasons therefore. A copy of the text of the report to be provided to the National Practitioner Data Bank, if any, shall be included. Copies of such decision shall be delivered to both parties in person or by Special Notice.

8.3-6 Further Review

Except where the matter is referred for further review and recommendation in accordance with Section 8.3-4,the final decision of the Governing Body following the appeal procedures set forth in this Article 8 shall be effective immediately and shall not be subject to further review. Provided, however, if the matter is referred back to the Judicial Review Committee for further review and recommendation, said Committee shall promptly conduct its review

and make its recommendations to the Governing Body in accordance with the instructions given by the Governing Body. This further review process and the report back to the Governing Body shall in no event exceed thirty (30) days in duration except as the parties may otherwise stipulate.

8.3-7 Right to One Hearing

Only Except as otherwise provided in this Article 8, no applicant or member shall be entitled as a matter of right to more than one (1) hearing before the Governing Body on any single matter which may be the subject of an appeal without regard to whether such subject is the result of action by the MEC or the Governing Body, or a combination of acts of such bodies.

8.3-8 Allied Health Professional Review Procedure

All Allied Health Professionals credentialed by the Medical Staff shall be given the opportunity to have any of the following actions reviewed as described below, before it becomes final and effective (except for a summary restriction, which shall be effective immediately):

- Denial of an application for appointment or reappointment to Allied Health Professional status;
- Denial of a request for initial or additional privileges;
- Reduction in existing privileges
- Suspension or expulsion from Allied Health Professional status.

Notwithstanding the above, an Allied Health Professional shall have no right to obtain review in the following instances:

- When an application is denied because it is incomplete;
- When the action is taken because the physician who is required by law and by the medical Staff and hospital to act as the sponsor or supervisor of the Allied Health Professional has lost or withdrawn such sponsorship or supervision, or has lost or resigned his/her/their Medical Staff Membership or necessary privileges;
- When the action is taken because of the existence of a contractual, employment, or other relationship between the Hospital and one or more Allied Health Professionals in the affected category, which limits the number of Allied Health Professionals in that class who may practice at the Hospital.

a. Request for Review

To obtain review, the Allied Health Professional must submit a written request to the Chief Executive Officer of the Hospital. Such request must be received within fourteen (14) days of the notice to the Allied Health Professional that his/her/their application and/or privileges have been denied or reduced. If the Allied Health Professional does not request review in this manner, the Allied Health Professional shall be deemed to have waived any review rights.

b. Notice of Hearing

Review shall be in the form of a hearing before a panel. Within a reasonable time in advance of the hearing, the Chief Executive Officer shall give the Allied Health Professional written notice of the time and date of the hearing and a written summary of the reasons for the action. If possible, this summary should include reference to representative patient care situations or to relevant events.

c. Composition of Panel

The hearing shall be before an ad hoc panel consisting of at least three (3) persons appointed by the MEC. The MEC shall ensure that panel members have not participated earlier in the formal consideration of the case. The MEC shall designate one member of the panel as its chairperson and may include an Allied Health Professional in the appropriate category as a panel member.

d. Conduct of Hearing

The panel shall have discretion about how to conduct the hearing. The panel shall consult with the Hospital administration prior to making major decisions regarding the conduct of the hearing. The person or entity responsible for the action or recommendation shall have the opportunity to present evidence in the presence of the Allied Health Professional, and the Allied Health Professional shall have the opportunity to present evidence in rebuttal. Evidence presented may include documentary or physical evidence or testimony by witnesses. Each party shall have the opportunity to cross-examine adverse witnesses. The panel shall determine the order in which the evidence is presented and the relevance or appropriateness of the evidence offered. Formal rules of evidence shall not apply. The panel shall permit any evidence, which in its view is relevant and which reasonable persons are accustomed to rely upon in the conduct of serious affairs. The panel may in its discretion allow both sides to be represented by legal counsel. The panel itself may choose to be advised by legal counsel, who may also serve as a hearing officer, without regard to whether the parties are represented by counsel.

e. Record of Hearing

The panel shall maintain a record of the hearing by means of an electronic recording or a certified shorthand reporter. The Hospital shall bear the costs of the appearance of the certified shorthand reporter. The party requesting the original of the transcript shall bear the cost of the preparation of the transcript.

f. Decision of Panel

Within fourteen (14) days of the conclusion of the hearing, the panel shall decide, on the basis of the evidence presented at the hearing, whether to affirm, modify, or overturn the action that led to the hearing. The panel shall uphold the action unless it finds that it was arbitrary and unreasonable. The panel shall render its decision in writing.

g. Final Decision

The decision shall be forwarded to the Governing Body. The Governing Body shall decide whether to affirm, modify, or overturn the decision of the panel. The decision of the Governing Body shall be the final decision of the Hospital.

8.3-9 National Practitioner Data Bank Reporting

The Credentialing Specialist shall report an adverse action to the National Practitioner Data Bank only upon its adoption as final action and only using the description set forth in the final action as adopted by the Governing Body. The Credentialing Specialist shall report any and all revisions of the adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

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

ARTICLE 9

DEPARTMENTS

9.1 Organization

Each department shall be organized as a separate component of the Medical Staff and shall have a chairperson who shall be responsible for the overall supervision of the work within the chairperson's department.

Each department shall report to the Governing Body only through its representatives on the MEC.

The following are the existing medical Staff departments:

9.1-1 Medicine;

9.1-2 Surgery;

9.1-3 Pathology and Laboratory Medicine;

9.1-4 Diagnostic Imaging

9.1-5 Anesthesiology

The departments of Medicine and Surgery are comprised of several divisions.

9.2 Assignment to Departments

9.2-1 General Procedures

The MEC shall, after consideration of the recommendations of the department/division chief(s), as transmitted through the Credentials Committee, recommend to the Governing Body the assignment of each Medical Staff member to one department, and except in the Departments of Pathology, Diagnostic Imaging, and Anesthesiology, each member shall also be assigned to one division. Members so assigned shall receive all notices of department/division meetings to which they have been assigned. Such members shall have responsibilities and prerogatives in such assigned department/division consistent with the Medical Staff category and the requirements of these Bylaws.

9.2-2 Practitioners with Privileges in More Than One Department/Division

Qualified Practitioners may exercise privileges outside of their assigned department/division. Such Practitioners, upon request, shall receive notice of such outside department/division meetings and may attend and participate in all meetings of such department(s)/division(s) consistent with the prerogatives of their Staff category.

An Active Staff member with multiple department/division privileges may only vote or hold elective office in the assigned department/division unless such Active Staff member applies to the MEC for multiple department/division assignment. To be eligible for multiple department/division assignment, such member must apply to the MEC and must meet the following conditions:

a. Fulfill all attendance requirements of all such department(s)/division(s) to which the Active Staff member seeks multiple assignment for at least twelve (12) months prior to such application;

b. Possess privileges in the department/division;

c. Practice medicine within that department/division on a regular basis To retain eligibility for multiple department/division assignment, the member must thereafter continue to comply with such requirements. Practitioners granted multiple department/division assignment may vote and hold office in the department(s)/division(s) so assigned but may not simultaneously hold office in more than one division or department. Practitioners granted multiple division assignments within the same department may only exercise one (l) vote at department meetings.

9.3 The Organization of Departments

The President of the Medical Staff shall be responsible for the maintenance and functioning of the clinical organization of the Hospital and shall maintain, or cause to be maintained, supervision over all the clinical work done in the Hospital.

9.4 Functions of Departments

Departments shall conduct such business as is brought to them by the chairperson or the MEC, and may consider business brought to them by a department member or members. Such business shall include the following:

9.4-1 Development of Criteria

Each clinical department shall be responsible for the development of criteria, consistent with the policies of the Medical Staff, for the granting of Clinical Privileges in the department. The criteria for granting Clinical Privileges shall be developed at the division level and approved by the applicable department's chairperson, the Credentials Committee, the MEC and the Governing Body.

9.4-2 Review of Clinical Work

The departments shall be responsible for assuring that appropriate performance reviews are conducted on the clinical work of Practitioners within their respective departments and divisions. Such reviews will be conducted in a manner consistent with the Performance Improvement Plan and the Medical Staff Rules and Regulations regarding Ongoing Professional Practice Evaluation (OPPE) and may occur at department meetings, division meetings or at medical Staff committee meetings. Such clinical reviews shall be conducted on a regular schedule. For the Departments of Surgery and Medicine, clinical reviews shall

be conducted at the division level. In instances where this function is carried out at the division level, the department shall retain responsibility to assure that such function is being carried out appropriately.

9.4-3 Required Attendance

During any peer review proceedings, the department chairperson shall have the authority to require the attendance of the Practitioner undergoing review and such appearance shall be mandatory. The affected Practitioner shall be notified of the time and place of such meeting; such notice shall include a statement that the subject Practitioner's attendance shall be mandatory, shall state that the purpose of the meeting is in connection with peer review proceedings, and shall further state that failure to attend such meeting may result in suspension of the Practitioner's Clinical Privileges. Failure by such Practitioner to attend any such meeting shall be grounds for corrective action.

9.5 Qualifications, Selection, Tenure and Duties of Department Chairpersons

9.5-1 Departments of Medicine, Surgery, and Anesthesiology, Qualifications and Selection

a. Each Department chairperson shall be a member of the Active Staff in good standing qualified by training, experience and demonstrated leadership ability for the position. A department chairperson must be certified by a specialty board in the department chairperson's respective specialty/subspecialty.

b. Each chairperson shall be elected for a three (3) year term, subject to the approval of the MEC. The term of office shall coincide with the Medical Staff year (April 1 through March 31). If the same person is elected for two consecutive complete terms, they may not be elected again unless another person has been selected for at least one complete term in the interim.

c. The current chairperson shall choose a nominating committee comprised of three Active Staff members of the Department.

d. In or before the month of January of the year in which a chairperson's or department's MEC at-large representative's term expires, or at such other time as the position shall be vacated, the chairperson of a department shall arrange for the nominating committee to meet and nominate a department chairperson, or an appropriate number of MEC representatives at-large for the Department.

e. The nominating committee's selection(s) shall be made and announced to all department members no less than 20 calendar days prior to the election. The selection(s) shall be subject to the nominee's(ees') consent to serve in the position(s) and to comply with the medical Staff rules and policies regarding disclosure of interests.

f. After announcement of the nominee(s) selected by the committee, the chairperson shall also accept, no later than fifteen (15) calendar days before the election meeting, further nominations of those willing to run for the position(s). No additional nominations may be made after that time. Each nominee must be nominated by no less than two department members, must be willing to serve in the position, and must comply with the medical Staff rules and policies regarding disclosure of interests.

g. The chairperson shall promptly notify the President of the Medical Staff of all nominee(s) for the position.

h. Voting shall be conducted by secret ballot electronically, on paper, or an electronic voting process. Only Active Staff members within the department are eligible to vote. The candidate who receives the most votes will be elected. In the event of a tie, the election will be repeated between the two candidates with the highest number of votes.

i. Neither the Governing Body, nor any board member, nor any person within hospital administration shall take any actions intended to influence who the nominees are, the nominations process, the outcome of the elections or the decision of the MEC to approve the elections.

j. The election of a chairperson shall not become final until it is approved by the MEC. In the event the elected chairperson is not approved by the MEC by the beginning of the Medical Staff Year, the President shall appoint an interim acting chairperson in accordance with this Article until such time as a new Chairperson is approved by subsequent election of the members of the Department and approved by the MEC.

k. Except as specified in subsection (j) above, the new chairperson will be installed at the annual Medical Staff meeting and will assume his/her/their duties on April 1.

l. Except as otherwise provided in these Bylaws, removal and replacement of a departmental chairperson and department representative at-large shall be as set forth in ARTICLE 12

m. If a chairperson is removed from the MEC, the chairperson shall be automatically removed from the position of chair of the department.

9.5-2 Departments of Pathology and Diagnostic Imaging

Each chairperson shall be a member of the Active Staff in good standing qualified by training, experience, and demonstrated leadership ability for the position. The Departments of Pathology and Diagnostic Imaging shall have chairpersons certified by a Specialty Board in the chairperson's respective specialty. The chairpersons shall be selected and approved by the MEC for a three year term no later than its March meeting or, if filling a vacancy before the end of a chairperson's regular term, as specified in Article 12. Upon consideration of the appointment of a chairperson, the MEC shall obtain the candidate's consent to serve in the position and to comply with the medical Staff rules and policies regarding disclosure of interests. A chairperson may be removed as set forth in ARTICLE 12.

9.5-3 Duties of Department Chairpersons

In the Departments of Medicine and Surgery, specific responsibilities may be delegated by the chairperson to the appropriate division chief; however, department chairpersons shall remain ultimately responsible for all duties enumerated in this section. The authority, duties and responsibilities of the department chairpersons shall include the following:

a. Clinically related activities of the department including developing and implementing policies and procedures that guide and support the provision of all clinically related services within the department. These duties include, but are not limited to:

1. establishing, together with medical Staff and administration, the type and scope of services required to meet the needs of the patients and the hospital as it relates to the services provided within the department;

2. developing and implementing policies and procedures that guide and support the provision of care, treatment and all other clinically related services within the department;

3. in consultation and cooperation with members of the department, recommending to the MEC the criteria for Clinical Privileges for members that are relevant to care provided in the department;

4. continuing surveillance of the professional performance of all individuals with Clinical Privileges in the department which shall include generally assuring that the quality of patient care and clinical performance rendered by members with Clinical Privileges in the department is being regularly monitored through a planned and systematic process;

5. maintaining quality control programs for the department, and continuously assessing and improving the quality of care, treatment, services and patient safety in the Department;

6. making recommendations on all applications and reapplications for Membership within the department, and on all applications for Clinical Privileges within the department;

7. determining the qualifications and competence of department personnel who are not licensed independent Practitioners and who provide patient care, treatment and services;

8. making recommendations for a sufficient number of qualified and competent persons to provide care, treatment and services;

9. assuring an adequate orientation and the continuing education of all persons in the department;

10. recommending to the relevant hospital authority, and assisting in accessing, off-site sources for needed patient care, treatment and services not provided by the department or otherwise available in the hospital;

11. Determining whether the resources needed for the privileges are sufficient, including whether sufficient space, equipment, Staffing, and financial resources are in place or available within a specified time frame to support each requested privilege of members within the Department. Recommendations regarding resources are forwarded to the relevant hospital authority.

b. Administratively-related activities of the department. These duties and responsibilities include, but are not limited to:

1. acting as presiding officer at departmental meetings;

2. integration of the department into the primary functions of the hospital organization;

3. coordination and integration of interdepartmental and intradepartmental services;

4. recommending to the MEC space and other resources needed by the department;

5. assisting in the preparation of such annual reports, including budgetary planning, pertaining to his/her/their department as may be required by the MEC or the Governing Body;

c. endeavoring to enforce the Medical Staff Bylaws, Rules and Regulations, and departmental rules, policies and regulations, and policies of the Hospital as those Hospital policies affect delivery of patient care or medical Staff operations. In the event the Department Chair disagrees with enforcement of a hospital policy, the matter must be referred to the MEC for review and decision. In the event the MEC determines enforcement of a hospital policy would be inappropriate, the dispute resolution mechanisms under section 12.2-5 shall apply.

d. implementing within the department appropriate actions taken by the Medical Executive Committee and by the Governing Body; and

e. performing such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff, the MEC, or the Governing Body.

9.6 Performance of Duties in Absence of Chairperson

When a chairperson is unavailable, the chairperson shall have the responsibility to appoint a designee who shall, in the chairperson's absence, temporarily assume the chairperson's full duties and authority.

9.7 Departmental Meetings

9.7-1 Except as otherwise specified in these Bylaws, the chairperson of departments shall establish times and dates for the scheduling of regular meetings. The chairpersons shall make every effort to assure that a list of scheduled departments meetings for the Medical Staff year is published in advance.

9.7-2 Minutes of all department meetings shall be recorded, signed by the chairperson, and submitted to the MEC.

9.8 Divisions

9.8-1 Creation of Division A division shall be created when the number of patients, the autonomous character of its work, or the number of active members makes it advisable to organize for periodic review of the professional activities and privilege evaluation of members in the specialty.

Additional divisions may be organized within a department by application for approval to the MEC by a group of members from the department and transmitted through the chairperson of the department.

If a division ceases to function, that fact shall be reported to the MEC by the department chairperson for the purpose of deleting the division from the list of recognized divisions.

9.8-2 Medical Staff Divisions

a. Department of Medicine

- Adolescent Medicine
- Allergy/Immunology/Rheumatology
- Cardiology
- Center for Child Protection
- Critical Care Medicine
- Dermatology
- Diabetes and Endocrinology
- Emergency Medicine
- Gastroenterology
- Hematology/Oncology
- Infectious Diseases
- Medical Genetics
- Mental Health and Child Development
- Neonatology
- Nephrology
- Neurology
- Pediatric Rehabilitation
- Pediatrics and General Medicine
- Pulmonary Medicine

b. Department of Surgery

- Dentistry
- Pediatric and General Surgery
- Neurosurgery
- Ophthalmology
- Orthopedics
- Otolaryngology/HNS/Oral and Maxillofacial Surgery

- Plastic Surgery/Reconstructive and Hand Surgery
- Thoracic Surgery
- Urology

9.8-3 Functions of Divisions

The responsibilities and functions as are delegated to the respective divisions shall be comparable to those responsibilities and functions granted departments, subject to the overall authority and responsibility of the department to which they report. Those responsibilities and functions shall generally include the responsibility: (1) to develop criteria for the granting of privileges within the division; (2) to review the performance of Practitioners within the division; and (3) to oversee the improvement of the quality of care within the division.

9.8-4 Qualification, Selection and Tenure of Division Chiefs

a. Each division chief shall be an Active Staff member in good standing of the division and qualified by training and demonstrated leadership ability for the position. Except for psychologists, a division chief must be certified by a Specialty Board in the division chief's respective specialty/subspecialty. The term of office shall coincide with the Medical Staff year (April 1 through March 31). All division chiefs shall have three (3) year terms. The term of office shall coincide with the Medical Staff year (April 1 through March 31).

b. Division Chiefs shall be selected as follows:

1. In or before the month of January of the year in which a division chief's term expires, or at such other time as the position shall be vacated, the current division chief shall collaborate with the Department Chair and division members to identify qualified nominees. Any nominee must be willing to serve in the position, and must comply with the Medical Staff Governing Documents regarding disclosure of interests.

2. The chief shall promptly notify the department chair and the President of the medical Staff of all nominee(s) for the position.

3. The election shall be held at least thirty days prior to the end of the current division chief's term. Voting may be conducted by secret ballot, on paper, or an electronic voting process. The candidate with the most votes will be elected. In the event of a tie, the election will be repeated between the two candidates with the highest number of votes.

4. The election of a chief shall not become final until it is approved by the MEC. In the event the elected chief is not approved by the MEC by the beginning of the Medical Staff Year, the President shall appoint an interim acting division chief in accordance with Section 9.10 until such time as the new chief is approved by subsequent election of the members of the division and approved by the MEC.

5. New chiefs will be installed at the annual Staff meeting and will assume their duties on April 1, subject to final confirmation by the MEC.

6. Neither the Governing Body, nor any board member, nor any person within hospital administration shall take any actions intended to influence who the nominees are, the nominations process, the outcome of the elections, or the decision of the MEC to approve the elections or to appoint division chiefs.

9.8-5 Removal of Division Chiefs

a. Removal of Division Chiefs shall be effected as follows:

1. Removal of an appointed Division Chief shall be made upon recommendation of the chairperson of the appropriate department and approval of the MEC, based on any grounds specified under subsection iii of this subsection a.

2. Removal of an elected Division Chief during the Division Chief's term of office may be initiated by a two- thirds (2/3) majority vote of all Active Staff members of the division, but no such removal shall be effective unless and until it has been approved by the MEC.

3. Removal of any Division Chief may be effectuated at any regular or special meeting of the MEC at its discretion, by majority vote and on proper motion, based on grounds of:

1. failure to fulfill the duties and/or carry out the responsibilities of the office;

2. physical or mental infirmity to a degree that renders the office holder unable to fulfill the duties and/or carry out the responsibilities of the office;

3. failure to demonstrate character, ethics and/or leadership of a caliber expected of a medical Staff leader;

4. violation of the Medical Staff Standards of Professional Conduct or other applicable governing documents;

5. serious acts of moral turpitude; or

6. conduct detrimental to the interests of the medical Staff, its operations or functions.

9.8-6 Duties of Division Chiefs

Division chiefs shall:

a. Be accountable for all clinical activities within the division chief's division.

b. Maintain a continuing review of the clinical performance of all Practitioners with Clinical Privileges in the division chief's division.

c. Assure the division complies with Ongoing Professional Practice Evaluation (OPPE) included in the Medical Staff Rules and Regulations.

d. Report regularly thereon to the department chairperson who shall transmit this information to the MEC.

e. Transmit to the MEC through the department chairperson and the Credentials Committee his/her/their division's recommendations concerning the Staff classification, the renewal of Membership and delineation of Clinical Privileges for all Practitioners in the division;

f. Be responsible for the teaching, education and research programs in the division chief's division in matters affecting patient care; and

g. Assist in the preparation of such reports, including budgetary planning, pertaining to the division chief's division as may be required by the MEC.

h. Assume such other duties and responsibilities as are delegated to the division chief by the chairperson of the department or President of the Medical Staff.

9.9 Special Meetings

9.9-1 Special Meetings

a. The chief of a department/division may call a special meeting of said department/division at any time.

b. The chief of a department/division shall call a special meeting within ten (10) days after receipt of a written request for the same signed by not less than ten percent (10%) and a minimum of two (2) of the Active Staff of the department/division and stating the purpose for such meeting.

9.9-2 Telephone, written or printed notice stating the place, day and hour of any special meeting of the department/division shall be delivered, either personally or by mail or electronically, to each Active Staff member in such department/division of not less than two (2) nor more than ten (10) days for the date of such meeting, by or at the direction of the chief of the department/division.

9.9-3 No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

9.10 Filling Vacancy of Division Chief.

9.10-1 In the event of vacancy of a division chief for any reason in a division of four or less members, the Department Chair shall fill the vacancy by appointment of a new chief, and that appointee shall serve out the remainder of the term for that position. In the event of a vacancy for any reason of a division chief in a division of more than four (4) members, the Department Chair shall fill the vacancy until elections are held as described in this section. In that case, if the vacancy occurs in the calendar year just prior to the year in which the division chief's service is to normally terminate under section 9.8-4, then the division chief appointed by the Department Chair shall serve out the remainder of the term for that position. Otherwise, the Department Chair shall cause elections to be held for a new division chief to serve out the remainder of the term for that position. The Department Chair shall employ substantially the same process and timelines set forth in 9.8-4, adjusted for the fact that the election is not taking place in the regular election month and year. The Department Chair's selection of the active division chief requires no approval by the MEC before it is effective. The election of a division chief requires MEC approval to be effective.

9.10-2 Prior to filling the vacancy by election, the President of the Medical Staff shall provide the identity of the nominee(s) to the Governing Body.

9.10-3 A vacancy in the office of Department Chair and at-large representation shall be filled as set forth in section 9.5-1.

ARTICLE 10

OFFICERS

10.1 Officers of the Medical Staff

The officers shall be the President, President-Elect (Vice President), Immediate Past President, and Secretary- Treasurer.

10.2 Qualifications of Officers

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

10.3 Election of Officers

10.3-1 A nominating committee shall be established. The nominating committee will nominate one (1) or more names for President-Elect and Secretary-Treasurer. The nominating committee will be composed of five (5) members of the Active Staff as follows:

a. The immediate Past President who shall chair the Committee;

b. The President of the Medical Staff;

c. One (1) Active Staff member each from the Departments of Medicine and Surgery elected by each department after due notification; neither member so elected may be a member of the MEC

d. One (1) MEC member selected by the MEC who may not be the President-Elect.

10.3-2 Only members of the Active Medical Staff shall be eligible to vote. Voting shall be by secret ballot.

Ballots will contain a provision for write-in candidates and will be sent, electronically or by mail, or using an approved electronic voting system to all voting members of the Staff three (3) or more weeks prior to the annual Staff meeting. Ballots must be received by four (4) p.m. on the day prior to the annual Staff meeting. Three (3) tellers, appointed by the President of the Staff, will count the votes. The results of the election will be announced and the officers installed at the annual Staff meeting. The officers will take office April 1.

In situations where there are three (3) or more candidates and no candidates receive a majority, there will be successive balloting with the name of a candidate receiving the fewest votes being omitted from each successive slate until a majority vote is obtained by one (1) candidate.

10.4 Term of Office

The term of office for all officers shall commence on April 1 and shall last for two (2) years.

10.5 Vacancies in Office

Vacancies in unexpired terms of elected officers will be filled by action of the MEC.

10.6 Responsibilities of Officers

10.6-1 President

The President shall serve as the Chief Administrative Officer of the Medical Staff with all duties outlined in these Bylaws. The President shall act in coordination with the Chief Executive Officer in all matters of mutual concern within the Hospital.

The President shall call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.

The President shall serve as Chairperson on the MEC, serve as Chairperson on the Medical Services Review and Planning Committee for the first six (6) months of the President's term and serve as a member thereafter, and the President shall serve as an ex-officio member of the following committees with vote: Joint Conference, Bylaws, Quality Improvement, Credentials and Utilization Management.

The President shall serve on the following Boards: (1) Hospital Board of Directors and such Hospital committees to which the President may be appointed (e.g., Finance, Strategic Planning, Human Resources, Quality Improvement, and Facilities Planning; (2) the Hospital Foundation Board of Trustees.

The President shall be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner.

Except as otherwise provided in these Bylaws and in the Rules and Regulations, the President shall appoint all committee chairs and, in consultation with the chairs, appoint members to all committees except the MEC.

The President shall receive and interpret the policies of the Governing Body to the Medical Staff, and report to the Governing Body on the performance of the Medical Staff.

The President shall be responsible for the educational activities of the Medical Staff; and be the spokesman for the Medical Staff in its external professional and public relations.

10.6-2 President-Elect (Vice President)

In the absence of the President, the President-Elect shall assume all the duties and have the authority of the President. The President-Elect shall automatically succeed the President when the latter's term expires, or in the event the President fails to serve or is unable to serve for any reason.

The President-Elect shall serve on the Medical Services Review and Planning Committee and take over as Chairperson for the last six (6) months of the President-Elect's term. The President-Elect shall also serve on the following committees:

a. MEC

b. Joint Conference

c. Continuous Quality Improvement

The President-Elect shall serve on the Hospital Board of Directors and on Hospital committees to which the President-Elect may be appointed.

By mid-term the President-Elect should begin to consider who the President-Elect will be appointing to committee chairs and to committee Membership positions upon assuming the President-Elect's responsibilities as President and should begin discussing such appointments as appropriate.

By mid-term the President-Elect should begin making preparations for the next Medical Staff retreat (usually held in May).

The President-Elect is expected to assume such other responsibilities as may be assigned by the President.

10.6-3 Immediate Past President

The Immediate Past President shall be a member of the MEC. The Immediate Past President shall serve in an advisory capacity, and, in the event that the President and President-Elect are unable to function, the Immediate Past President will serve as President until the MEC appoints a successor.

The Immediate Past President shall serve on the following committees:

a. MEC

b. Joint Conference The Immediate Past President shall serve on the Hospital Board of Directors.

The Immediate Past President shall continue to serve on projects started during the Immediate Past President's term as President where the Immediate Past President's continued personal involvement is important and shall assume such other duties and projects as requested by the President.

10.6-4 Secretary-Treasurer

The Secretary-Treasurer shall be a member of the MEC. The Secretary shall keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meetings on order of the President, attend to all correspondence and perform such other duties as ordinarily pertain to the Secretary's office. The Secretary shall account for Medical Staff funds.

10.7 Removal of Elected Officer

Any medical Staff officer may be removed from office for valid cause, including but not limited to, significant violation of the Medical Staff Bylaws, Rules and Regulations or other medical Staff policy; gross neglect or misfeasance in office, or serious acts of moral turpitude in accordance with Section 12.2-1.b.

ARTICLE 11

ADMINISTRATIVE AND MEDICO-ADMINISTRATIVE PRACTITIONERS

11.1 Practitioners Employed or Under Contract

Except for Practitioners enrolled in a formal training program (such as a resident or fellowship program) at the Hospital, Practitioners employed or under contract with the Hospital are required to be members of the Medical Staff and are subject to these Bylaws and Rules and Regulations.

The Credentials Committee shall cooperate with the Governing Body in reviewing the credentials of all Practitioner applicants for employment by the Hospital in order to assure a mechanism that qualifies such employees for regular Membership on the Medical Staff. The procedures to be followed in processing applications for regular Medical Staff appointment, and for continuing Staff privileges, shall be applicable to and controlling on such employed Practitioners as set forth in this Article.

Where such employment or contractual arrangement is terminated, it shall not result in termination of existing Medical Staff privileges, unless otherwise provided in an exclusive Hospital-Practitioner contract.

ARTICLE 12

COMMITTEES

12.1 Organization of Committees

a. Unless otherwise provided in these Bylaws, the President of the Medical Staff shall appoint all standing committees at the beginning of the Staff year.

b. Unless otherwise provided in these Bylaws, the President of the Medical Staff shall also designate a Medical Staff member as chairperson for each committee.

c. Chairpersons of standing committees may be requested to attend the MEC at the request of the President of the Staff..

d. Unless otherwise provided in these Bylaws, the chair of each committee shall be responsible for selecting, in consultation with the President of the Medical Staff, the members of the committee.

12.1-1 Types of Committees

a. The MEC and the other committees described in these Bylaws and the Rules and Regulations of the Medical Staff shall be the standing committees of the Medical Staff.

b. Special or ad hoc committees may be created by the MEC, Medical Staff President, departments or divisions to perform specified tasks. Any committee, whether Medical Staff-wide or department or division, or standing or ad hoc, that is carrying out all or any portion of a function or activity required by these Bylaws and/or the Rules and Regulations of the Medical Staff is deemed a duly appointed and authorized committee of the Medical Staff.

c. The existence of any committee, standing, special or ad hoc, shall cease upon completion of its purposes for which it was organized. Except as otherwise expressly provided, committees act in an advisory capacity and report to the MEC.

12.1-2 Quorum

Forty percent (40%) or three (3) voting members of any committee, whichever is more, unless otherwise provided in these Bylaws, shall constitute a quorum. If a quorum is not present, all action items and supporting documentation shall be forwarded to the MEC.

12.1-3 Staff Support

The Manager of Medical Staff Services or designee may attend and provide Staff support to Medical Staff Committee meetings.

12.1-4 Ex Officio Members

a. Unless otherwise indicated, persons serving under these Bylaws designated as ex officio members of a committee, shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum, shall not be entitled to vote, and may attend executive sessions of the committee upon specific invitation by the chair unless otherwise provided.

b. The President and the President-Elect and Immediate Past President shall be voting ex officio members of all Medical Staff committees. Except for attendance at the MEC, or as otherwise specified in these Bylaws, when attending a meeting of a Medical Staff Committee, the Immediate Past President shall not vote if either the President Elect or President are present, and the President Elect shall not vote if the President is present.

12.1-5 Appointment of Trainees/Hospital Personnel

The President may appoint trainees (physicians in residency or fellowship training programs) and other Hospital personnel to any medical Staff committee. Such personnel shall vote and be counted for purposes of deciding a quorum only if permitted by the Chairperson or by the rules of the committee.

12.1-6 Minutes

Minutes shall be maintained of all Medical Staff committee meetings. When appropriate, copies of such minutes shall be forwarded to the MEC.

12.1-7 Policies, Rules and Procedures

When written policies, rules and procedures are developed by a committee to assist it in fulfilling its functions, such rule shall be adopted as medical Staff policy provided in Section 17.4.

12.1-8 Confidentiality of Meetings and Meeting Records

Meetings of Medical Staff committees, including meetings of departments and divisions or committees thereof, shall conduct their proceedings as committees of this Medical Staff, having the responsibility for the evaluation and improvement of the quality of care rendered in this Hospital. Accordingly, the minutes, files, records and proceedings of such committees, including files containing information regarding any applicant or member, shall be afforded the fullest protections under California law. Such information shall be treated with strictest confidentiality within the Hospital and Medical Staff and dissemination of such information and records shall only be made where expressly required by law or pursuant to officially adopted policies of the Medical Staff or when determined by the MEC to be in furtherance of important activities of the medical Staff.

12.1-9 Breach of Confidentiality of Peer Review Records

Inasmuch as effective peer review and appropriate consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on

free discussions in Medical Staff committee meetings, any breach of confidentiality of the discussions and deliberations of such committees is considered below the professional and ethical standards of the Medical Staff and disruptive to the operations of the Hospital.

If it is determined that such a breach has occurred, the MEC shall undertake appropriate corrective actions which may include suspension or termination of eligibility to hold office or to serve as a member of Medical Staff committees. The confidentiality and other legal protections which attach to the proceedings and actions of Medical Staff committees shall pertain to departmental/divisional meetings and to any committees therein.

12.1-10 Consultants

The Membership of any Medical Staff committee may be augmented by the addition of consultants who are not members of the Medical Staff. Such consultants shall be appointed by the President of the Staff. All communications and records of such consultants, written and oral, shall be deemed part of the records and proceedings of the applicable committee and shall be viewed in strictest confidence, and disclosed only as authorized in written policies governing the confidentiality of Medical Staff committee records and files. The participation of consultants shall inform but shall not replace medical Staff peer review.

12.1-11 Representation on Hospital Committees and Participation in Hospital Deliberations

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

12.1-12 Removal

If a member of a committee ceases to be a member in good standing of the medical Staff or if any other good cause exists, that member may be removed by the MEC.

12.1-13 Vacancies Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that if an individual who obtains Membership by virtue of these Bylaws is removed for cause, a successor may be selected by the MEC.

12.2 Standing Committees

The standing committees are limited to the following:

12.2-1 MEC

a. Composition

The MEC shall be composed of the Officers (President, President-Elect, Immediate Past President, Secretary-Treasurer), Chair of the Department of Medicine, Chairman of the Department of Surgery, Chair of the Department of Pathology, Chair of the Department of Diagnostic Imaging, Chair of the Department of Anesthesiology, a representative from the residency program (e.g. the director or associate director), and three (3) Active Staff representatives at-large from the Department of Medicine (one of whom shall be an active or courtesy Staff community pediatrician) and two (2) from the Department of Surgery. The Chief Executive Officer, Chief Medical Officer, and Medical Director of Quality

Improvement shall serve as members ex officio as defined in this article. No member of the Active Medical Staff shall be considered to be ineligible to serve on the MEC solely because of the Active Medical Staff member's professional discipline or specialty. Only physicians may fill the offices of President and President-elect.

The President of the Medical Staff shall serve as the chair of the MEC. No elected department representative at-large shall hold office for more than two (2) consecutive complete terms.

b. Removal for Cause

1. Basis for removal. Any medical Staff member of the MEC may be removed from office for valid cause, including but not limited to failure to perform the duties expected of an MEC member, Department Chair, or department representative at-large; significant violation of the Medical Staff Bylaws, Rules and Regulations or other medical Staff policy; gross neglect or misfeasance in office; or serious acts of moral turpitude. This paragraph shall not apply to the Chief Executive Officer, Vice President of Medical Affairs, Chief Medical Officer or Medical Director of Clinical Quality.

2. Removal of Officers by Vote of the Medical Staff. The process of removal may be initiated by the Medical Staff by 2/3 of those present at any regular or special meeting thereof. No such action shall take effect until it has been ratified by a two-thirds (2/3) vote of all members of the MEC.

3. Removal by Vote of the MEC. The MEC may remove a member under this provision on its own initiative by a 2/3 vote of all voting members of the MEC at any regular or special meeting of the MEC. This provision shall not apply to removal of the President, President-Elect or Treasurer, which removal shall be reserved for the process set forth by vote of the general Medical Staff.

4. Removal of department chair or representative at-large by department. Removal of a department chair or departmental representative at-large to the MEC may be accomplished by a 2/3 vote of all Active Staff members of the department, but no such action shall take effect until it has been ratified by a two-thirds (2/3) vote of all voting members of the MEC at any regular or special meeting of the MEC.

5. Automatic removal from department position. Any department Chairperson or department representative at-large removed from the MEC under this section shall automatically be removed from the position of chair of the department, or position as department representative at-large, respectively.

6. Filling Vacancies: During period of vacancy, the President of the Medical Staff shall appoint a member of the active Staff from the appropriate department as applicable to serve on the MEC on an interim basis until the vacancy is filled. A vacancy on the MEC caused by removal of a Medicine or Surgery Department Chair, or any of representative at-large of such department sitting as an MEC member, shall be filled within 30 days by vote of the affected department. A vacancy on the MEC caused by removal of a Chair of Pathology or Diagnostic Imaging shall be filled at the next MEC meeting by vote of the MEC.

c. Duties

The duties of the MEC, as delegated by the Medical Staff, shall include, but not be limited to:

1. Representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, except for elections and Bylaws adoption and amendment and subject to such other limitations as may be imposed by these Bylaws. The MEC is accountable to the Medical Staff and reports its actions at each medical Staff meeting

2. Development of all Medical Staff Rules & Regulations (as consistent with these Bylaws) and policy;

3. Coordinating and implementing the professional and organizational activities and policies of the Medical Staff;

4. Receiving and acting upon reports and recommendations: from Medical Staff departments, divisions, committees, and assigned activity groups;

5. Recommending action to the Governing Body on matters of a medico-administrative nature

6. Evaluating the medical care rendered to patients in the Hospital;

7. Periodically reviewing the structure of the Medical Staff, including mechanisms to review credentials and delineate individual Clinical Privileges, the organization of performance improvement activities, termination of Medical Staff Membership and fair hearing procedures, as well as other matters relevant to the operation of an organized Medical Staff and recommending action to the Governing Body as appropriate;

8. Regularly reporting to the Governing Body through the President of the Medical Staff the outcomes of Medical Staff performance improvement programs with sufficient background and detail to assure the Governing Body that quality of care is consistent with professional standards;

9. Participating in the development of all Medical Staff and Hospital policy, practice and planning. The MEC shall enforce hospital policy that has been communicated reasonably to the Medical Staff. In the event the MEC disagrees with a proposed new or revised hospital policy, the dispute resolution mechanisms under section 12.2-5 shall apply.

10. Reviewing the qualifications, credentials, performance and professional competence and character of applicants and Staff members and making recommendations to the Governing Body regarding Staff appointments and reappointments, assignments to departments/divisions, Clinical Privileges, and corrective action;

11. Taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members, including the initiation of and participation in Medical Staff corrective or review measures when warranted;

12. Taking reasonable steps to develop continuing education activities and programs for the Medical Staff;

13. Designating and creating such committees as may be appropriate or necessary to assist in carrying out the functions of the Medical Staff;

14. Reporting to the Medical Staff at each regular Staff meeting;

15. Assisting in the obtaining and maintaining of accreditation and licensure of the Hospital;

16. Developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster;

17. Reviewing and establishing assessments, dues and the initial application fee on an annual basis in accordance with these Bylaws;

18. Establishing the limits for the professional liability insurance requirement, as specified in Section 3.1.

19. Oversight of the Medical Staff participation in the hospital wide Performance Improvement and Safety Programs;

20. Provides oversight and input in the process of analyzing and improving patient satisfaction;

21. Adopting a medical Staff budget annually.

d. The MEC may request the assistance of the Chief Medical Officer or designee in discharging these responsibilities.

e. The Medical Staff can remove the MEC's delegated authority by amending the Medical Staff Bylaws, Rules and Regulations, or policies as otherwise provided in these Bylaws.

f. Absences from the MEC Meeting. If a member of the MEC misses more than three (3) meetings within a rolling twelve (12) month period, the member may be removed by the vote of the MEC. This provision shall not apply to administration personnel who are ex officio members of the MEC.

g. Meetings

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

12.2-2 Bylaws Committee

a. Composition

This committee shall consist of at least five (5) members of the Medical Staff; including, where feasible, a Past President of the Medical Staff and at least one (1) other member of the MEC; and one (1) representative from Administration who shall be ex officio member without vote.

b. Duties

This committee shall be responsible for a continuing review and updating of the Bylaws, Rules and Regulations and Policies of the Medical Staff. The committee shall annually review hospital Bylaws, rules and related policy to promote collaboration and compliance with the medical Staff Bylaws.

c. Meetings

This committee shall meet at least yearly and more frequently as needed.

12.2-3 Credentials Committee

a. Composition

This committee shall consist of the Chief Medical Officer as ex officio non-voting, , the President of the Medical Staff, the Chairperson of the Departments of Medicine and Surgery, and at least three (3) division chiefs appointed by the President of the Medical Staff. The chairperson shall be appointed by the President of the Medical Staff.

b. Duties

The duties of this committee shall include:

1. the investigation, and review of the qualifications of all applicants and reapplicants for Medical Staff Membership and Clinical Privileges, and making recommendations to the MEC about such applications;

2. assignment of applicants and members to departments/divisions; and this committee shall have such other responsibilities as may be assigned to it by the MEC.

c. Meetings

This committee shall meet as often as necessary, but at least nine (9) times per year, and shall maintain a permanent record of its proceedings.

12.2-4 Joint Conference Committee

a. Composition

The Joint Conference Committee shall be composed of an equal number of members of the Governing Body and of the medical Staff, five from each as selected by the Governing Body and the MEC respectively. The medical Staff members shall at least include the President of the medical Staff, the President-elect, and the immediate past President or another past president if not available. The Governing Body members shall at least include the Governing Body chair, vice-chair, and Chief Executive Officer (CEO). The chair of the committee shall alternate every other meeting between the Governing Body and the Medical Staff.

b. Duties

The duties of this committee shall include providing a forum for the free and open discussion of any aspect of Hospital or medical Staff policy, practice or procedure that may reasonably be a subject to a group of this composition. This committee shall facilitate direct communication between the Governing Body, the medical

Staff, and the Administration. The Joint Conference Committee shall report to the MEC and to the Governing Body. The Committee shall have the following specific duties:

1. shall serve as the mechanism for managing conflict between leadership groups so as to assure a high quality of care and/or patient safety;

2. As appropriate, shall consult with and/or utilize individuals skilled in conflict management as issues arise:

3. Periodically review educational material relating to conflict management;

4. Assures a process is in place for review and discussion of conflict between leadership groups and/or individuals which includes:

    - Meeting with involved parties as early as possible to identify the conflict

    - Gathering information regarding the conflict

    - Working with parties to manage and when possible, resolve the conflict

    - Assuring high quality of care and patient safety are maintained throughout the process

Conflicts within the medical Staff will be subject to conflict management processes set forth in the Medical Staff Bylaws.

c. Meetings

The Joint Conference Committee shall meet at least annually, and shall transmit written reports of its activities to the MEC to the Governing Body, including any recommendations of the committee.

d. Disputes with the Governing Body

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

1. Invoking the Dispute Resolution Process. The MEC may invoke the good faith dispute resolution processes under this section, upon its own initiative, or upon written request of 25% of the members of the active Staff. The Governing Body may invoke the good faith dispute resolution process under this section, upon its own initiative.

2. Dispute Resolution Forum

    1. Ordinarily, the initial forum for dispute resolution shall be the Joint Conference Committee, which shall meet and confer as further described in subsection (b) of this section.

2. However, upon request of at least 2/3 of the members of the MEC, or of at least 2/3 of the members of the Governing Body (as the term "Governing Body" is defined herein) the dispute resolution forum will be conducted by a meeting of the full MEC and the full Governing Body, or a subcommittee agreed upon by both parties. A neutral mediator acceptable to both the Governing Body and the MEC may be engaged, but is not required, to further assist in dispute resolution if both the Governing Body and the MEC agree.

ARTICLE 13

MEDICAL STAFF MEETINGS

13.1 The Annual Meeting

The annual Staff meeting shall be held within thirty (30) days of the end of the Staff year of the Hospital. At this meeting, the President of the Medical Staff shall make an annual report and the new Medical Staff officers shall be installed. At the President's discretion, the officer of the Medical Staff, the chiefs of departments, and the standing committees shall make their annual reports, along with reports of any special committees.

13.2 Regular Meetings

The Medical Staff shall hold general Staff meetings for education purposes and to conduct business, as called by the President of the Staff.

13.3 Special Meetings

13.3-1 Calling Special Meetings

The President of the Medical Staff may call a special meeting of the general Medical Staff at any time. Except as provided in Article 17 relating to meetings of the medical Staff in amending governing documents, the President shall hold a special meeting within ten (10) days after receipt by the President of a written request for same signed by not less than twenty-five percent (25%) of the Active Staff and stating the purpose for such meeting.

13.3-2 Notification of Special Meetings

Each member entitled to attend shall receive notice of the special meeting including the place, day and hour of the meeting not less than two (2) days before the date of such meeting.

13.3-3 Agenda - Special Medical Staff Meetings

The agenda at special meetings shall be:

a. Reading of the notice calling the meeting;

b. Transaction of business for which the meeting was called;

c. Adjournment.

13.4 Decorum for All Meetings

All persons must conduct all business and discussions at any meeting of the general medical Staff or a medical Staff committee with courtesy, respect and professionalism. Hostile or offensive commentary, or disruptive behavior, shall be grounds for the presiding member, the general medical Staff, or the committee, to expel such individual(s) engaging in such behavior from the meeting room, or terminating all discussion if the individual(s) does not cooperate in leaving.

13.5 Executive Sessions

At the call of the meeting chair, the Medical Staff, any Medical Staff committee or department/division may meet in executive session. Attendance at executive session shall include [1] voting members of the meeting body, [2] a recording secretary, who may be a member of the meeting body, [3] advisors, consultants, or other attendees requested to attend by the chair, and [4] ex officio members if they are invited to attend by the chair.

13.6 Conflict and Dispute Management

13.6-1 Issues Raised by a Medical Staff Member. Any medical Staff member(s) may forward a communication to the MEC, or any MEC member, about any issue affecting the member or the Membership which, in the opinion of the member, requires MEC involvement for its resolution. The President of the Medical Staff may take any action as the President feels appropriate, including but not limited to, determining that no action is necessary, discussing the matter with the member(s) in an attempt to resolve the issue, and/or including such communication on the agenda of a meeting of the MEC for review and discussion, and possible action.

13.6-2 Issues Raised by 15% of the Active Members of the Medical Staff. Upon presentation of a petition signed by fifteen percent (15%) of active medical Staff members, two persons designated by the petition may attend an executive session of the MEC to discuss an issue of perceived or actual dispute or conflict between the petitioners and the MEC. The petition must set forth with clarity the nature of the issue, dispute or conflict, the interest(s) of petitioners in the dispute or conflict, and one or more suggested resolutions or mitigations of the matter. The executive session shall be held at the next MEC meeting that is more than fifteen calendar days after formal presentation of the petition. The President of the Medical Staff shall be responsible for notifying the petitioners' representatives of the time and date of the appearance at Executive Session, and of the amount of time that the MEC will reasonably dedicate in discussion with the representatives.

The President or the President's designee on the MEC shall preside over the MEC discussion with the representatives. The MEC may discuss the matter further in executive session after the joint discussion concludes and the petitioners' representatives depart, or take such further action as it may choose. The President shall promptly notify the petitioners' representatives of the MEC's decisions or conclusions arising from the joint discussion, or if no decision or conclusion is forthcoming, the next steps in deliberations, if any, that the MEC may plan to make on the issues presented in the joint discussion.

13.6-3 No Violation of Law, Governing Rules, or Accreditation Standards. These conflict and dispute management provisions shall not serve to permit or validate any violation of state or federal law, of the medical Staff Bylaws or Rules, or of any accreditation requirement applicable to the activities of the medical Staff or Children's Hospital.

13.7 Quorum

13.7-1 Committee Meetings

The quorum for meetings of the MEC shall be a majority of the voting Membership. For all other committees of the Medical Staff, the quorum shall be forty percent (40%) or three (3) voting members of any committee, whichever is more, unless otherwise provided in these Bylaws, If a quorum is not present, all action items and supporting documentation shall be forwarded to the MEC.

13.8 Electronic Voting

Unless otherwise provided in these Bylaws, any vote for an election, adoption, or amendment process may be accomplished through an electronic voting process approved by the MEC, so long as the MEC has determined that the electronic voting process has sufficient safeguards to protect the integrity of the vote and the process has been approved by the Governing Body. “Electronic voting process” includes, but is not limited to, email and web-based voting processes.

13.9 Conduct of Meetings

Any question of order not provided for in these Bylaws shall be governed by Roberts Rules of Order Newly Revised; however, failure to follow these rules shall not invalidate the action taken at the meeting.

ARTICLE 14

IMMUNITY FROM LIABILITY

14.1 Immunity From Liability

The following shall be explicit conditions to any Practitioner’s application for, or exercise of, Medical Staff Membership or Clinical Privileges at the Hospital.

FIRST, that any act, communication, report, recommendations or disclosure with respect to any such Practitioner, performed or made at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

SECOND, that such privileges shall extend to members of the Hospital’s Medical Staff, its Governing Body, its other Practitioners, its Chief Executive Officer and the Chief Executive Officer’s representatives, and to third parties, who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article, the term “third parties” means both individuals and organizations for whom information has been requested by an authorized representative of the Governing Body or of the Medical Staff.

THIRD, that there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

FOURTH, that such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution’s activities related, but not limited to:

a. Applications for appointment or Clinical Privileges;

b. Periodic reappraisals for reappointment or Clinical Privileges;

c. Corrective action, including summary suspension;

d. Hearings and appellate reviews;

e. Medical care evaluations;

f. Utilization reviews; and

g. Other Hospital, departmental, service or Committee activities related to quality patient care and inter professional conduct.

FIFTH, that the acts, communications, reports, recommendations and disclosures referred to in this Article may relate to a Practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

SIXTH, that in furtherance of the foregoing, each Practitioner shall, upon request of the Hospital, execute releases in a form which is consistent with the content of this Article in favor of the individuals and organizations specified in paragraph SECOND, subject to such requirements as may be applicable under the laws of this State.

SEVENTH, that the consents, authorizations, releases, rights, privileges and immunities provided by Article 5 of these Bylaws for the protection of this Hospital's Practitioners, other appropriate Hospital officials and personnel and third parties, in connection with applications for initial appointment and reappointment, shall also be fully applicable to the activities and procedures covered by this Article.

ARTICLE 15

QUORUM

15.1 Department/Division Meetings

The quorum for departmental or divisional meetings shall be twenty percent (20%) of the voting members.

15.2 General Medical Staff Meetings

The quorum for general and special Medical Staff meetings shall be twenty percent (20%) of the voting members.

ARTICLE 16

ADOPTION AND AMENDMENT OF BYLAWS, RULES, REGULATIONS AND POLICIES

16.1 Bylaws Amendment Initiated by Bylaws Committee or MEC

The Medical Staff Bylaws may be amended after consideration by the Bylaws Committee and submission of the proposed amendment in writing at any regular meeting of the MEC, or by the MEC on its own motion and with notification to the Bylaws Committee, by following these steps:

16.1-1 The affirmative vote of a majority of the Active Staff members eligible to vote who are present at a regular or special meeting of the general Medical Staff at which a quorum is present; provided at least thirty (30) days' written notice accompanied by the proposed Bylaws and/or alterations has been given of the intention to take such action with the date, time and place of the meeting at which such action is to be considered; and provided that notice is given by posting the same in the Practitioners' lounges on the Hospital premises and mailing same to the offices of or delivering the same in person to each Medical Staff member eligible to vote;

or

16.1-2 Submission of such proposed Bylaw amendments to the Active Medical Staff eligible to vote by a mail ballot, including, when the address is known, by e-mail.

The ballot shall include notice regarding the proposed changes which shall include the exact wording of the proposed additions or amendments.

Ballots shall be received by the Medical Staff Office within thirty (30) days of the date ballots were mailed (or e-mailed) so they may be counted. Ballots that were sent by e-mail may be submitted by return e-mail to the Medical Staff Office.

Ballots shall be counted by the Secretary Treasurer with the President in attendance. An affirmative vote of a majority of the votes cast shall be required for passage of any amendments or additions. Results shall be announced at the next Medical Staff meeting;

And

16.1-3 When approved by the Governing Body.

16.2 Amendment of Rules and Regulations Initiated by MEC.

The MEC must communicate a notice of its intent to change, and any proposed changes to, the Rules & Regulations (but not Medical Staff Policies) to the general medical Staff no less than 30 days prior to any scheduled vote of the MEC on the change(s). Such notice must be made via the same communication methods required for notice to the Membership of any proposed amendments to the Medical Staff Bylaws.

Notwithstanding the foregoing, where immediate changes are needed to avoid immediate jeopardy or penalty to the hospital or the medical Staff (for example, a directive by the Centers for Medicaid and Medicare Services to Children's Hospital demanding immediate action to change a relevant policy or policies), the MEC may recommend, and the Governing Body may approve changes to the Medical Staff Rules and Regulations without prior notice to the Medical Staff. If this occurs, the MEC shall promptly inform the Medical Staff of the required changes, and the Medical Staff may request reconsideration by a petition to the MEC, signed by at least 25% of the voting members of the Medical Staff. If the MEC fails to approve changes to the Medical Staff Rules and Regulations as petitioned, the Medical Staff may approve

and propose to the Governing Body alternative amendments to the Medical Staff Rules and Regulations, as provided in Section 17.4.

16.3 Such rules shall include functions relating to:

16.3-1 The admission, care and discharge of patients, including matters relating to patient consents;

16.3-2 Medical records, including the maintenance, protection and Confidentiality of such records;

16.3-3 Consultation requirements;

16.3-4 Confidentiality of Medical Staff committee files, records and proceedings;

16.3-5 Rules regulating the practice of allied health professionals

16.3-6 The Utilization Review Plan

16.3-7 The Performance Improvement Plan

16.3-8 The professional liability insurance requirement, if any;

16.3-9 On-call specialty coverage;

16.3-10 Department/Division rules and regulations;

16.3-11 Rules relating to the professional conduct of Medical Staff members

16.3-12 Any other rules necessary to interpret or make clearer the Medical Staff Bylaws

16.4 Amendment of Medical Staff Policies Initiated by MEC and Medical Staff Committees.

As the need arises, the MEC and other committees may enact policies, containing rules and procedures relating to the functions and areas of responsibility of these committees. Except as otherwise specified in these Bylaws, such policies, rules and procedures shall be effective when adopted by the MEC and shall be maintained as part of the Medical Staff Policies. Medical Staff policies shall be subject to approval by the Governing Body when so required by Title 22 of the California Code of Regulations, or when the medical Staff policies are intended to bring or keep the medical Staff in compliance with law, regulation or accreditation standards. The MEC must communicate the adoption of any policy or amendment thereto to the medical Staff promptly after adoption.

16.5 Amendment to Bylaws, Rules & Regulations or Policies Initiated by Petition from the Medical Staff.

The Medical Staff may adopt amendments to the Medical Staff Bylaws, Rules & Regulations, or policies.

16.5-1 Initiation by Petition

a. The process for amendment of the Medical Staff Bylaws, Rules & Regulations and/or policies may be initiated by petition of the medical Staff upon receipt of a petition signed by at least twenty-five percent (25%) of the Active Medical Staff members.

b. The petition must identify two representatives of the petitioners who shall appear before the MEC to discuss the issues relating to the proposed amendments.

c. The names of the two representatives must be clearly stated on each signature page of the petition so each signor is aware of the identity of the representatives at the time the petition was signed. The petition shall state that the two representatives will have authority to communicate with MEC about the proposed amendments on behalf of the signors. The petition shall be invalid if these conditions are not met.

d. Review by MEC

The petition and the draft proposed amendment(s) shall be transmitted to the Medical Staff Office which shall transmit a copy promptly to each member of the MEC. The proposed amendment(s) shall be place on the agenda for the next regularly scheduled MEC meeting that is on calendar no sooner than ten (10) business days after receipt by the Medical Staff Office. The two representatives of the petition shall appear at the MEC meeting to discuss the need for the amendment(s). The time allotted for the discussion shall be set by the President of the Medical Staff in advance of the meeting, with notice to the petitioner representatives. At the meeting, the MEC and petitioner representatives may negotiate changes to the draft amendment(s) as part of the discussion. After the discussion concludes with the petitioner representatives, they shall leave the meeting and the MEC shall move into executive session to carry out any further discussion and review necessary.

e. The MEC may determine it requires time for consideration of the amendment(s), and/or consultation with other persons, including legal counsel. Under those circumstances, the MEC shall bring the proposal back for consideration within sixty (60) days. The amendment(s) under consideration shall be the proposal as presented to the MEC by the petition, or as modified by agreement of the MEC with petitioner representatives.

f. The MEC shall determine by a majority vote of the members whether:

1. it supports the proposed amendment(s)

2. it opposes the proposed amendment(s), or any item if there are more than one; and/or

3. it neither supports nor opposes the proposed amendment(s), or any of them if there are more than one.

4. Non-Opposition by MEC. If, after review, the MEC determines that it does not oppose the amendment, or any of them if more than one, the President of the Medical Staff must cause a ballot to be sent on the proposed amendment(s) within thirty (30) days of the MEC meeting in accordance with this Article relating to amendments of the Bylaws. The following information must be included with the ballot sent on the proposed amendment:

1. that the proposed amendment(s) is initiated by a petition of at least 25% of the voting members of the medical Staff;

2. the proposed amendment or amendments presented with clear strikeouts (showing deletions) and underlines (showing new language);

3. any other relevant wording or provisions in the current Medical Staff governance documents that may provide context and/or may clarify the nature of the change(s) being proposed;

4. which amendment or amendments the MEC supports, and which amendment or amendments it neither supports nor opposes, and a clear explanation for same if so desired;

5. the quorum requirement, and the number of votes required, to adopt the amendment(s).

g. Opposition by MEC; Medical Staff Meeting. If, after review, the MEC determines that it opposes one or more specified amendment(s), the President must promptly provide written notice for a meeting of the general medical Staff regarding the amendment(s). The meeting so noticed shall be held no less than seven (7), nor more than thirty (30) calendar days from the date the MEC determines its opposition. The notice of the meeting shall state:

1. that the proposed amendment(s) is initiated by a petition of at least 25% of the voting members of the medical Staff;

2. the proposed amendment or amendments presented with clear strikeouts (showing deletions) and underlines (showing new language)

3. any other relevant wording or provisions in the current Medical Staff Governance documents that may provide context and/or may clarify the nature of the change(s) being proposed;

4. the fact that the MEC opposed one or more of the proposed amendment(s), to include which amendment(s) was opposed and a clear explanation for the opposition.

At this medical Staff meeting, the members in attendance may discuss any matters germane to the proposed amendment(s); modify or reject the proposed amendment(s); direct that the proposed or modified amendment(s) be sent out to the medical Staff for vote; or postpone consideration of all, or any part of, proposed amendment(s).

h. Procedures Required for Voting and Adoption. An amendment(s) sent out for a vote of the medical Staff under this section shall include in the ballot the same information specified, as applicable, under subsections (f)and (g) of this section, plus any further commentary or explanation the MEC may wish. The ballot must be sent out within fifteen (15) calendar days of the vote taken at the medical Staff meeting to send the ballot out to the medical Staff. The amendment(s) shall be approved by the medical Staff only upon receipt of the affirmative vote of two-thirds (2/3) of the Active Staff members eligible to vote. Voting medical Staff members shall be afforded no less than thirty (30) days to return their completed ballot to the Medical Staff Office. Ballots that were sent by e-mail may be submitted by return e-mail to the Medical Staff Office. Ballots shall be counted by the Secretary Treasurer with the President and petitioners, if available, in attendance. The President shall promptly announce the results by posting the same in the Practitioners' lounges on the Hospital premises or mailing or emailing same to the offices of, or delivering the same in person to, each Medical Staff member eligible to vote.

16.5-2 Limitations on Application of Provisions Permitting Amendment to Bylaws, Rules & Regulations or Policies Initiated by Petition from the Medical Staff

The provisions under these Bylaws permitting amendment of Governing Documents initiated by petition from the Medical Staff shall not apply in any of the following situations:

a. matters in which the amendment may violate or jeopardize confidentiality protections under state or federal law that apply to information about a person (e.g., peer review matters, personal health information);

b. an investigation under consideration, in progress or completed on behalf of the Medical Staff, whether formal or informal, of any matter regarding quality of care, patient safety or professional conduct of a member of the Medical Staff; or

c. proposed amendments for action, or any action already taken, by the MEC relative to any member of the Medical Staff.

d. Where amendment would permit or validate any violations of state or federal law, any accreditation requirement applicable to the activities of the Medical Staff or Children's Hospital, or would result in a conflict between the amendment(s) and some other existing provision of medical Staff governing documents.

16.6 Governing Body Action Required Under This Article

16.6-1 Amendments of Bylaws or Rules & Regulations adopted under this Article shall be effective only when approved by the Governing Body. When so approved, the Bylaws and Rules & Regulations shall be equally binding on the Governing Body and the Medical Staff. Medical Staff policies adopted by vote of the voting members of Medical Staff shall be subject to approval by the Governing Body when so required by Title 22 of the California Code of Regulations, or when the Medical Staff policies are intended to bring or keep the Medical Staff in compliance with law, regulation or accreditation standards.

16.6-2 Approval by the Governing Body shall not be unreasonably withheld. If approval is withheld, the reasons for doing so shall be specified by the Governing Body in writing, and shall be forwarded to the President of the Medical Staff, the MEC, and the Bylaws Committee. A copy of the writing shall be made available to the medical Staff through any method that satisfactorily communicates to all voting members of the medical Staff, and which shall include posting the writing in Medical Staff common areas, such as medical Staff offices, dining room, and lounges.

16.6-3 Neither the Medical Staff nor the Governing Body may unilaterally amend the medical Staff Bylaws or Rules & Regulations.

16.7 Binding Nature of Bylaws; Successors in Interest of Hospital; Merger of Medical Staffs.

The Bylaws, Rules & Regulations, and privileges of individual members of the Medical Staff accorded under these Bylaws, will be binding upon the Medical Staff and the Board of Directors of any successor in interest in this hospital, except where hospital medical Staffs are being combined. In the case that Staffs are being combined, the medical Staffs shall work together to develop new Bylaws which will govern the combined Medical Staff, subject to the approval of the hospital's Board of Directors or its successor in interest. Until such time as the Medical Staff develop new Bylaws and forward them for Governing Body approval, the existing Medical Staff Bylaws and Rules & Regulations of each institution will remain in effect.

16.8 Technical and Editorial Amendments

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

ARTICLE 17

MISCELLANEOUS

17.1 DOCUMENTATION REQUIREMENTS: Inpatient, Observation, Outpatient Surgery

17.1-1 History and Physical Examination

a. Medical History and Physical Examination

1. Medical history and physical examination (H&P) must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration.

2. An H&P that is dated 30 days or more prior to patient admission or registration cannot be used.

3. When the H&P is completed within 30 days before admission or registration, an updated medical record entry documenting an examination for any changes in the patient's condition must be completed and documented in the patient's medical record within 24 hours after admission or registration.

4. The history and physical shall be documented in the medical record and signed by the attending physician or credentialed Allied Health Professional (AHP) within 24 hours of the patient's admission to an in-patient, observation or outpatient surgery service.

5. A progress note addendum to or counter signature of a medical student's or resident's history and physical examination within 24 hours of the patient's admission to an in-patient, observation, or outpatient surgery service fulfills the H&P and/or update requirement so long as there is sufficient documentation by the attending physician of participation in the patient's assessment and plan of care.

6. Consultations may be accepted in lieu of an H&P if all elements are included in the documents. Countersignature guidelines apply for all consultations used in place of the H&P examination.

b. Patients having Surgery or Procedure requiring anesthesia services

1. Except in an emergency, an H&P is required prior to surgery and prior to procedures requiring anesthesia services regardless of whether care is being provided on an inpatient or outpatient basis.

2. Where the H&P was completed more than 24 hours prior to the surgery or procedures requiring anesthesia services an interval medical history and physical examination or consultation note with similar elements performed and recorded within the previous 24 hours is required.

3. An Emergency Department evaluation that includes the required elements is acceptable to fulfill the H&P requirements. A consultation note by the surgeon is required and must clearly document diagnosis, findings and assessment justifying the planned procedure.

c. History & Physical Examination: Dental and Podiatric Surgery

1. Prior to any dental or podiatric surgery performed in the Children's Hospital operating room, there must be a history and physical examination by a physician member of the Medical Staff, or Allied Health Professional credentialed in histories and physicals by the Interdisciplinary Practice Committee, recorded in the patient's chart.

2. Obtaining such a record is the responsibility of the operating dentist or podiatrist.

d. Required Format and Documentation in the H&P

1. The comprehensive H&P shall include the following elements:

- Chief Complaint
- History of the present illness
- Relevant past, family, behavioral, and social history
- An appropriate review of systems including growth and development
- Known allergies including foods, medications and latex
- Current medications
- A physical examination
- A provisional diagnosis
- A plan of care
- Problem list

2. The H&P shall be in the following format:

- Dictated
- Direct entry in the EMR
- Pre-operative Evaluation if completed by the physician or credentialed Allied Health

- Professional in the EMR

- Handwritten using H&P template/form during downtime or in situations of extreme emergency

3. The comprehensive H&P, as defined above, may be completed by multiple providers in separate documentation. For example:

   - A preoperative anesthesia clinic (Prepare) history,

   - An anesthesia examination to include airway, heart and lung examination and other physical assessment performed and documented within 24 hours prior to surgery, and

   - An appropriate condition-specific examination of the body part being operated on as documented in the interval note.

   The extent of the physical examination will be determined by the clinical context or the nature of surgery/procedure planned. The documentation will include clinically relevant information including the patient's co-morbidities, the patient's condition, and the procedure(s) being performed.

   The interval H&P must include an appropriate condition-specific examination of the body part being operated on.

   The interval H&P must be completed prior to the patient's procedure and before the patient enters the operating room and must be attested to by the attending proceduralist. For procedures taking place outside of the operating room, the interval H&P may be completed at the bedside, but prior to the procedure and before administration of anesthesia/sedation.

17.1-2 Consultation:

The findings and recommendations of any consultation that is conducted while the patient is hospitalized or receiving services must be recorded in the patient's medical record as soon as possible after the consultation, or prior to surgery, whichever comes first. The report should include the name of the provider requesting the consultation. Counter signature of a resident's note fulfills this obligation so long as there is adequate documentation of participation in the assessment and decision making process.

17.1-3 Progress Notes

A progress note shall be written and signed by the attending physician for each day and/or 24 hour period of the patient's hospital stay. Counter signature of a medical student's or resident's or allied health professional's (AHP) note fulfills this requirement so long as there is sufficient documentation by the attending physician of medical student, resident or nurse Practitioner supervision in the patient's assessment and ongoing plan of care.

17.1-4 Orders

All orders are subject to Section 12 of these Rules and Regulations. Each order or set of orders must be dated, timed and signed legibly by the person who wrote the order. Pharmacy orders must be written in the order entry system and timed.

Orders may be written by the attending physician, a resident, or by the resident or allied health professional acting under the supervision of the attending physician. Medical students may write orders but those must be countersigned by a resident or attending before acceptance. Orders written by a medical student, resident or nurse Practitioner or physician assistant must reflect the attending physician's plan of care for the patient.

17.1-5 Operative and Procedure Documentation

a. Pre-Operative Requirements:

1. A physician or credentialed Allied Health Professional involved in the patient's care documents the provisional diagnosis in the medical record before an operative or other high-risk procedure is performed.

2. The patient's medical history and physical examination are recorded in the medical record before an operative or other high-risk procedure is performed.

3. An anesthesiologist or other individual qualified to administer anesthesia shall perform a pre-anesthesia evaluation within 48 hours prior to surgery or a procedure requiring anesthesia services. The pre-anesthesia evaluation includes, at a minimum:

- Review of the medical history, including anesthesia, drug and allergy history
- Interview and examination of the patient
- Notation of anesthesia risk according to established standards of practice (ASA status)
- Identification of potential anesthesia problems
- Additional pre-anesthesia evaluation, if applicable and as required in accordance with standard practice prior to administering anesthesia
- Development of the plan for the patient's anesthesia care
- Discussion of the risks and benefits of the delivery of anesthesia with the patient or patient's representative
- Immediate pre-induction assessment of the patient.

b. Operative or Procedure Documentation

1. Surgeon's Responsibility:

(i) An operative or other high-risk procedure report is entered or dictated upon completion of the operative or other high-risk procedure. The report is considered late when dictated more than 24 hours following the operation or procedure.

(ii) The operative or other high-risk procedure report includes the following:

- Name of primary surgeon and assistants
- pre-operative (provisional)diagnosis
- post-operative diagnosis
- name of procedure performed
- date of procedure
- description and findings of the procedure including techniques used
- description of the specimens removed or altered
- estimated amount of blood loss

(iii) Brief Post-Operative Note: When the full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care.

(iv) This progress note includes:

- Name of primary surgeon(s) and assistant(s)
- Post-Operative Diagnosis
- Procedures performed
- Date of procedure
- Description of each procedure finding
- Specimens removed
- Estimated blood loss

2. Anesthesiologist's Responsibility:

(i) Anesthesia Record: The anesthesiologist shall be responsible for entering a signed report in the patient's chart promptly after completion of the procedure. The anesthesia record shall include:

- Name and hospital identification number of the patient
- Names of Practitioners who administered anesthesia, including the name and profession of the supervising anesthesiologist
- Significant aspects of the pre-operative evaluation

- Name, dosage, route and time of administration of drugs and anesthesia agents Techniques used and patient position, including the insertion/use of any intravascular or airway devices

- Type and amount of all fluids administered, including blood and blood products Time-based documentation of vital signs as well as oxygenation and ventilation parameters

- Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered and patient's response to treatment.

(ii) Post-Anesthesia evaluation: A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia. The evaluation shall take place after the patient has recovered sufficiently from the acute administration of anesthesia so as to participate in the evaluation, as permitted by age and developmental status. The elements of the post-anesthesia evaluation should include:

- Respiratory function, including respiratory rate, airway patency and oxygen saturation

- Cardiovascular function, including pulse rate and blood pressure

- Mental status

- Temperature

- Pain

- Nausea and vomiting

- Postoperative hydration

17.1-6 Discharge Summary (Not required for outpatient surgery)

In order to provide information to other caregivers and facilitate the patient's continuity of care the medical record contains a concise discharge summary which must be completed in the EMR by the designated resident, fellow, or Allied Health Professional or if there is no designate, the attending Practitioner at the time of the patient's discharge from the inpatient or observation service regardless of length of stay or disposition.

a. The Discharge Summary must be completed by dictation or direct entry into the EMR within fourteen (14) days of discharge and must include the following:

- Reason for hospitalization

- Procedures performed

- Care, treatment and services provided
- Patient condition and disposition at discharge
- Recommendations and arrangements for future care
- Discharge instructions and information provided to patient and family, including medications and allergies. (this section must be complete at the time of discharge).

b. Transfer Summary may be completed in place of a complete Discharge Summary when a patient is transferred to a different level of care within Children's (Acute care to ICU; ICU to Acute care). The designated resident, fellow, or Allied Health Professional, or if there is no designate the attending Practitioner will dictate or enter a Transfer Summary in Epic documenting the essential information relative to the following:

- Patient's diagnosis(es)
- Medications and known allergies
- The patient's hospital course
- Dietary Requirements
- Treatment plan

c. Death Summary

1. Expired patients must have a Discharge Summary completed within fourteen (14) days from the expiration date.

2. The Death Summary must include the following

- The reason for hospitalization
- Procedures performed
- Care, treatment and services provided
- The events leading to death
- Disposition of the body including autopsy, coroner's case, organ donation and name of the organ procurement organization.

17.2 DOCUMENTATION REQUIREMENTS: Ambulatory (Outpatient Primary Care & Subspecialty Care)

The Medical Staff, physicians in residency or fellowship programs, and/or Allied Health Professionals providing outpatient clinical care are responsible for the same components as noted in this section of these Rules and Regulations as applicable.

17.2-1 Documentation and closure of the ambulatory encounter should be completed as close to the date and time of the actual encounter as possible. Documentation and encounter

closure is considered late when it is completed more than 5 days following the patient's outpatient encounter and delinquent when not completed after 14 days following the patient's outpatient encounter. The attending physician or provider will be responsible for the completion documentation and closure ambulatory encounters of his/her/their patients.

17.2-2 Ambulatory History & Physical Examination – New Patient

a. The attending Practitioner is responsible for documenting the pertinent elements of a history and physical examination for any new patient to the department/service.

b. Completion of all similar elements within a consultation note fulfills this requirement

17.2-3 Documentation in the ambulatory medical record must also include:

a. Patient identification

b. Date and time of encounter

c. Chief complaint

d. Immunization record (if applicable)

e. Neonatal history (if applicable)

f. Growth chart (if applicable)

g. Problem List

h. Orders for all medications and other treatment (diagnosis must be included for referral testing)

i. Current medication ordered, prescribed, dispensed, administered, and any adverse medical reactions.

j. Allergies

k. A progress note (completion of an H&P or consult note fulfills this requirement

l. A visit diagnosis

m. Level of service.

17.2-4 Ambulatory Problem List*: A Problem List is included in the medical record for each outpatient who receives continuing ambulatory care services.

a. The Problem List is initiated in the EMR the patient's first visit and contains the following information:

- Any significant medical diagnoses and conditions (Location: Problem List)
- Any significant operative and invasive procedures (Location: Problem List)
- Any adverse or allergic drug reactions (Location: Allergies)

- Any current medications, over-the-counter medications, and herbal preparations

- (Location: Medication Reconciliation)

b. The patient's Problem List is updated at every encounter whenever there is a change in diagnoses, medications, or allergies to medications, and whenever a procedure is performed.

* The Joint Commission refers to the Ambulatory Problem List as the Summary List.

17.2-5 Ambulatory consultations should be sent via a message, fax or letter to the referring provider within 14 days

DEFINITIONS

	TERM	DEFINITION
1.	Chairman	Chairman will reference department leadership.
2.	Chief or Director	These terms are used interchangeably to reference division leadership.
3.	Chief Executive Officer	The individual appointed by the Governing Body to act on its behalf in the overall management of the Hospital.
4.	Clinical Privileges or "Privileges"	The permission granted to a Practitioner to render specific diagnostic, therapeutic, medical, surgical, dental, podiatric or clinical psychological services.
5.	Clinical Psychologist	An individual who is licensed to practice psychology in California.
6.	Credentialing Coordinator	That person or persons hired to serve the Medical Staff in those ways specified in these Bylaws and further described in the job description. Duties include assistance in the credentialing process, primary responsibility for protecting the confidentiality of Medical Staff records, Staffing Medical Staff committee meetings, and secretarial support to the officers of the Staff.
7.	Dentist	An individual who is licensed to practice dentistry in California.
8.	Ex Officio	Service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.
9.	Governing Body	Board of Directors of the Hospital.
10.	Governing Documents	The documents that create a system of rights, responsibilities, and accountability between the Medical Staff and the Governing Body, and between the Medical Staff and its Members; they include: the Medical Staff Bylaws, Rules and Regulations, Policies; Department Rules and Regulations; Privilege Request Forms; Hospital policies adopted by the Medical Executive Committee; other Hospital policies specifically required by state or federal law, applicable public health department mandates, or by the standards of national accrediting organizations such as the Joint Commission (or equivalent); and any other document adopted by the Medical Staff directly applicable to Medical Staff operations, the granting of Membership or privileges on the Medical Staff, or the exercise of privileges.
11.	Hospital	Children's Hospital & Research Center at Oakland (dba UCSF Benioff Children's Hospital Oakland), including its in-patient and out-patient facilities and any health care facility

	TERM	DEFINITION
		owned or operated by Children's Hospital & Research Center at Oakland.
12.	In Good Standing	means a Practitioner who, at the time of the assessment of standing, has Membership and/or Clinical Privileges that are 1) not subject to an adverse action or recommendation by the MEC for a medical disciplinary cause or reason that constitutes grounds for a Formal Hearing under Article 8 of the Bylaws and 2) not subject to an automatic suspension or termination under Section 7.2-2 of the Bylaws.
13.	Medical Executive Committee	The Executive Committee of the Medical Staff. Known as MEC.
14.	Medical Staff or Staff	All duly licensed physicians, dentists, podiatrists and clinical psychologists who have been admitted to the Medical Staff.
15.	Monthly	When referring to a committee, departmental or division meetings, shall mean at least nine (9) meetings per year.
16.	Notice	A written notification sent to the addressee via the United States Postal Service, first-class postage prepaid, or an alternative delivery mechanism if it is reliable and expeditious (e.g., email with read receipt, fax, or in-house Medical Staff Member mailboxes or any manner identified in the Special Notice definition). Any notice to a Member, applicant or other party, shall be to the addressee at the address (whether mailing, fax or email) as it last appears in the official records of the Medical Staff or the Hospital. Each Member is responsible for ensuring that the official records of the Medical Staff and Hospital reflect the current mailing address at which the Member receives and reviews mail on a regular basis (and, if desired, also current email address and/or fax number). To the extent that fax or email transmissions prove unreliable, the default address of record shall be the mailing address on file. (See also definition of Special Notice, below.)
17.	Physician	An individual who is licensed to practice medicine in California and holds a M.D. or D.O. degree.
18.	Podiatrist	An individual who is licensed to practice podiatry in California.
19.	Practitioner	Unless otherwise indicated, any physician, dentist, podiatrist or clinical psychologist applying for or exercising Clinical Privileges in UCSF Benioff Children's Hospital Oakland.
20.	President of the Medical Staff (President)	The individual elected by the Medical Staff to serve as its chief administrative officer and report to the Governing Board in order to assure that the responsibilities of the Medical Staff, as enumerated in these Bylaws, are satisfied.

	TERM	DEFINITION
21.	Special Notice	A process of transmittal whereby information is deemed conveyed when sent 1) by United States Postal Service, certified or registered mail, return receipt requested or via a courier service that documents delivery (such as, but not limited to, FedEx or UPS) at the last address as it appears in the official records of the Medical Staff or Hospital; or 2) hand delivered, with a signed receipt (or, if there is a refusal to sign, documentation that is was delivered).
22.	Specialty Board	A board recognized by the ABMS (American Board of Medical Specialties), the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, or the American Board of Foot and Ankle Surgery.
23.	Staff Year	The period from April 1 through March 31.