ALAMEDA HEALTH SYSTEM

MEDICAL STAFF BYLAWS

September 24, 2013

BYLAWS OF THE MEDICAL STAFF OF

ALAMEDA HEALTH SYSTEM

TABLE OF CONTENTS

PREAMBLE.....1

DEFINITIONS.....2

ARTICLE 1 NAME AND PURPOSES.....4

ARTICLE II MEMBERSHIP

2.1 NATURE OF MEMBERSHIP.....5

2.2 QUALIFICATIONS FOR MEMBERSHIP.....6

2.3 EFFECT OF AFFILIATION.....9

2.4 NONDISCRIMINATION.....10

2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP.....10

2.5-1 ORGANIZED HEALTH CARE ARRANGEMENT.....12

2.6 BEHAVIOR.....13

2.7 HARASSMENT PROHIBITED.....13

ARTICLE III CATEGORIES OF MEMBERSHIP

3.1 CATEGORIES.....14

3.2 ACTIVE STAFF.....14

3.3 COURTESY STAFF.....15

3.4 CONSULTING STAFF.....16

3.5 PROVISIONAL STAFF.....17

3.6 HONORARY AND EMERITUS STAFF.....19

3.7 TEMPORARY STAFF.....20

3.8 ADMINISTRATIVE STAFF.....21

ARTICLE IV APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL 23

4.2 BURDEN OF PRODUCING INFORMATION..23

4.3 COMPLETE APPLICATION –PREREQUISITE FOR ACTION 23

4.4 APPOINTMENT AUTHORITY 25

4.5 DURATION OF APPOINTMENT AND REAPPOINTMENT 25

4.6 APPLICATION FOR INITIAL APPOINTMENT..25

4.7 REAPPOINTMENTS AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES 31

4.8 LEAVE OF ABSENCE 33

ARTICLE V CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES 34

5.2 DELINEATION OF PRIVILEGES..34

5.3 PROCTORING 35

5.4 CONDITIONS FOR PRIVILEGES OF LIMITED

LICENSE PRACTITIONERS 36

5.5 HISTORY AND PHYSICAL – COMPLETION OF: 37

5.6 TEMPORARY PRIVILEGES 38

5.7 EMERGENCY PRIVILEGES..41

5.8 DISASTER PRIVILEGES..41

5.9 MODIFICATION OF CLINICAL PRIVILEGES……………………………..……...43

5.10 LAPSE OF APPLICATION……………………………………………………..…43

5.11 DISSEMINATION OF PRIVILEGES LIST…………………………………….43

ARTICLE VI ALLIED HEALTH PROFESSIONALS

6.1 QUALIFICATIONS 43

6.2 CATEGORIES OF AHPS 44

6.3 VOTING PRIVILEGES AND COMMITTEE MEETINGS 44

ARTICLE VII CORRECTIVE ACTION

7.1 CORRECTIVE ACTION 45

7.2 SUMMARY RESTRICTION OR SUSPENSION 48

7.3 AUTOMATIC SUSPENSION OR LIMITATION 49

7.4 INITIATION OF CORRECTIVE ACTION BY BOARD OF TRUSTEES 53

ARTICLE VIII HEARINGS AND APPELLATE REVIEWS

8.1 GENERAL PROVISIONS 54

8.2 GROUNDS FOR HEARING 55

8.3 REQUESTS FOR HEARING..56

8.4 HEARING PROCEDURE..59

8.5 APPEAL 63

8.6 RIGHT TO ONE HEARING..66

8.7 EXCEPTIONS TO HEARING RIGHTS 66

8.8 CHALLENGES TO RULES 66

ARTICLE IX OFFICERS

9.1 OFFICERS OF THE MEDICAL STAFF..67

9.2 DUTIES OF OFFICERS 69

9.3 COMPENSATION OF MEDICAL STAFF OFFICERS………………………..71

9.4 MEDICAL STAFF REPRESENTATIVE TO THE BOARD…………………...72

ARTICLE X CLINICAL DEPARTMENTS AND DIVISIONS

10.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND DIVISIONS...........72

10.2 DEPARTMENTS AND DIVISIONS AT AHS 72

10.3 ASSIGNMENT TO DEPARTMENT AND DIVISION 73

10.4 FUNCTIONS OF DEPARTMENTS 73

10.5 FUNCTIONS OF DIVISIONS 74

10.6 CHAIR OF THE DEPARTMENT 74

10.7 DIVISION CHIEFS 78

I. ARTICLE XI COMMITTEES

11.1 DESIGNATION 79

11.2 GENERAL PROVISIONS 80

11.3 MEDICAL EXECUTIVE COMMITTEE 81

11.4 CREDENTIALS COMMITTEE 84

11.5 JOINT CONFERENCE COMMITTEE 85

11.6 OTHER MEDICAL STAFF COMMITTEES 86

II. ARTICLE XII MEETINGS

12.1 MEETINGS 87

12.2 COMMITTEE AND DEPARTMENTS MEETINGS 88

12.3 QUORUM 89

12.4 ATTENDANCE REQUIREMENTS 90

12.5 CONDUCT OF MEETINGS 91

ARTICLE XIII CONFIDENTIALITY, IMMUNITY AND RELEASES

13.1 AUTHORIZATION AND CONDITIONS 91

13.2 CONFIDENTIALITY OF INFORMATION 91

13.3 IMMUNITY FROM LIABILITY 92

13.4 ACTIVITIES AND INFORMATION 92

13.5 RELEASES……………………………………………………………………...93

13.6 INDEMNIFICATION…………………………………………………………93

ARTICLE XIV GENERAL PROVISIONS

14.1 RULES AND REGULATIONS, DEPARTMENT RULES AND REGULATIONS AND MEDICAL STAFF POLICIES AND PROCEDURES……………………………………. …………………………94

14.2 DUES AND ASSESSMENTS...97

14.3 CONSTRUCTION OF TERMS AND HEADINGS 97

14.4 AUTHORITY TO ACT 98

14.5 DIVISION OF FEES 98

14.6 NOTICES...98

14.7 DISCLOSURE OF INTEREST 98

14.8 NOMINATION OF MEDICAL STAFF REPRESENTATIVES TO OUTSIDE ORGANIZATIONS 98

14.9 CONFIDENTIALITY OF THE CREDENTIAL FILES 99

14-10 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING……………......100

14.11 MEDICAL STAFF REPRESENTATION BY LEGAL COUNSEL…… ……..100

ARTICLE XV ADOPTION AND AMENDMENT OF THE BYLAWS

15.1 PROCEDURE……………..…………………………..………..…....................100

15.2 ACTION ON BYLAW CHANGE………………………...…………….........102

15.3 APPROVAL……………………………………………………………......102

15.4 EXCLUSIVITY………………………...…….…………………………........102

15.5 REVIEW…………………………………...102

15.6 TECHNICAL AND EDITORIAL REVISIONS……………………….………102

PREAMBLE

Whereas, *Alameda Health System is an Alameda County institution organized under the Laws of the State of California; and*

Whereas, *its purpose is to serve as a Medical Center providing patient care as well as medical education and research; and*

Whereas, *it is recognized that the Medical Staff is responsible for the quality of medical care and education in the Medical Center and must accept and discharge this responsibility subject to the ultimate authority of the Governing Body, and that the cooperative efforts of the Medical Staff, the Chief of Staff, the Chief Medical Officer, the Chief Executive Officer and the Board of Trustees are all necessary to fulfill the obligations of the Medical Center to its patients and house staff;*

Therefore, *the physicians, dentists, podiatrists, and clinical psychologists of Alameda Health System hereby organize themselves into a Medical Staff in conformity with these Bylaws, Rules and Regulations.*

DEFINITIONS

---

1. The term "**Medical Center"** means the Alameda Health System, including its Highland campus, Fairmont campus, John George Pavilion campus and the Ambulatory clinics at, Eastmont Wellness Center, Newark Health Center, Winton Wellness Center, and others as applicable.

2. The term "**Practitioner**" means a licensed Physician (medical or osteopathic), Dentist, Podiatrist, or Clinical Psychologist.

3. The term "**Medical Staff**" means the organization of those medical physicians, osteopathic physicians, dentists, podiatrists or clinical psychologists who have been granted recognition as members of the Medical Staff pursuant to the terms of these Bylaws.

4. The term **"Member"** unless otherwise expressly limited, means any medical physician, osteopathic physician, dentist, podiatrist or clinical psychologist holding a current license to practice within the scope of his or her licensure who is a Member of the Medical Staff.

5. The term "**Board of Trustees**" means the Alameda County Medical Center Authority Board of Trustees, which is the governing body of the Medical Center.

6. The term "**Chief Medical Officer**" means the individual or duly authorized designee appointed to direct the medical - professional affairs of the Alameda Health System.

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

8. The term **"Quality Professional Services Committee"** (QPSC) means the subcommittee of the governing body of the Medical Center who has been delegated by the Board of Trustees, the authority to render initial appointment, reappointment and renewal or modification of clinical privilege decisions.

9. The term **"Chief Executive Officer"** means the individual appointed by the Governing Body to act in its behalf in overall management of the Medical Center.

10. The term **"Department Chair**" refers to the individual appointed by the Chief Executive Officer with the concurrence of the Governing Body and in consultation with the Chief of Staff and the Medical Executive Committee, to direct one of the Departments of the Medical Center. The Chair is to live locally and work at the Medical Center a minimum of 1800 hours.

11. The term "**Division Chief**" refers to the individual appointed by the Chair of the Department with the concurrence of the Chief Medical Officer and the Chief of Staff to direct one of the Divisions of the Department.

12. The term "**Allied Health Professional**" or "**AHP**" means an individual who practices in an AHP category approved by the Board of Trustees and who meets the requirements contained in the AHP Rules and Regulations and other applicable Medical Staff documents.

13. The term "**Medical Staff Year**" refers to the period beginning at the annual general Medical Staff meeting of a given year and ending at the annual general Medical Staff meeting of the following year.

14. The term "**House Staff**" means individuals who are accepted into an approved postgraduate medical education program at this institution, or an affiliated facility, and who treat patients under the supervision and direction of the faculty members of the Medical Staff.

15. The term **"Monthly"** when referring to meetings, means at least ten (10) times per year.

16. The term **"Good Standing"** means a member is not currently the subject of any recommended or final corrective action against his or her membership or privileges.

17. The term **"Chief of Staff**" means the chief officer of the medical staff elected by members of the medical staff.

ARTICLE I
NAME AND PURPOSES

1.1 NAME

The name of this organization is **THE MEDICAL STAFF OF THE ALAMEDA HEALTH SYSTEM** (referred to elsewhere in this document as the Medical Center).

1.2 PURPOSES AND RESPONSIBILITIES

The Medical Staff's purposes are:

a. to assure that all patients admitted to or treated at Alameda Health System receive care at a level of quality and efficiency consistent with generally accepted standards attainable within the Medical Center's means and circumstances, and that patient care services are provided only by a member or members of the Medical Staff or under supervision or direct order of a member or members of the Medical Staff, and within the scope of the clinical privileges granted that member or those members by the Board of Trustees;

b. to provide for a level of professional performance that is consistent with generally accepted standards attainable within the Medical Center's means and circumstances;

c. to organize and support professional education and community health education and support services;

d. to initiate and maintain Medical Staff Rules and Regulations that govern how the Medical Staff carries out its responsibilities for the professional work performed in the Medical Center;

e. to provide a means for the Medical Staff, Board of Trustees and Administration to discuss issues of mutual concern;

f. to provide for accountability of the Medical Staff to the Board of Trustees for the quality of all medical care to patients and for the ethical and professional practices of its members; and

g. to self-govern. There is no intent in these Bylaws to obligate the Board of Trustees, except as the Board of Trustees has agreed. Any provision in these Bylaws which addresses the responsibility and accountability of the Board of Trustees is only effective if the Board has adopted such responsibility and accountability.

1.3 **SELF GOVERNANCE**

The Medical Staff's right of self-governance shall include, but not limited to, the following statements,

a. These bylaws recognize that the organized medical staff has the authority to establish and maintain patient care standards, including full participation in the development of Medical Center-wide policy involving the oversight of care, treatment, and services provided by members and others at Alameda Health System. The medical staff is also responsible for and involved with all aspects of delivery of health care within the Medical Center including, but not limited to, the treatment and services delivered by practitioners credentialed and privileged through the mechanisms described in these bylaws and the functions of credentialing and peer review.

b. These bylaws acknowledge that the provision of quality medical care in the Medical Center depends on the mutual accountability, interdependence, and responsibility of the medical staff and the Medical Center governing board for the proper performance of their respective obligations.

1.4 AUTHORITY OF THE MEDICAL STAFF AND DELEGATION OF AUTHORITY TO THE MEDICAL EXECUTIVE COMMITTEE

The Medical Staff has delegated to the Medical Executive Committee certain authorities as described in Sections 11.3, 14.1, and other sections in these Bylaws including the ability to recommend to the Medical Staff changes to the Bylaws and formulate and approve Medical Staff rules and regulations and policies. The Medical Staff reserves the right to override or modify any recommendation or decision made by the Medical Executive Committee related to Medical Staff Bylaws, rules and regulations, and policies and propose additions or modifications to these documents directly to the Board of Trustees. The process for Medical Staff amendment of Bylaws is described in Section 15.1 and recommendations regarding amendments to the Bylaws may be made by the Medical Staff directly to the Board of Trustees with or without the prior recommendation of the Medical Executive Committee. Adoption or amendment of Medical Staff rules and regulations and/or policies by the voting Medical Staff Members can occur following the same process as described in Section 15.1 and recommendations regarding modification of these documents may be made directly to the Board of Trustees with or without the prior recommendation of the Medical Executive Committee. Other delegated duties authorities of the Medical Executive Committee may be removed by voting Medical Staff Members as described in Section 11.3-5.

ARTICLE II
MEMBERSHIP

2.1 NATURE OF MEMBERSHIP

No Physician, Dentist, Podiatrist or Clinical Psychologist, including those in a medical administrative position by virtue of a contract or employment with the Medical Center, shall admit or provide medical or health-related services to patients in the Medical Center unless he/she is a member of the Medical Staff or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws. Appointment to the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws.

2.2 QUALIFICATIONS FOR MEMBERSHIP

Membership and privileges shall be granted, revoked or otherwise restricted or modified based only on the professional training, experience and other criteria as set forth in these bylaws.

2.2-1 GENERAL QUALIFICATIONS

Medical Staff membership and clinical privileges shall be extended only to practitioners who are professionally competent and continuously meet the qualifications, standards, and requirements set forth in these Bylaws and Rules. Medical Staff membership (except Honorary Medical Staff) shall be limited to practitioners who are currently licensed and qualified to practice medicine, podiatry, clinical psychology, or dentistry in California.

2.2-2 BASIC QUALIFICATIONS

A practitioner must demonstrate compliance with all the basic standards set forth in this Section 2.2-2 in order to have an application for Medical Staff membership accepted for review.

a. The practitioner must possess a current licensure under California law as follows.

   1. Physicians must be currently licensed to practice medicine by the Medical Board of California or the Osteopathic Medical Board of California.

   2. Dentists must be currently licensed to practice dentistry by the California Board of Dental Examiners.

   3. Podiatrists must be currently licensed to practice podiatry by the California Board of Podiatric Medicine.

   4. Clinical Psychologists must be currently licensed to practice clinical psychology by the California Board of Psychology.

b. Additional training and certification requirements for all Physicians, Podiatrists and Oral Surgeons. All Physicians initially appointed to the Medical Staff and initially granted clinical privileges after January 1, 2008:

1. Must be currently certified by a board recognized by the American Board of Medical Specialties, the American Osteopathic Association, American Board of Podiatric Surgery, American Board of Oral Maxillofacial Surgery as recognized by the American Dental Association or another board or association with equivalent requirements approved by the Medical Board of California, in a specialty and/or a sub-specialty appropriate to the area of his/her practice as determined by the Medical Executive Committee; or

2. Have successfully completed an approved residency/fellowship training program recognized by the American Board of Medical Specialties, the American Osteopathic Association or another board or association with equivalent requirements approved by the Medical Board of California, in a specialty and/or sub-specialty appropriate to the area of his/her practice as determined by the Medical Executive Committee. Those applicants who are not yet board certified must demonstrate that they currently meet all board certification eligibility requirements as established by the applicable board and are currently an active candidate in the board certification process. For purposes of this Section the term "active candidate" means the physician either has an active application for certification with the applicable board, or has committed in writing to submit an application for certification to the board within six (6) months of initial appointment, and that he/she continues to meet all requirements established by the applicable board as part of the certification process. The Medical Executive Committee shall determine if an applicant or Member is an active candidate in the certification process based on information submitted by the practitioner and on information obtained by the applicable board. A physician who is not yet board certified must maintain his/her active candidate status until they become board certified. The Medical Staff Services Department shall monitor the board certification status of all initial applicants and Members appointed to the Medical Staff after January 1, 2008 who are active candidates for board certification. Board certification must be achieved within the timeframe established by the applicable board.

3. Once board certification is achieved, the physician must continuously maintain his/her board certification status in the specialty and/or sub-specialty in which he/she holds clinical privileges.

4. Exceptions to the provisions in this Section related to board certification, active candidacy, and maintenance of board certification may be made by the Medical Executive Committee, at its sole discretion, for good cause show. This section applies only to practitioners initially appointed to the Medical Staff and initially granted clinical privileges after January 1, 2008 and shall not apply to dentists, podiatrists, clinical psychologists, or physicians appointed to the Medical Staff prior to January 1, 2008. Exception shall also be made for "moonlighting practitioners" pursuant to the Medical Staff Policy "Moonlighting Practitioners".

c. Additional training requirements for Clinical Psychologists. All Clinical Psychologists must have not less than two years of clinical experience in a multidisciplinary facility operated by this or another state or by the United States to provide health care or be listed in the latest edition of the National Register of Health Services Providers in Psychology.

d. The applicant, at the time of application and continuously thereafter, shall also:

1. Have liability insurance covering the exercising of all requested privileges in not less than $1,000,000 per occurrence and $3,000,000 aggregate;

2. Be a member, employee, or subcontractor of a group or person that has a contract in departments operated under an exclusive contract;

3. Not be currently excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid (Medi-Cal); and

4. Maintain current DEA certification if the practitioner is requesting privileges to prescribe medications.

A practitioner who does not meet these basic standards is ineligible to apply for Medical Staff membership, and the application shall not be accepted for review. If an applicant does not meet all of the basic qualifications, the application shall not be processed. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in Article VIII of these Bylaws.

2.2-3 QUALIFICATIONS FOR MEMBERSHIP

In addition to meeting the basic standards, the practitioner must document his or her:

a. adequate experience, education, and training in the requested clinical privileges;

b. current professional competence including:
   1. medical/clinical knowledge
   2. technical and clinical skills
   3. clinical judgment
   4. communication skills
   5. interpersonal skills, and
   6. professionalism

c. good judgment;

d. ability to perform the procedures for which he/she has requested privileges to demonstrate to the satisfaction of the Medical Staff that he or she is professionally and ethically competent so that patients can reasonably expect to receive the quality of care generally recognized in this community; and

e. determination by the Medical Staff to be:

   1. willing and able to adhere to the lawful ethics of his or her profession;

   2. able to work cooperatively with others in the Medical Center setting so as not to adversely affect patient care or Medical Center operations, and

   3. willing and able to participate in and properly discharge Medical Staff responsibilities.

2.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership on the Medical Staff, assignment to a particular staff category, or the granting or renewal of particular clinical privileges merely because of the fact that such person:

a. is licensed to practice a profession in this or any other state;

b. is a member of any particular professional organization;

c. has held in the past, or currently holds Medical Staff membership or privileges at any hospital or health care facility;

d. resides in the geographic service area of the Medical Center;

e. is certified by a particular specialty board; or

f. requires a hospital affiliation in order to participate on health plan provider panels or to pursue other personal business interests unrelated to the treatment of patients at this facility.

2.4 NONDISCRIMINATION

2.4.1 No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of gender, sexual orientation, race, age, creed, color or national origin, or any physical or mental or other disability if, after any necessary reasonable accommodation, the applicant complies with the Bylaws and Rules and Regulations.

2.4.2 The Medical Staff of Alameda Health System shall comply with the AHS Medical Staff Diversity Policy and Procedure to ensure a medical staff fully reflective of the diversity of the community and patients we serve.

2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

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

a. Providing patients with the quality of care meeting the professional standards of the Medical Staff of this Medical Center.

b. Abiding by the Medical Staff Bylaws and Rules & Regulations.

c. Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed on the member by virtue of Medical Staff membership including committee assignments.

d. Preparing and completing in a timely fashion medical records for all patients to whom the member provides care in the Medical Center.

e. Abiding by the lawful ethical principles of the California Medical Association or other applicable professional association.

f. Aiding in any Medical Staff approved educational programs for medical students, interns, resident physicians, resident dentists, staff physicians and dentists, nurses and other personnel although members who choose not to participate in

professional graduate educational programs shall not be subject to denial of Medical Staff membership and privileges.

g. Working cooperatively with members, nurses, Medical Center administration and others so as to create a working environment conducive to quality patient care;

h. Providing continuing coverage for his/her patients and making appropriate arrangements for clinical coverage for his/her patients as required by the Medical Executive Committee;

i. Refusing to engage in fee splitting or in improper inducements for patient referral;

j. Participating in continuing education programs as required by the Medical Executive Committee;

k. Participating in such emergency service coverage or consultation panels as may be required by the Medical Staff;

l. Cooperating in performance improvement activities and the accreditation process;

m. Serving as a proctor or other peer reviewer, and otherwise participating in medical staff peer review as reasonably requested;

n. Discharging such other staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Committee;

o. Providing information to or testifying on behalf of the Medical Staff or accused practitioner regarding any matter under investigation pursuant to Article VII, or which is the subject of a hearing pursuant to Article VIII;

p. Promptly notifying the Chief Executive Officer and the Chief of Staff of the Medical Staff in writing of, and providing such additional information as may be requested, regarding each of the following:

1. The revocation, limitation, or suspension of his or her professional license or DEA registration, any reprimand or other disciplinary action taken by any state or federal governmental agency relating to his or her professional license, or the imposition of terms of probation by any state.

2. Loss, suspension, restriction or denial of staff membership or privileges at any hospital or other health care institution, whether temporary or permanent.

3. Lapse, cancellation or change of professional liability coverage including any change of carrier or amount of coverage.

4. Receipt of a quality inquiry letter, an initial sanction, or notice of the commencement of an investigation, the filing of charges relating to health care matters or exclusion from any federally funded health care organization including Medicare or Medicaid (Medi-Cal), or other action by a Medicare peer review organization, the Department of Health Human Services, or any law enforcement agency or health regulatory agency of the United States or the State of California.

5. Receipt of notice of the filing of any suit against the practitioner alleging professional liability in connection with the treatment of any patient.

6. The development of any mental or physical condition or other situation that could compromise the practitioner's ability to perform the functions associated with his or her clinical privileges in a safe and effective manner.

q. Protecting and preserving the confidentiality of patient health, services, and payment information consistent with federal and state confidentiality laws and the confidentiality policies of Alameda Health System.

2.5-1 ORGANIZED HEALTH CARE ARRANGEMENT

Alameda Health System is a clinically integrated health care setting in which individuals can receive health care from more than one health care provider and Alameda Health System is considered an Organized Health Care Arrangement.

a. The Medical Staff participates in the Alameda Health System Organized Health Care Arrangement.

b. The Alameda Health System Organized Health Care Arrangement utilizes a Joint Notice with respect to protected health care information as described in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

c. Members of the Medical Staff agree to abide by the terms of the Joint Notice utilized by the Alameda Health System Organized Health Care Arrangement with respect to protected health information created or received as part of participation in the Organized Health Care Arrangement.

2.6 BEHAVIOR

Members of the Medical Staff and others holding clinical privileges shall demonstrate a willingness and capability based on current behavior and evidence of performance including:

a. Working with and relate to other staff members, members of other health disciplines, Medical Center management and employees, visitors and the community in general in a cooperative, professional, non-disruptive manner that promotes a culture of safety that is essential for maintaining a hospital environment appropriate to quality and efficient patient care;

b. Discharging the basic obligations of Medical Staff membership and to participate equitably in the discharge of staff obligations appropriate to staff membership category.

Failure of a member to demonstrate behavior as described in 2.6 (a) and (b) may result in responsive action by the medical staff which may include, but is not limited to, disciplinary action as described in Article VIII.

2.7 HARASSMENT PROHIBITED

Harassment by a Medical Staff member against any individual (e.g., against another medical staff member, house staff, Medical Center employee, or patient) on the basis of race, religion, color, national origin, ancestry, physical disability or mental disability, marital status, gender, or sexual orientation shall not be tolerated.

“Sexual harassment” is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as display of derogatory cartoons, drawings, or posters).

Sexual harassment includes unwelcome advances, requests for sexual favors and any other verbal, visual, or physical conduct of a sexual nature when:

a. Submission to or rejection of this conduct by an individual is used as factor in decisions effecting hiring, evaluation, retention, promotion or other aspects of employment; or

b. This conduct substantially interferes with the individual’s employment or creates an intimidating, hostile, or offensive work environment.

Sexual harassment also includes conduct, which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

All allegations of sexual harassment shall be immediately investigated by the Medical Staff, and, if confirmed, will result in appropriate responsive action, from reprimands up to and including termination of Medical Staff privileges or membership, if warranted by the facts.

ARTICLE III
CATEGORIES OF MEMBERSHIP

3.1 CATEGORIES

The categories of the Medical Staff include the following Active, Courtesy, Consulting, Provisional, Honorary and Emeritus, Temporary, Administrative, and Affiliate Staffs. At each time of reappointment, the member's staff category shall be determined.

3.2 ACTIVE STAFF

3.2-1 QUALIFICATIONS

The Active Staff shall consist of members who:

a. meet the general qualifications for membership set forth in Section 2.2;

b. have offices or residences that, in the opinion of the Medical Executive Committee, are located closely enough to the Medical Center to provide appropriate continuity of quality care;

c. regularly care for patients in this Medical Center or are regularly involved in Medical Staff functions. "Regularly care for patients" shall mean are involved in at least forty (40) inpatient or outpatient care activities in two (2) years at Alameda Health System. These patient care activities may consist of admissions (inpatient or outpatient), assisting in surgery, consultations and/or other patient care procedures. Exceptions to this requirement may be made for good cause by the Medical Executive Committee; and

d. have satisfactorily completed their term in the Provisional Staff category as set forth in Section 3.5.

3.2-2 PREROGATIVES

Except as otherwise provided, the prerogatives of an Active Medical Staff member shall be entitled to:

a. apply for admitting and attending privileges and exercise such clinical privileges as are granted pursuant to Article V;

b. attend and vote on matters presented at general and special meetings of the Medical Staff and of the Department and Committees of which he/she is a member; and

c. hold staff, division, or department office and serve as a voting member of committees to which he/she is duly appointed or elected by the Medical Staff or is a duly authorized representative thereof.

3.2-3 TRANSFER OF ACTIVE STAFF MEMBER

After two consecutive years in which a member of the Active Staff fails to regularly care for patients in this Medical Center or be regularly involved in Medical Staff functions as required by the Medical Staff, that member shall be automatically transferred to the appropriate category, if any, for which the member is qualified. In the event that the member is not eligible for any other category, his or her Medical Staff membership shall automatically terminate. No such transfer or termination shall be subject to the provisions of Article VIII.

3.3 COURTESY MEDICAL STAFF

3.3-1 QUALIFICATIONS

The Courtesy Medical Staff shall consist of members who:

a. meet the general qualifications set forth in subsections a and b of Section 3.2-1;

b. admit, refer, or otherwise provide services for at least six (6) patients, but engage in no more than forty (40) patient care activities at the Medical Center per two (2) year period. These patient care activities may consist of admissions (inpatient or outpatient), assisting in surgery, consultations and/or other patient care procedures. Exceptions to this requirement may be made for good cause by the Medical Executive Committee;

c. are members in good standing of the Active Medical Staff of another California licensed hospital, and have been involved in at least eight (8) patient care activities at that hospital, although exceptions to this requirement may be made by the Medical Executive Committee for good cause; and

d. have satisfactorily completed their term in the Provisional Staff category as set forth in Section 3.5.

3.3-2 PREROGATIVES

Except as otherwise provided, the Courtesy Medical Staff member shall be entitled to:

a. apply for admitting and attending privileges within the limitations of Section 3.3-1 b. and exercise such clinical privileges as are granted pursuant to Article V;

b. attend in a non-voting capacity, meetings of the Medical Staff and the Department of which he/she is a member including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment; and

c. Courtesy Staff members shall not be eligible to hold office on the Medical Staff.

3.3-3 RELINQUISHMENT OF COURTESY STAFF

Courtesy Staff members who do not meet the requirements of section 3.3-1 (a-d) shall be deemed to have voluntarily relinquished Courtesy Staff status and shall be automatically transferred to the appropriate staff category, if any, for which the member is eligible. In the event the member is not eligible for any other category, his or her medical staff membership shall automatically terminate. No such transfer or termination shall be subject to the provisions of Article VIII.

3.4 CONSULTING STAFF

3.4-1 QUALIFICATIONS

Any member of the Medical Staff in good standing may consult in his or her area of expertise. However, the Consulting Staff shall consist of such practitioners who:

a. are not otherwise members of the Medical Staff and meet the general qualifications set forth in Section 2.2, except that this requirement shall not preclude an out-of-state practitioner from appointment as may be permitted by law if that practitioner is otherwise deemed qualified by the Medical Executive Committee;

b. are involved in at least one (1) patient care activity at the Medical Center per two (2) year period. This patient care activity(s) may consist of assisting in surgery, consultations and/or other patient care procedures. Exceptions to this requirement may be made for good cause by the Medical Executive Committee;

c. possess a level of clinical and professional expertise deemed adequate by the Medical Executive Committee;

d. are willing and able to come to the Medical Center on schedule or promptly respond when called to render clinical services within their area of competence;

e. are members of the Active Medical Staff of another hospital licensed by California or another State, although exceptions to this requirement may be made by the Medical Executive Committee for good cause; and

f. have satisfactorily completed their term in the Provisional Staff category as set forth in Section 3.5.

3.4-2 PREROGATIVES

The Consulting Medical Staff member shall be entitled to:

a. neither admit nor provide primary care to patients as an attending practitioner but may otherwise exercise such clinical privileges as are granted pursuant to Article V;

b. attend meetings of the Medical Staff and the Department of which he/she is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment;

c. Consulting Staff members shall not be eligible to hold office in the Medical Staff organization, but may serve on committees.

3.4-3 RELINQUISHMENT OF CONSULTING STAFF

Consulting Staff members who do not meet the requirements of Section 3.4.1 (a-f) shall be deemed to have voluntarily relinquished Consulting Staff status and shall be automatically transferred to the appropriate staff category, if any, for which the member is eligible. In the event the member is not eligible for any other category, his or her medical staff membership shall automatically terminate. No such transfer or termination shall be subject to the provisions of Article VIII.

3.5 PROVISIONAL STAFF

All initial applicants to the Medical Staff requesting initial clinical privileges shall be appointed to the Provisional Staff.

3.5-1 QUALIFICATIONS

The Provisional Staff shall consist of members who:

a. meet the general qualifications set forth in Sections 3.2-1 a. and b., 3.3-1 a and b, and 3.4-1 a and b; and

b. immediately prior to their application and appointment were not members (or were no longer members) in good standing of this Medical Staff.

3.5-2 PREROGATIVES

The Provisional Staff member shall be entitled to:

a. exercise such provisional clinical privileges during a period of proctoring as are granted pursuant to Article V;

b. attend meetings of the Medical Staff and the department of which he/she is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

c. Provisional Staff members shall not be eligible to hold office in the Medical Staff organization but may serve on committees.

d. Provisional Staff members who hold the title of the Chair of the Department or the Division Chief shall have full voting rights during their provisional period provided they maintain their Chair or Chief position.

3.5-3 OBSERVATION OF PROVISIONAL STAFF MEMBER

Each Provisional Staff member shall undergo a period of observation by designated monitors as described in Section 5.3. The observation shall be to evaluate the member's:

a. proficiency in the exercise of clinical privileges initially granted; and

b. overall eligibility for continued staff membership and advancement within staff categories.

Proctoring, Focused Professional Practice Evaluations (FPPE), shall include, but not be limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation as described in the Medical Staff Policy and Procedure on Proctoring. Appropriate records shall be maintained. The results of the observation shall be communicated by the Department Chair to the Credentials Committee and the Medical Executive Committee.

3.5-4 TERMS OF PROVISIONAL STAFF STATUS

A member shall remain on the Provisional Staff for a period of at least 6 months but not more than one (1) year, unless that status is extended by the Medical Executive Committee for an additional period of up to one (1) year on a determination of good cause, which determination shall not be subject to review pursuant to Articles VII or VIII.

3.5-5 ACTION AT CONCLUSION OF PROVISIONAL STATUS

a. If the Provisional Staff member has satisfactorily demonstrated his/her ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued Medical Staff membership, the member shall be eligible for placement in the Active, Courtesy, or Consulting Staff, as appropriate, on recommendation of the Medical Executive Committee.

b. In all other cases, the appropriate department shall advise the Credentials Committee, which shall make its report to the Medical Executive Committee, which, in turn, shall make its recommendation to the Board of Trustees regarding a modification or termination of clinical privileges.

c. At the discretion of the Medical Executive Committee, failure to complete one or more “advanced” proctoring requirements shall not of itself preclude advancement to another staff category provided that all core proctoring requirements have been successfully completed pursuant to **Medical Staff Policy and Procedure: Proctoring.**

3.6 HONORARY AND EMERITUS STAFFS

3.6-1 QUALIFICATIONS

a. **Honorary Staff**
The Honorary Staff shall consist of physicians, dentists, podiatrists and clinical psychologists who do not actively practice at the Medical Center but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to healthcare and medical science, or their previous long-standing service to the Medical Center, and who continue to exemplify high standards of professional and ethical conduct.

b. **Emeritus Staff**
The Emeritus Staff shall consist of members who have retired from active practice and, at the time of their retirement, were members in good standing of the Active Medical Staff for a period of at least fifteen (15) continuous years and who continue to adhere to appropriate professional and ethical standards.

3.6-2 PREROGATIVES

Honorary and Emeritus staff members are not eligible to admit patients to the Medical Center, or to exercise clinical privileges in the Medical Center, or to vote or hold office in this Medical Staff organization, but they may serve on committees with or without vote at the discretion of the Medical Executive Committee. They may attend staff and department meetings, including open committee meetings and educational programs.

3.7 TEMPORARY STAFF

3.7-1 QUALIFICATIONS

The Temporary Staff shall consist of physicians, dentists, podiatrists or clinical psychologists, who:

a. do not actively practice at the Medical Center but are important resource individuals for Medical Staff quality assessment and peer review. Such persons shall be qualified to perform the quality assessment and peer review functions for which they are made temporary members of the staff; or

b. hold temporary privileges pursuant to Article 5, Section 5.5.

3.7-2 PREROGATIVES

Temporary Staff members shall be afforded the following prerogatives:

a. Temporary Staff members appointed to engage in specific quality assessment and peer review activities shall be entitled to attend all meetings of committees to which they have been appointed for the limited purpose of carrying out quality assessment and peer review functions. They shall have no privileges to perform clinical services in the Medical Center. They may not admit patients to the Medical Center, or hold office in the Medical Staff organization. They may attend other Medical Staff meetings only upon invitation.

b. Temporary Medical Staff members who hold temporary privileges pursuant to Article 5, Section 5.5, shall perform such clinical services as are defined pursuant to the practitioner's delineated clinical privileges. Such practitioners may not vote or hold office in the Medical Staff organization. They may serve on designated committees at the discretion of the Medical Executive Committee. They may attend other Medical Staff meetings only upon invitation.

3.7-3 APPOINTMENT

Recommendation for appointment to the Temporary Medical Staff for the purpose of quality assessment and peer review shall be made by the Chief Medical Officer or designee acting on behalf of the Board of Trustees utilizing the same process as described in Article 5, Section 5.5, except that clinical privileges will not be granted. A Temporary Staff Member assisting the Medical Staff in quality assessment and peer review activities shall be verified as competent to provide an opinion regarding the clinical matters he or she is being asked to review.

Appointment to the Temporary Medical Staff shall occur automatically with the granting of temporary privileges pursuant to Article 5, Section 5.5.

3.7-4 TERM

Membership on the Temporary Medical Staff shall be time limited and the exact duration of membership shall be specified at the time of appointment to the Temporary Medical Staff. For Practitioners holding temporary privileges pursuant to Article 5, Section 5.5, the duration of Temporary Medical Staff membership shall coincide with the duration of temporary privileges.

3.8 ADMINISTRATIVE STAFF

3.8-1 QUALIFICATIONS

Administrative Staff category membership shall be held by any Physician who is not currently a Medical Staff Member in another staff category and who is retained by the Medical Center or Medical Staff solely to perform ongoing medical administrative activities.

The Administrative Staff shall consist of Members who:

a. are charged with assisting the Medical Staff in carrying out medical-administrative functions, including but not limited to quality assessment, peer review, performance improvement, and utilization review;

b. document their current licensure, adequate experience, education and training, current professional competence, good judgment, and current physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent to exercise their duties, and;

c. are determined to adhere to the ethics of their respective professions, to be able to work cooperatively with others so as not to adversely affect their judgment in carrying out the quality assessment and improvement functions, and to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff.

3.8-2 PREROGATIVES

The Administrative Staff:

a. Shall be entitled to attend meetings of the Medical Staff, departments, sections, and committees, but shall have no right to vote at such meetings, except to the extent the right to vote is specified at the time of appointment.

b. Shall not be eligible to hold office in the Medical Staff organization, admit patients or exercise Clinical Privileges.

c. Shall not be required to maintain professional liability insurance.

3.10 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these Bylaws and by the Medical Staff Rules and Regulations.

3.11 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership in the Medical Staff, unless otherwise required by law, dentists, podiatrists, and clinical psychologists:

a. shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the Chair of the meeting, subject to final decision by the Medical Executive Committee; and

b. shall exercise clinical privileges only within the scope of their licensure and as set forth in Section 5.4.

3.12 MODIFICATION OF MEMBERSHIP CATEGORY

On its own, on recommendation of the Credentials Committee, or pursuant to a request by a member under Section 4.6-1(b), the Medical Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of the Bylaws.

ARTICLE IV
APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL

Except as otherwise specified herein, no person (including persons engaged by the Medical Center in administratively responsible positions), shall exercise clinical privileges in the Medical Center unless and until he/she applies for and receives appointment to the Medical Staff or is granted temporary privileges as set forth in these Bylaws. By applying to the Medical Staff for appointment or reappointment, the applicant acknowledges responsibility to first review these Medical Staff Bylaws, Rules and Regulations, Medical Staff and Medical Center policies and procedures and agrees that throughout any period of membership he/she will comply with responsibilities of Medical Staff membership and with the Bylaws and Rules and Regulations of the Medical Staff as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws. For the purpose of this article, the term "Member" or "applicant" shall include members of or applicants to the Medical Staff and Allied Health Practitioner Staff, as applicable under the circumstances.

4.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for, appointment, reappointment, advancement, transfer or a request for new or additional privileges, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. This burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Executive Committee, which may select the examining physician. Failure of the practitioner to produce required information related to an authorized Medical Staff peer review, quality assessment, performance improvement, or credentialing activity in a timely manner, shall result in an automatic suspension of all clinical privileges until such time as the required information has been provided. If within thirty (30) days after the automatic suspension, the required information is not produced, the lack of response will be considered a voluntary resignation.

4.3 COMPLETE APPLICATION – PREREQUISITE FOR ACTION

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

An application for appointment, reappointment or new clinical privileges shall be deemed "incomplete" for purposes of this section 4.3 unless and until:

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

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

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

4.3-1 REQUEST FOR NEW OR ADDITIONAL PRIVILEGES

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

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

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

4.3-2 ACTION ON INCOMPLETE APPLICATION

An application that is determined to be incomplete shall not qualify for a credentialing recommendation by any Medical Staff official or committee or by the Board of Trustees regardless of any assessment or determination that may have been made as to its completeness at an earlier stage in the process. Should the applicant fail to make the application complete after being given a reasonable opportunity to do so, the applicant will be deemed withdrawn and the credentialing process will be terminated. A "reasonable opportunity" under this Section shall be thirty (30) days unless extended for good cause by the official or committee before whom the application is pending. Termination of the

credentialing process under this Section shall not be subject to the provisional of Article VIII.

4.3-3 APPLICATION UPDATE

Until notice is received from the Board of Trustees regarding final action on an application for appointment, reappointment or new clinical privileges, the applicant shall be responsible for keeping the application current and complete by informing the Medical Staff, in writing, of any material change in the information provided or of any new information that might reasonably have an effect on the applicant's candidacy. Failure to meet this responsibility will be grounds for denial of the application, nullification of an approval, if granted and/or immediate termination of Medical Staff membership and/or clinical privileges.

4.4 APPOINTMENT AUTHORITY

Appointments, denials and revocations of appointments to the Medical Staff shall be made as set forth in these Bylaws, but only after there has been a recommendation from the Medical Executive Committee.

4.5 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these Bylaws, initial appointments to the Medical Staff and reappointments and/or renewal of clinical privileges shall be for a period of up to two (2) years

4.6 APPLICATION FOR INITIAL APPOINTMENT

4.6-1 APPLICATION FORM

An application form shall be developed by the Medical Executive Committee. The Medical Staff application forms are peer review documents, an official record of the Medical Executive Committee, and are afforded all protections pursuant to California Evidence Code 1157. The form shall require detailed information which shall include, but not be limited to, information concerning:

a. postgraduate training, including the name of each institution, degrees granted, programs completed, dates attended and the names of practitioners responsible for the applicant's performance;

b. specialty or subspecialty board certification and eligibility;

c. the applicant's qualifications, including but not limited to, professional training and experience, current licensure, current DEA registration, special certification, where applicable, ability to perform privileges

requested and continuing medical education information related to the clinical privileges to be exercised by the applicant;

d. peer references familiar with the applicant's professional competence and ethical character;

e. requests for membership categories, department assignments, and clinical privileges;

f. past or pending professional disciplinary action to any licensure or registration, voluntary or involuntary denial, revocation, suspension, reduction or relinquishment of medical staff membership or privileges or any such licensure or registration and related matters; current physical and mental health status;

g. final judgments or settlements made against the applicant in professional liability cases and any filed and served cases pending;

h. all past and present out of-state medical licenses;

i. past practice history;

j. current hospital affiliations;

k. the existence and circumstances of any professional liability claim or other cause of action that has been lodged against the practitioner, and the status or outcome of each such matter, including all final judgments and/or settlements involving the practitioner;

l. any voluntary or involuntary termination or denial of Medical Staff membership or voluntary or involuntary limitation, suspension, reduction, relinquishment, or other loss of clinical privilege at any other hospital or health care facility;

m. any prior or pending government agency or third party proceeding or litigation challenging or sanctioning the practitioner's admission, treatment, discharge, billing, collection, or utilization practices, including but not limited to Medicare and Medicaid (Medi-Cal) fraud and abuse proceedings, convictions, and/or settlements;

n. information as to any current or pending sanctions affecting participation in any Federal Health Care Program or any action which might cause the practitioner to become an ineligible person, as well as any sanctions from a Medicare professional review organization; and

o. information as to whether the applicant has ever been subject to criminal conviction or whether any such action is pending.

Each application for initial appointment to the Medical Staff shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. When an applicant requests an application form, he/she shall be given a copy of these Bylaws and the Medical Staff Rules and Regulations.

4.6-2 EFFECT OF APPLICATION

In addition to the matters set forth in Section 4.1, by applying for appointment to the Medical Staff each applicant:

a. signifies his/her willingness to appear for interviews in regard to the application;

b. authorizes consultation with others who have been associated with him/her and who may have information bearing on his/her competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;

c. consents to inspection of records and documents that may be material to an evaluation of his/her qualifications and ability to exercise clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

d. releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant;

e. releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;

f. consents to the disclosure to other hospitals, medical associations, and licensing boards, and to other similar organizations as required by law, any information regarding his/her professional or ethical standing that the hospital or Medical Staff may have, and releases the Medical Staff and hospital from liability for so doing to the fullest extent permitted by law;

g. if a requirement then exists for Medical Staff dues, acknowledges responsibility for timely payment;

h. pledges to provide for continuous quality care for his/her patients;

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

j. pledges to be bound by the Medical Staff Bylaws, Rules and Regulations and Medical Staff and Medical Center organizational policies and procedures.

4.6-3 VERIFICATION OF INFORMATION

The applicant shall deliver a completed application to the Medical Staff Services Department and an advance payment of Medical Staff dues or fees, if any is required. Failure to submit a completed application shall result in the application being filed as administratively incomplete and the applicant shall not have a right to a hearing pursuant to Article VIII. The Medical Staff Services Department shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to provide the required information. No final action will be taken on an application until all necessary information has been verified. When collection and verification is accomplished, all such information shall be transmitted to the Credentials Committee for action.

4.6-4 DIVISION CHIEF AND DEPARTMENT ACTION

After receipt of the application, the Division Chief, where applicable, and the Chair of the Department to which the application is submitted, shall review the application and supporting documentation, and may conduct a personal interview with the applicant at his/her discretion. The Division Chief and the Chair of the Department shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges granted, and shall transmit to the Credentials Committee a written report and recommendation as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached. The Division Chief and the Chair of the Department may also request that the Medical Executive Committee defer action on the application.

4.6-5 CREDENTIALS COMMITTEE ACTION

The Credentials Committee shall review the application, evaluate and verify the supporting documentation, the Department Chair's report and recommendations, and other relevant information. The Credentials Committee may elect to interview

the applicant and seek additional information. As soon as practicable, the Credentials Committee shall transmit to the Medical Executive Committee, a written report and its recommendations as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The Credentials Committee may also recommend that the Medical Executive Committee defer action on the application.

4.6-6 MEDICAL EXECUTIVE COMMITTEE ACTION

At its next regular meeting after receipt of the Credentials Committee report and recommendation, or as soon thereafter as is practicable, the Medical Executive Committee shall consider the report and any other relevant information. The Medical Executive Committee may request additional information, return the matter to the Credentials Committee for further investigation, and/or elect to interview the applicant. The Medical Executive Committee shall forward, for prompt transmittal to the Quality Professional Services Committee, where applicable, and Board of Trustees, a written report and recommendation as to Medical Staff appointment, and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The Committee may also defer action on the application. The reasons for each recommendation shall be stated.

4.6-7 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

a. Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, it shall be promptly forwarded, together with supporting documentation, as appropriate, to the Board of Trustees.

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

4.6-8 ACTION ON THE APPLICATION

The Board of Trustees may accept or reject the recommendation of the Medical Executive Committee or may refer the matter back to the Medical Executive Committee for further consideration, stating the purpose for such referral. If the Board of Trustees' action is a ground for a hearing under Article VIII of the Bylaws, the Chief of Staff or his or her designee shall promptly inform the applicant that he or she shall be entitled to the procedural rights as provided by Article VIII. In the case of an adverse Medical Executive Committee

recommendation or an adverse Board of Trustees decision, the Board of Trustees shall take final action in the matter only after the applicant has exhausted or has waived his or her Bylaws Article VIII procedural rights.

4.6-9 NOTICE OF FINAL DECISION

a. Notice of the final decision shall be given to the Chief of Staff, the Medical Executive and Credentials Committees, the Chair of each Department concerned, the applicant, the Chief Medical Officer, and the Chief Executive Officer.

b. A decision and notice to appoint or reappoint shall include, where applicable, the:

1. staff category to which the applicant is appointed;

2. department to which he/she is assigned;

3. clinical privileges granted; and

4. special conditions attached to the appointment.

4.6-10 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

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 two (2) years after the date of the final adverse decision. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

4.6-11 TIMELY PROCESSING OF APPLICATIONS

Applications for Staff appointments which have been deemed by the Medical Staff Services Department to be complete shall be considered in a timely manner by all persons and committees required by these Bylaws to act thereon. While special or unusual circumstances may constitute good cause and warrant exceptions, the following time periods provide a guideline for routine processing of applications.

a. Evaluation, review, and verification of the application and all supporting documents within sixty (60) days from receipt of an application that is complete and includes all necessary supporting documentation.

b. Review and recommendation by the Division Chief and the Chair of the Department(s) within thirty (30) days after receipt of all necessary documentation from the Medical Staff Services Department.

c. Review and recommendation by the Credentials Committee within thirty (30) days after receipt of all necessary documentation.

d. Review and recommendation by the Medical Executive Committee within sixty (60) days after receipt of all necessary documentation.

e. Final action of the Board of Trustees within sixty (30) days after receipt by the Board of Trustees of all necessary documentation or within fourteen (14) days after the conclusion of proceedings under Article VIII.

The failure to meet these time periods shall not confer any rights to appointment or privileges upon an applicant.

4.7 REAPPOINTMENTS AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES.

4.7-1 APPLICATION

a. Approximately six (6) months prior to the expiration date of the current Staff appointment, a reapplication form developed by the Medical Executive Committee shall be mailed or delivered to the member. At least one hundred and twenty days (120) days prior to the expiration date, each Medical Staff member must submit to the Medical Staff Services Department the completed application form for renewal of appointment to the Staff for the coming term of appointment, and for renewal or modification of clinical privileges. If an application for reappointment is not received by the Medical Staff Services Department at least one hundred and twenty days (120) days prior to the expiration date, written notice shall be promptly sent from the Medical Staff Services Department to the applicant advising the applicant that the application has not been received. The reapplication form 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 4.6-1, as well as other relevant matters. On receipt of the application, the information shall be processed as set forth commencing at Section 4.6-3.

b. A Medical Staff member who seeks a change in Medical Staff status or modification of clinical privileges may submit such a request at any time except that such request may not be filed within one (1) year of the time a similar request has been denied. Such applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the change requested, of resolving any

reasonable doubts about these matters, and of satisfying requests for information.

4.7-2 EFFECT OF APPLICATION

The effect of an application for reappointment or modification of Staff status or privileges is the same as that set forth in Section 4.6 except that the recommendations of the Department Chair shall be sent directly to the Medical Executive Committee for action on all Level 1 reappointment applications. Department Chair recommendations regarding Level 2 reappointment applications will be sent by the Department Chair to the Credentials Committee prior to submission to the Medical Executive Committee. Level 1 and Level 2 criteria are described in **Medical Staff Policy and Procedure: Reappointment Levels.**

4.7-3 STANDARDS AND PROCEDURE FOR REVIEW

When a Staff member submits the first application for reappointment, and at every subsequent reappointment, or when the member submits an application for modification of staff status or clinical privileges, the member shall be subject to an in-depth review generally following the procedures set forth in Section 4.6-3 through 4.6-11. In each such instance, the member’s eligibility for Medical Staff membership as set forth in Article II, and the member’s eligibility for assignment to a category of the Medical Staff as set forth in Article III, shall be determined.

4.7-4 TIME-LIMITED APPOINTMENT

If an application for reappointment has not been fully reviewed by the expiration date of the member's appointment, the staff member shall maintain membership status and clinical privileges until such time as the review is completed unless the delay is due to the member's failure to timely complete and return the reappointment application form or provide other documentation or cooperation. The time-limited appointment pursuant to this section does not create a vested right in the member for continued appointment through the entire next term but only until such time as review of the application is concluded. If processing of the application is delayed due to a member's failure to timely complete and return the reappointment application form or provide other documentation or cooperation, the matter will be handled as described in Section 4. 7-5.

4.7-5 FAILURE TO FILE REAPPOINTMENT APPLICATION

Failure to return a completed application form to the Medical Staff Services Department within ninety (90)days prior to the applicant's appointment expiration date shall result in an automatic suspension of the member's privileges at the end of the current staff appointment, unless otherwise extended by the Medical Executive Committee with the approval of the Board of Trustees. If the

member fails to submit a completed application for reappointment within thirty (30) days of initiation of the automatic suspension, the member's membership shall be deemed to have automatically terminated. In the event membership terminates for the reasons set forth in this paragraph, the procedures set forth in Article VIII shall not apply.

4.8 LEAVE OF ABSENCE

4.8-1 LEAVE STATUS

At the discretion of the Medical Executive Committee, a Medical Staff member may obtain a voluntary leave of absence from the staff on submitting a written request to the Medical Executive Committee stating the approximate period of leave desired, which may not exceed one (1) year. During the period of the leave, the member shall not exercise clinical privileges at the Medical Center, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the Medical Executive Committee.

4.8-2 TERMINATION OF LEAVE

At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff member may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee. All applicants for reinstatement shall demonstrate their continuing qualifications to exercise their clinical privileges to the satisfaction of the Medical Executive Committee. The Staff member shall submit a summary of relevant activities during the leave, if the Medical Executive Committee so requests. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the member's privileges and prerogatives following the procedure provided in Sections 4.1 through 4.5-11.

4.8-3 FAILURE TO REQUEST REINSTATEMENT

Failure without good cause to request reinstatement shall result in automatic termination of membership, privileges, and prerogatives. In the event membership terminates for the reasons set forth in this paragraph, the procedures set forth in Article VIII shall not apply. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

ARTICLE V
CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws, a Member providing clinical services at this Medical Center shall be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be Medical Center specific, within the scope of any license, certificate or other legal credential authorizing practice in this State and consistent with the Medical Staff Bylaws, Rules and Regulations, Medical Staff and Medical Center Policies and Procedures.

5.2 DELINEATION OF PRIVILEGES IN GENERAL

5.2-1 REQUESTS

a. Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. Independent Allied Health Practitioners who seek to exercise independent clinical privileges must specifically delineate the privileges requested. A request by a member for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request.

b. Each department is responsible for developing criteria for granting clinical privileges.

c. The burden of providing sufficient information to evaluate a request for privileges rests with the applicant. The provisions of 4.2 apply to requests for privileges.

5.2-2 BASIS FOR PRIVILEGES DETERMINATION

a. Requests for clinical privileges shall be evaluated on the basis of the member's education, training, experience, current licensure, demonstrated professional competence and judgment, clinical performance, current health status, and the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges.
b. No specific privilege may be granted to a member if the task, procedure or activity constituting the privilege is not available within the hospital despite the member's qualifications or ability to perform the requested privilege.

5.2-3 CRITERIA FOR "CROSS-SPECIALTY" PRIVILEGES WITHIN THE MEDICAL CENTER

Any request for clinical privileges that are either new to the Hospital or that overlap more than one department shall initially be reviewed by the appropriate departments, in order to establish the need for, and appropriateness of, the new procedure or services. The MEC shall facilitate the establishment of hospital-wide credentialing criteria for new or trans-specialty procedures, with the input of all appropriate departments, with a mechanism designed to ensure that quality patient care is provided for by all individuals with such clinical privileges. In establishing the criteria for such clinical privileges, the MEC may establish an ad-hoc committee with representation from all appropriate Departments. Attention should be given to the education, training, and experience necessary to perform the clinical privileges in question, and the extent of monitoring and supervision that should be required.

5.3 PROCTORING

5.3-1 GENERAL PROVISIONS

Except as otherwise determined by the Medical Executive Committee, all initial appointees to the Medical Staff and all members granted new clinical privileges shall be subject to a period of proctoring. In addition, the Medical Executive Committee may require members to be proctored as a condition of renewal of privileges (for example, where a member has performed a procedure so infrequently that it is difficult to assess competency in that area), or whenever the Medical Executive Committee determines that additional information is needed to assess a practitioner's performance. Each member or recipient of new clinical privileges shall be assigned to a department where performance on an appropriate number of cases as established by the medical executive committee, or the department as designee of the medical executive committee, shall be observed by the chair of the department, or the chair's designee, during the period of proctoring to determine suitability to continue to exercise the clinical privileges granted in that department. Proctoring shall also be subject to such rules and regulations or policies as the Medical Staff may adopt. The exercise of clinical privileges in any other department shall also be subject to direct observation by that department's chair or the chair's designee. The member shall remain subject to such proctoring until the Medical Executive Committee has been furnished with:

a. a report signed by the Chair of the Department(s) to which the member is assigned describing the types and numbers of cases evaluated and the evaluation of the applicant's performance, including a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused

the prerogatives of the category to which the appointment was made; and

b. a report signed by the chair of the other department(s) in which the appointee may exercise clinical privileges, describing the types and number of cases evaluated and the evaluation of the applicant's performance and a statement that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments.

5.3.2 FAILURE TO COMPLETE PROCTORING

a. If an initial appointee fails within the time of provisional membership to complete the proctoring requirement in Section 5.3-1, or if a member exercising new clinical privileges fails to complete the proctoring requirement, those specific clinical privileges shall automatically terminate, and the member shall not be entitled to a hearing pursuant to Article VIII.

b. If a member of the Provisional Staff fails to complete the proctoring requirement in Section 5.3-1 for all of the clinical privileges requested, that individual's medical staff membership shall terminate, and the member shall not be entitled to a hearing pursuant to Article VIII.

c. If a practitioner fails to complete proctoring requirements because of quality of care concerns or any medical disciplinary cause or reason (as that term is defined in Business and Professions Code section 805), the failure will constitute a termination of the clinical privileges in question and the provisions of Article VIII shall apply.

d. At the discretion of the Medical Executive Committee, a practitioner may be advanced from the Provisional category to another category of membership when the practitioner has successfully completed all core proctoring requirements as described on the Proctoring Requirement Form even if one or more of the proctoring requirements for advanced privileges has not been completed.

5.4 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

5.4-1 ADMISSIONS

Every patient admitted to the Medical Center shall have a history and physical examination completed by a physician or other Practitioner who has been determined by the Medical Staff to be qualified and competent to perform history

and physical examinations and holds appropriate clinical privileges or practice prerogatives. Dentists, oral surgeons, podiatrists and clinical psychologists who are members of the Medical Staff but do not hold privileges to perform the history and physical exam, may only admit patients if a physician member of the Medical Staff holding such privileges must document and conduct or directly supervises the admitting history and physical examination (except the portion related to dentistry, oral surgery, podiatry, or clinical psychology) and assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization and which are outside the limited license practitioner's lawful scope of practice.

If a history and physical examination is performed by a Practitioner authorized to perform such examinations by the Medical Staff but who is not a Licensed Independent Practitioner, the history and physical examination must be reviewed and authenticated within 24 hours of admission by a Licensed Independent Practitioner who has been authorized by the Medical Staff to perform history and physical examinations.

5.4-2 SURGERY

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

5.4.3 MEDICAL APPRAISAL

All patients admitted for care in the Medical Center by a dentist, podiatrist or clinical psychologist shall receive the same basic medical appraisal as patients admitted to other services, and a physician member shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based on medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate department(s).

5.5 HISTORY AND PHYSICAL – COMPLETION OF:

a. Every patient receives a history and physical within twenty-four (24) hours of admission, unless a previous history and physical performed within thirty days of admission is on record, in which case that history and physical will be updated within twenty-four hours of admission. Every patient admitted for surgery must have a history and physical within twenty-four (24) hours prior to surgery, unless a previous history and physical performed within thirty (30) days prior to the surgery is on record, in which case that history and physical will be updated within twenty-four hours of the surgery.

b. Histories and physicals can be conducted or updated only pursuant to specific privileges granted upon request to qualified physicians and other practitioners who are members of the medical staff or seeking temporary privileges, acting within their scope of practice.

5.6 TEMPORARY PRIVILEGES

5.6.1 REQUIREMENT OF NEED AND DEFINITION OF CIRCUMSTANCES

a. Temporary privileges may be granted for a limited period of time on a case-by-case basis when:

1. there is an important patient care need that mandates an immediate authorization to practice; or

2. in pendency of Medical Executive Committee and Board of Trustees action on a completed application

b. Temporary privileges may therefore be granted in the following circumstances:

1. Care of a Specific Patient: Temporary clinical privileges may be granted where good cause exists to allow a physician, dentist, podiatrist, clinical psychologist to provide care to a specific patient (but not more than 4 during a calendar year) provided that the procedure described in Section 5.6-2 has been completed.

2. Locum Tenens: Based on documentation of patient care need, temporary privileges may be granted for a specified period not to exceed a total of 120 days to a person serving as a locum tenens for a current member of the Medical Staff. Such person may attend only patients of the member for whom he or she is providing coverage. The practitioner serving as a locum tenens must have the same qualifications and privileges as the person for whom he or she is providing coverage.
Temporary clinical privileges may be granted to a person serving as a locum tenens for a current member of the medical staff to meet the care needs of that member's patients in his/her absence, provided that the procedure described in Section 5.6-2 has been completed. Such person may attend only patients of the member(s) for whom that person is providing coverage, for a period not to exceed 120 days, unless the medical executive committee recommends a longer period for good cause.

3. Pending Completion of the Credentialing Process: Temporary clinical privileges may be granted to an applicant while that person's application for medical staff membership and privileges is completed and awaiting review and approval of the medical executive committee or the board of trustees provided that the procedure described in Section 5.6-2 has been completed, and that the applicant has no current or previously successful challenge to professional licensure or registration, no involuntary termination of medical staff membership at any other organization, and no involuntary limitation, reduction, denial or loss of clinical privileges. Such persons may only attend patients for a period not to exceed 120 days.

5.6.2 APPLICATION AND REVIEW

a. Upon request of temporary privilege application related to 5.6-1(b)(1) or (2) and receipt of all required fees and supporting documentation from a physician, dentist, podiatrist or clinical psychologist who is authorized to practice in California and who meets one of the requirements for need, the Board of Trustees through the Chief Executive Officer or administrative designee may grant temporary privileges to an individual who appears to have qualifications, ability, and judgment consistent with Article II, but only after the following has occurred.

1. The passage of a minimum of five (5) working days to permit verification of information, although exceptions may be made for good cause.

2. Primary source verification in writing or through a documented telephone conversation of licensure status, current competence relevant to the privileges requested, and insurance status is obtained.

3. A National Practitioner Data Bank query.

4. An OIG sanction report and GSA List query to ensure that applicant is not an excluded provider.

5. Review of information and written or verbal recommendation has been obtained from the Chair or designee of each department from which the applicant is requesting privileges.

6. The applicant's file, including the recommendation of the Chair of the Department or designee, is reviewed on behalf of the Medical Executive Committee by the Chief of Staff or designee.

7. Documentation of patient care need mandating the granting of temporary privileges is obtained.

8. The Chief of Staff or designee recommends and the Board of Trustees, through the Chief Medical Officer, concurs in the granting of temporary privileges.

b. All practitioners requesting temporary privileges pursuant to Section 5.6-1(b)(1) or (2) must demonstrate Active Staff membership at a Joint Commission approved hospital, although exceptions may be made by the Chief of Staff or designee for good cause.

c. Upon receipt of a completed Medical Staff application and a request for temporary privileges related to Section 5.6-1(b)(3), temporary privileges may be granted when an applicant is awaiting review and approval of the Medical Executive Committee and Board of Trustees provided that the:

1. completed application with no current or previously successful challenge to licensure or registration has received a favorable recommendation from the appropriate Chair of the Department and is ready for immediate submission to the Medical Executive Committee for action;

2. provider is not subject to involuntary termination of medical staff membership or restriction of privileges at another organization

3. practitioner has not been involved in a Medical Staff or licensure disciplinary action which resulted in a decision adverse to the practitioner, and

4. Chief of Staff or designee recommends and the Board of Trustees, through the Chief Executive Officer, concurs in the granting of temporary privileges.

d. In the event of a disagreement between the Board of Trustees and the Medical Executive Committee regarding the granting of temporary clinical privileges, the matter shall be referred to the Medical Staff Joint Conference Committee for resolution.

e. The omission of any information, response or recommendation specified in this section shall preclude the granting of temporary privileges.

5.6-3 GENERAL CONDITIONS

a. Temporary privileges shall be exercised under the supervision of the Chair of each department to which the applicant has been assigned. The applicant shall ensure that the Chair, or the Chair's designee, is kept closely informed as to the applicant's activities within the Medical Center.

b. All temporary privileges are time limited and shall automatically terminate at the end of the designated period. The provisions of Article VIII shall not apply to such termination.

c. Requirements for proctoring shall be imposed on individuals granted temporary privileges at the discretion of the Chief of Staff or designee. The requirements shall be determined by the Chief of Staff or designee after consultation with the Chair of any department to which the applicant is assigned.

d. All persons requesting or receiving temporary privileges shall be bound by the Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Medical Center policies and procedures.

5.7 EMERGENCY PRIVILEGES

In the event of an emergency, any person shall be permitted to do whatever is reasonably possible to save the life of a patient from serious harm. Such persons shall promptly yield such care to qualified member(s) of the Medical Staff when such member(s) becomes reasonably available.

5.8 DISASTER PRIVILEGES

In the case of a disaster in which the disaster plan has been activated and the hospital is unable to handle the immediate patient needs, the Chief Executive Officer of the Hospital or Chief of Staff or their designee are authorized to grant disaster privileges. The grant of privileges under this subsection shall be on a case-by-case basis at the sole discretion of the individual authorized to grant such privileges. An initial grant of disaster privileges is reviewed by a person authorized to grant disaster privileges within 72 hours to determine whether the disaster privileges should be continued.

(a) The verification process of the credentials and privileges of individuals who receive disaster privileges under this subsection shall be developed in advance of a disaster situation. This process shall begin as soon as the immediate disaster situation is under control, and shall meet the following requirements in order to fulfill important patient care needs:

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

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

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

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

(5) Those authorized under subsection (a) may grant disaster privileges upon presentation of a valid picture ID issued by a state or federal agency and at least one of the following:

(i) A current picture hospital ID card clearly identifying professional designation.

(ii) A current license to practice.

(iii) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organizations or groups.

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

(v) Identification by current hospital or medical staff member(s) with personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

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

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

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

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

(c) Members of the medical staff shall oversee those granted disaster privileges.

5.9 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

On its own, on recommendation of the Credentials Committee, or pursuant to a request under Section 4.6-1 (b), the Medical Executive Committee may recommend a change in the clinical privileges or department assignment(s) of a member. The Medical Executive Committee may also recommend that the granting of additional privileges to a current Medical Staff member be made subject to monitoring in accordance with procedures similar to those outlined in Section 5.3-1.

5.10 LAPSE OF APPLICATION

If a Medical Staff member requesting membership, clinical privileges, renewal of existing privileges or modification of clinical privileges or department assignments, fails to furnish the information necessary to evaluate the request in the time frame as established in these Bylaws, the application shall automatically lapse and the applicant shall not be entitled to a hearing as set forth in Article VIII.

5.11 DISSEMINATION OF PRIVILEGES LIST

Documentation of current privileges (granted, modified, or rescinded) shall be disseminated to the hospital to maintain an up-to-date listing of privileges for purposes of scheduling and monitoring to assure that practitioners are appropriately privileged to perform all service rendered.

5.12 TELEMEDICINE PRIVILEGES

5.5-1 Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care by a practitioner at a distant site to patients located at an originating site. Practitioners who render a diagnosis or otherwise provide clinical treatment to a patient at this hospital by telemedicine are subject without exception to the Medical Staff credentialing and privileging process in these Bylaws.

5.5-2 Services
Services provided by telemedicine shall be identified by each specific department

5.5-3 Qualification for Privileges to Provide Services Via Telemedicine
In order to qualify for telemedicine privileges, the practitioner must meet all the requirements set forth in these Bylaws for privileges (either temporary or granted in connection with membership).

ARTICLE VI
ALLIED HEALTH PROFESSIONALS

6.1 QUALIFICATIONS

Allied Health Professionals (AHPs) are not eligible for Medical Staff membership. AHPs who demonstrate evidence of current licensure, relevant training and/or experience, professional competence, and continuously meet the qualifications, standards, and requirements set forth in these Bylaws and the applicable Rules and Regulations including the AHP Rules and Regulations, may be granted clinical privileges or practice prerogatives by the Medical Center.

6.2 CATEGORIES OF AHP

6.2.1 DELINEATION OF ELIGIBLE AHP CATEGORIES

The types of AHPs granted clinical privileges or practice prerogatives in the Medical Center are determined by the Board of Trustees, based on the comments of the Committee on Interdisciplinary Practice, Credentials Committee, Medical Executive Committee and such other information as may be available to the Board of Trustees.

6.2.2 CURRENT ELIGIBLE CATEGORIES

AHPs, who practice in categories that have been accepted for admission to this Medical Center by the Board of Trustees, are eligible for appointment to AHP status.

The Board of Trustees has approved the following categories of Independent AHPs:

a. Acupuncturist
b. Audiologist
c. Optometrist

The Board of Trustees has approved the following categories of Dependent Allied Health Practitioners:

a. Nurse Practitioner
b. Certified Registered Nurse Anesthetist
c. Certified Nurse Midwife

d. Physician Assistant

6.2-3 NON-ELIGIBLE CATEGORIES

An AHP who does not have licensure or certification in an AHP category identified as eligible to apply for practice prerogatives in Section 6.2-2 above may not apply for practice prerogatives, but may submit a written request to the Chief Medical Officer asking that the Board of Trustees consider identifying the relevant category of AHPs as eligible to apply for practice prerogatives. The Board of Trustees may refer the request to the Medical Executive Committee for recommendation.

6.3 VOTING PRIVILEGES AND COMMITTEE MEETINGS

AHPs shall not be entitled to vote on Medical Staff matters or to satisfy any Medical Staff attendance requirements. They shall, however, be expected to attend and participate actively in the clinical meetings of their respective departments to the extent permitted by the Department Chair.

ARTICLE VII
CORRECTIVE ACTION

7.1 CORRECTIVE ACTION

7.1-1 ROUTINE MONITORING AND EDUCATION

The departments and committees are responsible for carrying out delegated peer review and quality improvement functions. They may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the practitioner is only required to provide reasonable notice of admissions and procedures) in the course of carrying out those functions without initiating formal corrective action. Comments, suggestions, and warnings may be issued orally or in writing. The practitioner shall be given an opportunity to respond in writing and may be given an opportunity to meet with the department or committee. Any informal actions, monitoring, or counseling shall be documented in the member’s file. Medical Executive Committee approval is not required for such actions, although the actions shall be reported to the Medical Executive Committee. Such actions shall not constitute a restriction of privileges or grounds for any formal hearing or appeal rights under Article VIII.

7.1-2 CRITERIA FOR INITIATION OF CORRECTIVE ACTION

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct, reasonably likely to be:

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

b. unethical or unprofessional, including violations of patient privacy;

c. contrary to the Medical Staff Bylaws, Rules and Regulations, Medical Staff policies or the Medical Center compliance program; or

d. inconsistent with the performance standards of the Medical Staff, a request for an investigation or action against such member may be initiated by the Chief of Staff, a department chair, the Medical Executive Committee, the Chief Medical Officer, the Chief Executive Officer, or the Board of Trustees.

7.1-3 INITIATION OF CORRECTIVE ACTION

A request for an investigation must be in writing, submitted to the Medical Executive Committee, and supported by reference to specific activities or conduct alleged. If the Medical Executive Committee initiates the request, it shall make an appropriate recording of the reasons.

7.1-4 INVESTIGATION

If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Chief of Staff may act on behalf of the Medical Executive Committee to initiate an investigation, subject to subsequent review and approval of the Committee. The Medical Executive Committee may conduct the investigation itself, or may assign the task to an appropriate Medical Staff Officer, Medical Staff Department, or standing or ad hoc committee of the Medical Staff. The Medical Executive Committee, in its discretion, may appoint practitioners who are not members of the Medical Staff for the sole purpose of serving on or advising a standing or ad hoc committee, and not for the purpose of granting these practitioners temporary clinical privilege under Section 5.6-2. If the investigation is delegated to an officer or committee other than the Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action. The member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and on such terms as the investigative body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved. However, such investigation shall not constitute a "hearing" as that term is used in Article VIII, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the

Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

7.1-5 EXECUTIVE COMMITTEE ACTION

As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall take action that may include, without limitation:

a. determining no corrective action be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's file;

b. deferring action for a reasonable time where circumstances warrant;

c. issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude department chairs or division chiefs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file;

d. recommending the imposition of terms of probation or special limitation on continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring;

e. recommending reduction, modification, suspension or revocation of clinical privileges;

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

g. recommending suspension, revocation or probation of Medical Staff membership;

h. taking summary action to restrict or suspend clinical privileges; and

i. taking other actions deemed appropriate under the circumstances.

Prior to the Medical Executive Committee taking any action or making any recommendation described above in subsections 7.1-5(c) through (g), the Committee shall afford the member an opportunity for a meeting with the Committee, or with a designated subcommittee of the Committee, with at least five (5) days notice to the member.

7.1-6 SUBSEQUENT ACTION

If corrective action as set forth in Section 7.2(a)-(k) is recommended by the Medical Executive Committee, that recommendation shall be transmitted to the Board of Trustees.

a. If the Medical Executive Committee has imposed or recommended action as to which the member may request a hearing, the Board of Trustees shall take no action until the member has waived or exhausted the hearing rights set forth in Article VIII.

b. If the Medical Executive Committee has taken or recommended corrective action and the member has waived his right to a hearing or an appeal, and the Board of Trustees questions or disagrees with the action of the Medical Executive Committee, the matter may be remanded back to the Committee for further consideration. Otherwise the action or recommendation of the Medical Executive Committee shall become final.

7.2 SUMMARY RESTRICTION OR SUSPENSION

7.2-1 CRITERIA FOR INITIATION

The Chief of Staff, the Chief Medical Officer, the Medical Executive Committee, or the Chair of the Department or designee of the department in which the member holds privileges may summarily restrict or suspend the Medical Staff membership or clinical privileges of such member if it is reasonably believed that failure to take that action may result in an imminent danger to the health of any individual, including future Medical Center or clinic patients. Such summary restriction or suspension shall become effective immediately on imposition and the person or body responsible shall promptly give written notice to the member, the Board of Trustees, the Medical Executive Committee and the Chief Executive Officer. Such suspensions may be imposed as an interim or precautionary measure for the protection of patients and in the absence of complete information so long as prompt steps are taken to gather information and to determine whether the suspension should be continued, discontinued, or if other less restrictive action is appropriate. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated, or if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the responsible Chair of the Department or by the Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute member. Unless an investigation of the suspended member is already underway at the time the summary suspension or restrictions imposed, the imposition of a

summary suspension shall constitute a request for action or investigation pursuant to this Article.

7.2-2 WRITTEN NOTICE

Within one working day of imposition of a summary restriction suspension, the affected Medical Staff member shall be provided with written notice of such action, including a statement of facts supporting it.

7.2-3 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as practicable after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee shall be convened to review and consider the action. The member shall attend such meeting and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the member, constitute a "hearing" within the meaning of Article VIII, nor shall any of Article VIII procedural rules apply. The Medical Executive Committee shall determine whether the summary restriction or suspension should be continued and may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the member with written notice of its decision.

7.2-4 PROCEDURAL RIGHTS

Unless the Medical Executive Committee promptly terminates the summary restriction or suspension, the member shall be entitled to the procedural rights to the extent provided under Article VIII.

7.2-5 INITIATION BY BOARD OF TRUSTEES

If none of the persons described above in Section 7.2-1 is available to impose a summary restriction or suspension, the Board of Trustees, or designee, may take such action if it is reasonably believed that a failure to do so is likely to result in an imminent danger to the health or safety of any person, including future Medical Center or clinic patients. Prior to taking such action, the Board or designee must make reasonable attempts to contact the Chief of Staff or designee. Such a suspension is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify the Board's action within two working days, excluding weekends and holidays, the action shall terminate automatically. If the Committee does ratify the Board's action, all other provisions under Section 7.2 of these bylaws will apply. In this event, the date of imposition of the summary action shall be considered to be the date of ratification by the Medical Executive Committee for purposes of compliance with notice and hearing requirements.

7.3 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the member's privileges or membership may be suspended or limited as described, which action shall be final without a right to hearing or further review.

7.3-1 LICENSURE

a. Revocation and Suspension: Whenever a member's license or other legal credential authorizing practice in this State is revoked, Medical Staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

b.

c. Restriction: Whenever a member's license or other legal credential authorizing practice in this State is limited, restricted, by the applicable licensing or certifying authority, any clinical privileges which the member has been granted at the Medical Center which are within the scope of said limitation or restriction shall be automatically limited, restricted, or suspended in a similar manner, as of the date such action becomes effective and throughout its term.

d. Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, his/her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

7.3-2 CONTROLLED SUBSTANCES

a. Whenever a member's DEA certificate is expired, revoked, limited, or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

b. Probation: Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

7.3-3 CONVICTION OF A FELONY

When the Medical Executive Committee becomes aware that a member has been convicted of a felony, the Medical Executive Committee shall automatically suspend the member's privileges.

7.3-4 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

A member, who fails without good cause, to appear and satisfy the requirements of Section 12.4-3 shall, in addition to any other remedies provided in these bylaws, be grounds for corrective action.

7.3-5 MEDICAL RECORDS

a. Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the Medical Executive Committee. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, shall be imposed by the Chief of Staff, or his/her designee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this Section, "related privileges", means scheduling surgery, assisting in surgery, consulting on Medical Center cases, and providing professional services within the Medical Center for future patients. Members shall remain responsible for emergency on-call coverage obligations as scheduled and may exercise such clinical privileges as may be required to fulfill such obligations. Members shall be given seven (7) days notice of impending suspension; however no hearing shall be afforded the suspended member pursuant to Article VIII. Bona fide vacation or illness may constitute an excuse subject to approval by the Medical Executive Committee.

b. Whenever a member removes any patient record from the Medical Center without permission, the member's privileges (except with respect to patients already in the Medical Center) shall, after written warning to return the records within twenty-four (24) hours, be automatically suspended if all records are not returned in that period. The suspension shall remain in effect until the Chief of Staff or designee is satisfied that all records have been returned.

7.3-6 PROFESSIONAL LIABILITY INSURANCE

All Medical Staff members and AHPs shall maintain professional liability insurance for which the practitioner will apply through Alameda County or shall maintain on their own initiative. Members and AHPs shall give immediate written notice to the Medical Staff Services Department of any lapse, cancellation, termination, or other change in the amount or scope of their professional liability insurance coverage. Regardless of whether such notice is given, a practitioner's failure to maintain Professional Liability Insurance, in the amounts established by

the Board of Trustees after consultation with the Medical Executive Committee, shall result in immediate and automatic suspension of a member's privilege to admit and/or provide services to patients for whom the practitioner may receive compensation from non-county sources. The suspension shall remain in effect until such time as the member or AHP provides evidence acceptable to the Medical Executive Committee that the requisite amount of professional liability coverage has been secured, which shall include, unless excused by the Medical Executive Committee for good cause, "prior acts" coverage for the period of time during which the member or AHP had allowed his or her coverage to lapse. If evidence of such coverage is not provided within sixty (60) days after the date the automatic suspension became effective the practitioner's clinical privileges and Medical Staff or AHP membership shall automatically terminate. The failure to give notice of cancellation, termination or other change in coverage shall be independent grounds for corrective action under section 7.1-2. Suspension or deemed resignation under this section shall not give rise to hearing rights under Article VIII.

7.3-7 EXCLUSION FROM FEDERAL HEALTH CARE PROGRAM

Whenever a practitioner is excluded from any federal health care program and becomes an ineligible person, the event shall result in an immediate suspension of practice in the Medical Center and automatic termination of Medical Staff membership.

7.3-8 FAILURE TO FOLLOW MEDICAL STAFF BYLAWS, RULES AND REGULATIONS, AND/OR POLICIES

Failure to follow Medical Staff Bylaws, Rules and Regulations, and/or policies may result in automatic suspension of Medical Staff clinical privileges as described in the **Medical Staff Progressive Discipline Guideline**.

7.3-9 FAILURE TO RESPOND OR APPEAR

Members are expected to cooperate with Medical Staff committees and representatives in the discharge of their official functions. This includes responding promptly and appropriately to correspondence, providing requested information, and appearing at appropriately announced meetings regarding quality of care issues, utilization management issues, Medical Staff administrative issues, and other issues that may arise in the conduct of Medical Staff affairs. It also includes submitting to mental or physical examinations, as requested by the Medical Staff Chief of Staff or the Medical Executive Committee, for the purpose of resolving issues of fitness to perform mental or physical functions associated with the practitioner's privileges or related issues of reasonable accommodation. Failure to comply shall constitute grounds for the Medical Staff Chief of Staff or a Department Chair to suspend the Member's clinical privileges or take other appropriate action until a response is provided which is satisfactory to the

requesting party. Any such suspension or action shall remain in effect until the Member is expressly notified that it is rescinded.

For purposes of this section, the information a Member can be expected to provide includes but is not limited to the following:

a. Physical or mental examinations and reports.

b. Information related to an Investigation or other peer review action, including information concerning action taken by licensing or accreditation bodies and other healthcare entities.

c. Information from a member's private office that is necessary to resolve questions that have arisen through the peer review process.

d. Information related to professional liability coverage and/or actions.

7.3-10 Failure to Pay Dues/Assessments

Failure without good cause as determined by the medical executive committee, to pay dues or assessments, as required under Section 14.1, shall be ground for automatic suspension of a member's clinical privileges, and if within (3 months) after written warnings of the delinquency the member does not pay the required dues or assessments, the member's membership shall be automatically terminated.

7.3-11 EXECUTIVE COMMITTEE DELIBERATION; PROCEDURAL RIGHTS

a. As soon as practicable after action is taken or warranted as described in Sections 7.3-1(b) or (c), Sections, 7.3-2, 7.3-3, 7.3-4, 7.3-5, 7.3-6, 7-3.8, the Medical Executive Committee shall convene to review and consider the facts, and may take or recommend such further corrective action as it may deem appropriate following the procedure generally set forth commencing at Section 7.1-3.

b. There shall be no hearing rights under Article VIII for automatic actions affecting a member's Medical Staff status or clinical privileges pursuant to this Section 7.3. However, the practitioner may be given an opportunity to be heard by the Medical Executive Committee related solely to the question whether grounds exist for the special action as described above, and the Medical Executive Committee shall reverse any action that was based on a material mistake of fact as to the existence of the grounds for such special action. Notwithstanding the foregoing, any additional corrective action taken or recommended by the Medical Executive Committee on a discretionary basis under this Section 7.3 shall be subject to hearing rights to the extent provided by Article VIII.

7.3-11 MEMBER OBLIGATIONS

Members are responsible for complying with the limitations imposed by the provisions of this Section 7.3 and member shall immediately provide written notice to the Medical Staff Services Department of any of the actions or events described in this Section relating to action taken by a state licensing agency, failure to maintain adequate professional liability insurance, action by the DEA, or action by a federal health care program. The member shall also promptly provide the Medical Staff Services Department with a written explanation of the basis for such actions, including copies of relevant documents. The limitations described above shall take effect automatically as of the date of the underlying action or event, regardless of whether the member provides notice thereof to the Medical Staff Services Department. The Medical Executive Committee may request the member to provide additional information concerning the above described actions or events, and a failure of the member to provide such information may extend the special actions listed above, even though the underlying limitation may have been removed. A Member's failure to observe the limitations of this section shall be grounds for corrective action.

7.4 INITIATION OF CORRECTIVE ACTION BY BOARD OF TRUSTEES

If the Medical Executive Committee decides not to conduct an investigation or otherwise initiate corrective action proceedings as set forth above, the matter shall be subject to review by the Board of Trustees. The Board of Trustees may concur in the Medical Executive Committee's decision or, if the Board of Trustees reasonably determines the Medical Executive Committee's decision to be contrary to the weight of the evidence presented, the Board of Trustees may consult with the Chief of Staff and thereafter direct the Medical Executive Committee to conduct an investigation or otherwise initiate corrective action proceedings. In the event the Medical Executive Committee fails to take action in response to a directive from the Board of Trustees, the Board of Trustees may, after written notification to the Medical Executive Committee, conduct an investigation or otherwise initiate corrective action proceedings on its own initiative. Any such proceedings shall afford the member the rights to which he or she is entitled under these Bylaws and applicable law. The decision following such proceedings shall be the final decision of the Medical Center.

ARTICLE VIII

8.1 GENERAL PROVISION HEARINGS AND APPELLATE REVIEWS

8.1-1 INTENT

The intent of these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect applicants or members (as described below) and at the same time to protect the peer review participants from liability. It is further the intent to establish flexible procedures, which do not create burdens

that will discourage the Medical Staff and Board of Trustees from carrying out peer review. Accordingly, discretion is granted to the Medical Staff and Board of Trustees to create a hearing process which provides for the least burdensome level of formality in the process while still providing a fair review and to interpret these Bylaws in that light. The Medical Staff, Board of Trustees, and their officers, committees and agents hereby constitute themselves as peer review bodies under the Federal Health Care Quality Improvement Act of 1986 and the California peer review hearing laws and claim all privileges and immunities afforded by the federal and state laws.

8.1-2 EXHAUSTION OF REMEDIES

If adverse action described in Section 8.2 is taken or recommended, the applicant or member must exhaust the remedies afforded by these Bylaws before resorting to legal action.

8.1-3 INTRA-ORGANIZATIONAL REMEDIES

The hearing and appeal rights established in these Bylaws are strictly “judicial” rather than “legislative” in structure and function. The Judicial Review Committees have no authority to adopt or modify rules and standards or to decide questions about the merits or substantive validity of Bylaws, Rules or policies. However, the Board of Trustees may, at its discretion, entertain challenges to the merits or substantive validity of Bylaws, Rules and Regulations or policies and decide those questions. If the only issue in a case is whether a Bylaw, Rule and Regulation or policy is lawful or meritorious, the member is not entitled to a hearing or appellate review. In such cases, the member must submit his challenges first to the Board of Trustees. The Board shall consult with the Medical Executive Committee before taking final action regarding the Bylaw, Rule or policy involved. All actions concerning any Bylaw, Rule or policy must conform to the requirements and processes specified in these Bylaws.

8.1-4 APPLICATION OF ARTICLE

a. For purposes of this Article, the term "member" may include "applicant”, as it may be applicable under the circumstances.

b. If a recommendation is made by the Board of Trustees, rather than the Medical Executive Committee, then the provisions of this Article applicable to the Medical Executive Committee, shall apply to the Board of Trustees.

8.1-5 SUBSTANTIAL COMPLIANCE

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

8.2 GROUNDS FOR HEARING

Except as otherwise specified in these Bylaws, Rules and Regulations or policies, any one or more of the following actions or recommended actions, shall be deemed grounds for a hearing:

a. Denial of Medical Staff membership, reappointment and/or Clinical Privileges, based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patient.

b. Revocation of Medical Staff membership, based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients.

c. Revocation or reduction of Clinical Privileges, based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients.

d. Significant restriction of Clinical Privileges (except for proctoring incidental to Provisional status, new privileges insufficient activity, or return from leave of absence) for more than fourteen (14) days based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients.

e. Suspension of Medical Staff membership and or Clinical Privileges for more than fourteen (14) days based on professional competence or conduct which affects or could affect adversely the health or welfare of a patient or patients.

f. Any other disciplinary action or recommendation that must be reported according to state law to the Medical Board of California or the California Board of Osteopathic Examiners.

g. No actions or recommendations except those described above shall entitle the Practitioner to request a hearing as described in this Article

8.3 REQUESTS FOR HEARING

8.3-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which action has been taken or a recommendation made as set forth in Section 8.2, said person or body shall give the member prompt notice of the recommendation or action including the following information.

a. A description of the action or recommendation.

b. A brief statement of the reasons for the action or recommendation.

c. A statement that the Practitioner may request a hearing.

d. A statement of the time limit within which a hearing may be requested.

e. A summary of the Practitioner's rights at a hearing.

f. Whether the action or recommendation must be reported to the Medical Board of California and/or the National Practitioner Data Bank,

8.3-2 REQUEST FOR HEARING

The member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Chief of Staff pursuant to Section 14.6 of these Bylaws and must be received by the Medical Staff Services Department within the thirty (30) day period. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. Said action shall thereupon become the final action of the Medical Staff. The action or recommendation shall be presented for consideration by the Board of Trustees, which shall not be bound by it. If the Board of Trustees ratifies the action or recommendation, it shall thereupon become the final action of the Medical Center. However, if the Board of Trustees, after consulting with the Medical Executive Committee, is inclined to take action against the Practitioner that is more adverse than the action recommended by the Medical Staff, the Practitioner shall be so notified and given an opportunity for a hearing based on "an adverse action by the Board of Trustees," as provided in Section 8.3-8.

8.3-3 TIME AND PLACE FOR HEARING

On receipt of a request for hearing, the Chief of Staff shall schedule a hearing and, within twenty-one (21) days (but in no event less than thirty (30) days prior to the hearing) give notice to the member of the time, place and date of the hearing. Unless extended by the Judicial Review Committee, the date of the commencement of the hearing shall be not less than thirty (30) days, nor more than sixty (60) days from the date of receipt of the request by the Medical Executive Committee for a hearing; provided however, that when the request is received from a member who is under summary suspension, the hearing shall

commence as soon as the arrangements may reasonably be made, but not to exceed forty-five (45) days from the date of receipt of the request.

8.3-4 NOTICE OF CHARGES

Together with the notice of hearing, the Medical Executive Committee shall state clearly and concisely in writing the reasons for the adverse action taken or recommended, including the acts or omissions with which the member is charged and a list of the charts in question, where applicable. The notice of charges may be supplemented or amended at any time prior to the issuance of the Judicial Review Committee's decision, provided the member is afforded a fair and reasonable opportunity to respond.

8.3-5 JUDICIAL REVIEW COMMITTEE

a. When a hearing is requested, the Chief of Staff shall appoint a Judicial Review Committee which shall be composed of not less than three (3) members of the Active Medical Staff and alternates as needed who shall gain no direct financial benefit from the outcome and who have not acted as accusers, investigators, fact-finders or initial decision-makers, and otherwise not have actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Judicial Review Committee. Practice in the same specialty as the Member under review, in and of itself, shall not be presumed to create bias or a direct financial benefit in the outcome of the hearing. In the event that it is not feasible to appoint a Judicial Review Committee from the Active Medical Staff, the Medical Executive Committee may appoint members from other staff categories or practitioners who are not members of the Medical Staff. Such appointment shall include designation of the Chair. Membership on a Judicial Review Committee shall consist of one member who shall have the same healing arts licensure as the accused. Where feasible, one Judicial Review Committee member shall practice the same specialty as the member. The same Judicial Review Committee member may satisfy both the aforementioned provisions. All other members shall have M.D. or D.O. degree.

b. A majority of the Judicial Review Committee must be present throughout the hearing. In unusual circumstances when a Committee member must be absent from any part of the proceedings, he or she shall not be permitted to participate in the deliberations or the decision unless and until he or she has read the entire transcript of the portion of the hearing from which he or she was absent.

8.3-6 Alternatively, the Chief of Staff shall have the discretion to have the hearing held before an arbitrator or arbitrators selected by a process mutually acceptable to the Member and the Medical Executive Committee. In such case the arbitrator(s) shall have the powers and authority of a Judicial Review Committee and Hearing Officer as described herein.

FAILURE TO APPEAR
Failure without good cause of the member to personally attend or to proceed in an efficient and orderly manner shall be deemed to constitute a waiver of hearing rights and a voluntary acceptance of the recommendations or actions involved. Good cause shall be determined by the hearing officer. The practitioner's voluntary acceptance of an action or recommendation pursuant to this provision shall be presented for consideration by the Board of Trustees, and the matter will be addressed in the same manner as a waiver of hearing rights.

8.3-7 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the Hearing Officer within his or her discretion, following consultation with the Judicial Review Committee or its Chair, upon a showing of good cause.

8.3-8 ADVERSE ACTION BY THE BOARD OF TRUSTEE

If the hearing is based upon an adverse action by the Board of Trustees, the Chair of the Governing Body shall fulfill the functions assigned in this Article to the Chief of Staff. The procedure may be modified as warranted under the circumstances, but the practitioner shall have all of the same rights to a fair hearing

8.4 HEARING PROCEDURE

8.4-1 VOIR DIRE

The Practitioner shall have the right to a reasonable opportunity to voir dire the Judicial Review Committee members and the hearing officer, and the right to challenge the appointment of any member or the hearing officer. The hearing officer shall establish the procedure by which this right may be exercised, which may include reasonable requirements that voir dire questions be proposed in writing in advance of the hearing and that the questions be presented by 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.

8.4-2 PREHEARING PROCEDURE

a. Each party may inspect and copy (at its own expense) any documentary information relevant to the charges that the other party has in its possession or under its control. The requests for discovery shall be fulfilled as soon as practicable. Failure to comply with reasonable discovery requests at least thirty (30) days prior to the hearing shall be good cause for the Hearing Officer to grant a continuance of the hearing.

b. The parties must exchange all documents that will be introduced at the hearing at least ten (10) days prior to the hearing. A failure to comply with this rule is good cause for the Hearing Officer to grant a continuance. Repeated failures to comply shall be good cause for the Hearing Officer to limit the introduction or use of any documents not provided to the other side in a timely manner.

c. It shall be the duty of the parties to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. The parties shall be entitled to file motions or otherwise request rulings as deemed necessary to give full effect to rights established by the Bylaws and to resolve such procedural matters as the Hearing Officer determines may properly be resolved outside the presence of the full Judicial Review Committee. All such motions or requests, the arguments presented by both parties, and rulings thereon shall be reflected in the hearing record in a manner deemed appropriate by the Hearing Officer.

d. The Hearing Officer shall rule on discovery disputes that the parties cannot resolve. Discovery may be denied or safeguards may be imposed when justified to protect peer review or in the interest of fairness and equity. Further, the right to inspect and copy by either party does not extend to confidential information referring to individually identifiable practitioners other than the member under review, nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information.

In ruling on discovery disputes, the factors that may be considered include: (a) whether the information sought may be introduced to support or to defend against the charges; (b) whether the information is "exculpatory" in that it would dispute or cast doubt upon the charges or "inculpatory" in that it would prove or help support the charges and/or recommendation; (c) the burden imposed on the party in possession of the information sought, if access is granted; and (d) any previous requests for access to information submitted or resisted by the parties to the same proceeding.

e. Not less than fifteen (15) days prior to the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that party at the hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. Failure to provide the name of any witness at least ten (10) days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

8.4-3 REPRESENTATION

The hearings provided for in these Bylaws are for the purpose of inter-professional resolution of matters bearing on professional conduct, professional competency, or character. Neither the member nor the Medical Executive Committee shall be represented at the hearing by an attorney at law. The member shall be entitled to be accompanied by and represented at the hearing only by a practitioner licensed to practice in the State of California who is not also an attorney at law. The Medical Executive Committee shall appoint a representative or representatives who is/are not attorney(s) to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions. The foregoing shall be not be deemed to deprive any party of its right to be represented by legal counsel for the purpose of preparing for the hearing.

8.4-4 THE HEARING OFFICER

The Chief Executive Officer or designee shall appoint a Hearing Officer to preside at the hearing. The Hearing Officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, but an attorney regularly utilized by the Medical Center for legal advice regarding its affairs and activities shall not be eligible to serve as Hearing Officer. The Hearing Officer shall not be biased for or against either party, shall gain no direct financial benefit based on the outcome of the proceedings (payment for the Hearing Officer's services does not constitute a direct financial benefit) and must not act as a prosecuting officer or as an advocate. The Hearing Officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as seems warranted by the circumstances. The Hearing Officer shall participate in the

deliberations of the Judicial Review Committee and be a legal advisor to it, but the Hearing Officer shall not be entitled to vote.

8.4-5 RECORD OF THE HEARING

A shorthand reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings if deemed appropriate by the Hearing Officer. The cost of attendance of the shorthand reporter shall be borne by the Medical Center, but the cost of the transcript, if any, shall be borne by the party requesting it. The Judicial Review Committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

8.4-6 ATTENDANCE

Except as otherwise provided in these Bylaws and subject to reasonable restriction by the hearing officer, the following shall be permitted to attend the entire hearing in addition to the hearing officer, the court reporter, and the parties and their hearing representatives: The Medical Staff Coordinator(s), one or more key consultants for each party, one or more key witnesses for each party, and the Chief Executive Officer or his or her designee. An individual shall not be excluded from attending any portion of the hearing solely by reason of the possibility or expectation that he or she will be a witness for one of the parties.

8.4-7 RIGHTS OF THE PARTIES

Within reasonable limitations and so long as these rights are exercised in an efficient and expeditious manner, both parties may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, rebut evidence, receive all information made available to the Judicial Review Committee, and submit a written statement. The member may be called by the Medical Executive Committee and examined as if under cross-examination.

8.4-8 MISCELLANEOUS RULES

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted 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. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. The Hearing Officer shall also have discretion to ask questions of witnesses if he or she deems it appropriate for clarification or efficiency. At its discretion, the Judicial Review Committee may request both sides to file written arguments.

8.4-9 BURDENS OF PRESENTING EVIDENCE AND PROOF

a. At the hearing, the Medical Executive Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The member shall be obligated to present evidence in response.

b. If the practitioner is an initial applicant for Medical Staff membership and privileges, the applicant shall bear the burden of persuading the Judicial Review Committee by a preponderance of the evidence of his/her qualifications for Medical Staff membership and clinical privileges by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning their current qualifications. Initial applicants shall not be permitted to introduce information not produced on request of any committee or person on behalf of the Medical Staff during the application process unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence. This provision shall not be construed to compel the Medical Staff to act on, or to afford an applicant a hearing regarding, an incomplete application.

c. Except as provided for initial applicants, the Medical Executive Committee shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted. The term “reasonable and warranted” means within the range of reasonable and warranted alternatives open to the Medical Executive Committee, as a matter of discretion, and not necessarily the only or best action or recommendation that could be formulated in the opinion of the Judicial Review Committee.

8.4-10 ADJOURNMENT AND CONCLUSION

After consultation with the Chair of the Judicial Review Committee, the Hearing Officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Both the Medical Executive Committee and the member may submit a written statement at the close of the hearing. On conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

8.4-11 BASIS FOR DECISION

The decision of the Judicial Review Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the Judicial Review Committee shall be final, subject to the provisions of Section 8.5 hereof.

8.4-12 DECISION OF THE JUDICIAL REVIEW COMMITTEE

Within thirty (30) days after final adjournment of the hearing, the Judicial Review Committee shall render a decision which shall be accompanied by a report in writing and shall be delivered to the Medical Executive Committee. If the member is currently under suspension, the time for the decision and report shall be fifteen (15) days. A copy of said decision shall also be forwarded to the Chief Executive Officer, the Chief Medical Officer, the Medical Executive Committee, the Chief of Staff, the Board of Trustees, and to the member. The report shall contain the Judicial Review Committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. The decision of the Judicial Review Committee shall be considered final, subject only to such rights of appeal or review as described in these Bylaws.

8.5 APPEAL

The process for appeal to the Board of Trustees from the decision of a Judicial Review Committee is set forth in the Bylaws of the Board of Trustees as well as in these Bylaws of the Medical Staff. In the event of any conflict between Board of Trustees Bylaws and the Medical Staff Bylaws as to the appellate process described in this Section 8.5, the Board of Trustees Bylaws shall control.

a. Time For Appellate Review

Within thirty (30) days after receipt of the decision of the Judicial Review Committee, either the member, the Medical Executive Committee, or the Board of Trustees, if applicable, may request an Appellate Review hearing ("Appellate Review"). A written request for Appellate Review shall be delivered to the Chief of Staff, the Chief Executive Officer, and to either the member, the Medical Executive Committee, or the Board of Trustees, as applicable. If such a request for Appellate Review is not received within such period, that Judicial Review Committee decision shall thereon become final, subject only to review by the Board of Trustees.

It shall be the obligation of the party requesting a appellate review to produce the record of the Judicial Review Committee's proceedings ("Appellate Record"). If the Appellate Record is not produced within fifteen (15) days following the request for Appellate Review, appellate rights shall be deemed waived. The Appellate Record shall consist of at least the following: the decision of the Judicial Review Committee; the request for Appellate Review; a complete transcript of the hearing below, including opening and closing statements, testimony, and any oral arguments made outside the presence of the Judicial Review Committee; all documentary exhibits received into evidence; the Hearing Officer's record of correspondence and other documentation regarding procedural matters; any documentary exhibits that were offered into evidence but excluded by the Hearing Officer; and any written statements or arguments submitted by the

parties for consideration by the Hearing Officer or Judicial Review Committee. The party requesting Appellate Review shall produce the Appellate Record in a format and in such numbers as may be specified by the Board of Trustees.

b. Grounds For Appellate Review

The grounds for Appellate Review shall be:

1. substantial noncompliance with the standards or procedures required by these Bylaws, or applicable law, which has created demonstrable prejudice;

2. the decision was arbitrary or capricious;

3. the evidence introduced in the Judicial Review Committee hearing did not support the Judicial Review Committee's findings;

4. the Judicial Review Committee's findings did not support the Judicial Review Committee's decision;

5. the Judicial Review Committee's failure to sustain an action or recommendation of the Medical Executive Committee that, based on the evidence, was reasonable and warranted; or

6. the decision was inconsistent with applicable law.

c. Appeal Board

The Board of Trustees shall determine the composition of the Appeal Board, consistent with the provisions of the Board of Trustees Bylaws. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board so long as that person did not take part in a prior hearing on the action or recommendation being challenged. The Appeal Board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal.

d. Time, Place And Notice

If an Appellate Review is to be conducted, the Appeal Board shall give notice, consistent with the provisions of the Board of Trustees Bylaws.

e. Appellate Review Procedure

The Appellate Review shall be in the nature of an appellate hearing based on the record of the Judicial Review Committee hearing, consistent with the provisions of the Board of Trustees Bylaws. Each party shall have the right to be represented

by legal counsel in connection with the Appellate Review, to present a written statement in support of his/her/its position on appeal and to personally appear and make oral argument. However, the Appeal Board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence, and subject to the same rights of cross-examination or confrontation that are provided at a hearing. The Appeal Board shall also have the discretion to remand the matter to the Judicial Review Committee for the taking of further evidence or for clarification or reconsideration of the Committee's decision. In such instances, the Judicial Review Committee shall report back to the Appeal Board within such reasonable time limits as the Appeal Board imposes.

Each party shall have the right to be represented by legal counsel in connection with the Appellate Review, to present a written statement in support of his/her position on appeal and to personally appear and make oral argument, subject to such reasonable requirements as the Appeal Board may impose. After the arguments have been submitted, the appeal board shall conduct its deliberations outside the presence of the parties and their representatives. The Appeal Board, if other than the Board of Trustees, shall present to the Board of Trustees its written recommendations as to whether the Board of Trustees should affirm, modify or reverse the Judicial Review Committee decision, or remand the matter to the Judicial Review Committee for further review and decision.

f. Decision

The Board of Trustees shall render a decision in writing, consistent with the provisions of the Board of Trustees Bylaws. The Board may affirm, reverse or modify the decision of the Judicial Review Committee, or it may remand the matter to the Judicial Review Committee for reconsideration. If the matter is remanded to the Judicial Review Committee for further review and recommendation, the Judicial Review Committee shall promptly conduct its review and make its recommendations to the Board of Trustees. This further review and the time required to report back shall not exceed 30 days in duration except as the parties may otherwise agree or for good cause as jointly determined by the Board of Trustees and the Judicial Review Committee. The decision of the Board of Trustees shall constitute the final decision of the Medical Center. Any recommendation affirmed by the Board shall become effective immediately

8.6 RIGHT TO ONE HEARING

No member shall be entitled to more than one Judicial Review Committee hearing and one Appellate Review related to a particular Judicial Review Committee decision.

8.7 EXCEPTIONS TO HEARING RIGHTS

8.7-1 MEDICAL-ADMINISTRATIVE OFFICERS AND CONTRACT PHYSICIANS

The hearing rights of Article VIII do not apply to the termination of contracts for practitioners who have contracted with the Medical Center to provide administrative or clinical services. Removal of these practitioners from office and of any exclusive privileges held pursuant to such contracts (but not their Medical Staff membership) shall instead be governed by the terms of their individual contracts and agreements with the Medical Center. Notwithstanding the foregoing, the hearing rights of this Article VIII shall apply if an action is taken which must be reported pursuant to Business and Professions Code Section 805 and/or the practitioner's Medical Staff membership status or privileges that are independent of the practitioner's contract are removed, restricted or suspended and such actions would otherwise be grounds for a hearing under Section 8.2.

8.7-2 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

Except as otherwise stated in Section 7.3, any automatic suspension or limitation initiated pursuant to Section 7.3 does not invoke hearing rights as described in these Bylaws.

8.8 CHALLENGES TO RULES

The hearings provided for in this article shall not be utilized to make determinations as to the merits or substantive validity of a bylaw, rule, regulation or policy. Where the merits or substantive validity of such bylaw, rule, regulation or policy is the only issue, the Practitioner shall have direct appeal to the Medical Executive Committee. The Medical Executive Committee shall review the challenge under such procedures as it may establish and shall issue a written decision regarding the validity of the bylaw, rule, regulation or policy being challenged. The practitioner shall be entitled to appeal the decision to the Board of Trustees that shall issue a written decision. Any future challenge shall be filed in the Superior Court of the State of California, County of Alameda pursuant to California Code of Civil Procedure Section 1085.

ARTICLE IX
OFFICERS

9.1 OFFICERS OF THE MEDICAL STAFF

9.1-1 IDENTIFICATION

The officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, Secretary/Treasurer, and the Immediate Past Chief of Staff.

9.1-2 QUALIFICATIONS

Officers must be members of the Active Medical Staff at the time of their nomination and election. The Chief of Staff and Vice Chief of Staff shall be physicians with demonstrated competence in their fields of practice and with demonstrated qualifications to direct the medico-administrative aspects of Medical Staff activities. Officers must remain members in good standing during their term of office and failure to maintain such status shall immediately result in expulsion from office.

9.1-3 NOMINATIONS

a. The Medical Staff election year shall be each even-numbered year. A Nominating Committee shall be appointed by the incumbent Chief of Staff no later than one-hundred (120) days prior to the annual staff meeting to be held during the election year or at least forty five (45) days prior to any special election. The Nominating Committee shall consist of seven (7) members, at least one of whom is from the Fairmont Campus, one from John George Psychiatric Pavilion, one from the AHS freestanding clinics, and at least three (3) of whom are not members of the Medical Executive Committee. The Nominating Committee shall nominate one or more nominees for each office. The nominations of the committee shall be reported to the Medical Executive Committee at least sixty (60) days prior to the annual meeting in each election year and shall be delivered by, emailed or mailed to the voting members of the Medical Staff at least forty (40) days prior to the election.

b. Further nominations may be made for any office by any voting member of the Medical Staff, provided that the name of the candidate is submitted in writing to the Chair of the Nominating Committee, is endorsed by the signature of at least 10% of the Medical Staff members who are eligible to vote, and bears the candidate's written consent. These nominations shall be delivered to the Chair of the Nominating Committee as soon as reasonably practicable, but at least twenty (20) days prior to the date of election. If any nominations are made in this manner, the voting members of the Medical Staff shall be advised by notice at least ten (10) days prior to the meeting at which an election will be held. Nominations from the floor will be recognized if the nominee is present and consents.

9.1-4 ELECTIONS

The Vice Chief of Staff and Secretary/Treasurer shall be elected at the Annual Meeting of the Medical Staff in each election year. Voting shall be by written ballot, mail in ballot, or e-mail ballot. A nominee shall be elected on receiving a majority of the votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two

candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Medical Executive Committee shall decide the election by written ballot at its next meeting or a special meeting called for that purpose.

9.1-5 TERMS OF ELECTED OFFICE

All officers shall serve two (2) year terms, commencing on the first day of the Medical Staff year following his/her election. Each officer shall serve in each office until the end of his/her term, or until a successor is elected, unless he shall sooner resign or be removed from office. At the end of his/her term, the Chief of Staff shall automatically assume the office of immediate Past-Chief of Staff, and the Vice Chief of Staff shall automatically assume the office of Chief of Staff.

9.1-6 REMOVAL OF OFFICERS

A Medical Staff Officer may be removed from office during his/her term of office for cause, including, but not limited to, neglect or malfeasance in office, serious acts of moral turpitude or failure to discharge satisfactorily the duties of his/her office. Removal of a Medical Staff Officer may be initiated by either a two-thirds majority vote of the Medical Executive Committee or a petition signed by at least one-third (1/3) of the members of the Medical Staff eligible to vote for officers. Removal shall be considered at a special meeting called for that purpose. Removal shall require a two-thirds (2/3) vote of the Medical Staff members eligible to vote for Medical Staff Officers who actually cast votes at the special meeting in person, by mail in ballot or e-mail ballot.

9.1-7 VACANCIES IN ELECTED OFFICE

Vacancies in office occur on the death or disability, resignation, or removal of the officer, or such officer's loss of membership on the Medical Staff. Vacancies, other than that of Chief of Staff and Vice Chief of Staff of the Medical Staff, shall be filled by appointment by the Medical Executive Committee until the next regular election. If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff shall serve out that remaining term and shall immediately appoint an ad hoc committee to decide promptly on nominees for the office of Vice Chief of Staff. Such nominees shall be reported to the Medical Executive Committee and to the Medical Staff. A special election to fill the position shall occur at the next regular staff meeting. If there is a vacancy in the office of vice Chief of Staff , that office need not be filled by election, but the Medical Executive Committee shall appoint an interim officer to fill this office until the next regular election, at which time the election shall also include the office of Vice Chief of Staff.

9.2 DUTIES OF OFFICERS

9.2-1 CHIEF OF STAFF

The Chief of Staff shall serve as Chief Officer of the Medical Staff. The duties of the Chief of Staff shall include, but not be limited to:

a. enforcing the Medical Staff Bylaws and Rules and Regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;

b. calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;

c. serving as Chair of the Medical Executive Committee;

d. serving as an ex-officio member of all other staff committees with vote;

e. interacting with the Chief Executive Officer, Chief Medical Officer, and Board of Trustees in all matters of mutual concern within the Medical Center;

f. appointing, in consultation with the Medical Executive Committee, committee members for all standing and special medical staff, liaison, or multi-disciplinary committees, except where otherwise provided by these Bylaws, and, except where otherwise indicated, designating the Chair of these committees;

g. representing the views and policies of the Medical Staff to the Chief Medical Officer, Chief Executive Officer, and Board of Trustees;

h. being a spokesperson for the Medical Staff in external professional and public relations;

i. performing such other functions as may be assigned to him/her by these Bylaws, the Medical Staff, or by the Medical Executive Committee; and

j. serving on liaison committees with the Board of Trustees and Administration, as well as outside licensing or accreditation agencies.

9.2-2 VICE CHIEF OF STAFF

The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice Chief of Staff shall be a member of the Medical Executive Committee and Joint Conference Committee and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws, or by the Medical Executive Committee. Vice Chief of Staff will succeed the Chief of Staff following term of office.

9-2-3 IMMEDIATE PAST CHIEF OF STAFF

The Immediate Past Chief of Staff shall be a member of the Medical Executive Committee and Joint Conference Committee shall perform such other duties as may be assigned by the Chief of Staff or delegated by these Bylaws or by the Medical Executive Committee. The Immediate Past Chief of Staff shall assume the duties of the Chief of Staff if the Chief of Staff and the Vice Chief of Staff are not available.

9.2-4 SECRETARY/TREASURER

The Secretary/Treasurer shall be a member of the Medical Executive Committee. The duties shall include, but not be limited to:

a. maintaining a roster of members;

b. keeping accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings;

c. calling meetings on the order of the Chief of Staff or Medical Executive Committee;

d. attending to all appropriate correspondence and notices on behalf of the Medical Staff;

e. receiving and safeguarding all funds of the Medical Staff;

f. excusing absences from meetings on behalf of the Medical Executive Committee; and

g. performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff.

9.3 COMPENSATION OF MEDICAL STAFF OFFICERS

Medical staff officers should be compensated for their work spent representing and leading the medical staff. Such compensation shall come from the medical staff bank account, for which the medical staff has sole responsibility or in combination with administration as determined by the Medical Staff. The payment to individual physicians should be in the amount determined by the MEC. If the hospital provides any funds specifically earmarked for such compensation, those funds should be requested and accounted for in the medical staff budget for hospital approval.

9.4 MEDICAL STAFF REPRESENTATIVE TO THE BOARD

The medical staff shall elect 1 member from the active staff to serve as voting member of the board of trustees of the hospital, and, where applicable, system in which the hospital is affiliated, representing the interests of the medical staff organization in the same manner and at the same time as provided in sections 9.1 for the nomination and election of officers. The representatives shall report to the medical executive committee. The hospital shall have no right to appoint a medical staff member to serve as a member of the board.

ARTICLE X
CLINICAL DEPARTMENTS AND DIVISIONS

10.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND DIVISIONS

The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a Chair selected and entrusted with the authority, duties, and responsibilities specified in Section 10.6. A department may be further divided, as appropriate, into divisions which shall be directly responsible to the department within which they function, and which shall have a Division Chief selected and entrusted with the authority, duties and responsibilities specified in Section 10.7. When appropriate, the Medical Executive Committee may recommend to the Medical Staff the creation, elimination, modification, or combination of departments or divisions.

10.2 DEPARTMENTS AND DIVISIONS AT AHS

There shall be Departments of Ambulatory Care and Preventive Medicine, Anesthesiology, Emergency Medicine, Imaging, Maternal and Child Health, Medicine, Pathology and Laboratory Medicine, Psychiatry, Rehabilitation and Restoration, and Surgery under the administrative supervision of the Chief of Staff. The following departments shall be further divided into divisions, as follows and as may be further defined by the Medical Staff Departments:

a. The Department of Medicine shall include Divisions of HIV Services, Cardiology, Critical Care Medicine, Dermatology, Endocrinology, Gastroenterology, Geriatrics and Palliative Care, Hematology & Oncology, , Highland Campus-Primary Care Medicine, John George Campus/Fairmont-Internal Medicine, Infectious Diseases, Highland Campus- Inpatient Medicine, Nephrology, Neurology, Pulmonary and Rheumatology.

b. The Department of Surgery shall include Divisions of Dentistry, General Surgery, Neurological Surgery, Ophthalmology, Oral Surgery, Orthopedics, Otolaryngology, Plastic Surgery, Trauma Surgery, and Urology. Podiatry shall be a section of the Orthopedic Surgery Division and Optometry services shall be a section of Ophthalmology.

c. The Department of Imaging.

d. The Department of Maternal and Child Health shall include Divisions of Ambulatory Pediatrics and Newborn Services, Gynecology, and Obstetrics.

e. The Department of Emergency Medicine .

f. The Department of Psychiatry shall include Divisions of Inpatient Psychiatry and Psychiatric Emergency Services.

g. The Department of Rehabilitation and Restoration shall include the Division of Physical Medicine and Rehabilitation and the Division of Long-Term Care.

10.3 ASSIGNMENT TO DEPARTMENT AND DIVISIONS

Each member shall be assigned primary membership in one department and to a division, if applicable, within such department, but may also be granted clinical privileges in other departments or divisions subject to the rules and regulations of that department under the authority of the Chair of the Department.

10.4 FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

a. conducting patient care reviews, \, for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. The number of such reviews to be conducted during the year shall be as determined by the Medical Executive Committee in consultation with other appropriate committees. The department shall routinely collect information about important aspects of patient care provided in the department, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work subject to such review is a member of that department;

b. recommending to the Medical Executive Committee criteria for the granting of clinical privileges and the performance of specified services within the department;

c. recommending to the medical executive committee criteria for the granting of clinical privileges and the performance of specified services within the department.

d. conducting, participating, and making recommendations regarding continuing education programs pertinent to departmental clinical practice;

e. reviewing and evaluating departmental adherence to:

1. Medical Staff policies and procedures; and

2. sound principles of clinical practice;

f. coordinating patient care provided by the department's members with nursing and ancillary patient care services;

g. submitting written reports to the Medical Executive Committee concerning:

1. the department's review and evaluation of activities related to the Medical Staff and/or organizational quality assessment and performance improvement activities, actions taken thereon, and the results of such action; and

2. recommendations for maintaining and improving the quality of care provided in the department and the Medical Center.

h. meeting at least quarterly for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other department and staff functions;

i. establishing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols;

j. taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified;

k. accounting to the Medical Executive Committee for all professional and medical staff administrative activities within the department;

l. appointing such committees as may be necessary or appropriate to conduct department functions, performance improvement and peer review activates.

m. formulating recommendations for departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee;

10.5 FUNCTIONS OF DIVISIONS

Subject to the approval of the Medical Executive Committee, each Division shall perform the functions assigned to it by the Chair of Department. Such functions may include, without limitation, retrospective patient care reviews, evaluation of patient care practices, credentials review and privileges delineation and continuing education

programs. The Division shall transmit regular reports to the Chair of the Department on the conduct of its assigned functions.

10.6 CHAIR OF THE DEPARTMENT

10.6-1 QUALIFICATIONS

Each department shall have a chair that shall be a member of the Active Medical Staff or Provisional Staff and shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the Department. All Chairs of the Departments initially appointed after May 1, 2003, shall be board certified by an appropriate specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association, or has been affirmatively established by the Medical Executive Committee, through the credentialing process, as having comparable competence.

10.6-2 SELECTION OF CHAIR

The Medical Executive Committee, on the recommendation of the Chief of Staff, shall appoint not less than five (5) nor more than eleven (11) members to the Search Committee. The Search Committee shall be composed of practitioners, a majority of whom are members of the Medical Staff, including the Chief of Staff, at least one (1) Chair of a Department, one (1) Division Chief, and the Chief Medical Officer as an ex officio member. The Chair of the Search Committee shall be appointed by the **Chief of Staff a**nd shall be a Chair of a Department or a Division Chief. The Search Committee shall make one or more recommendations to the Chief Executive Officer (CEO) regarding candidates for consideration as the Chair of the Department. The CEO may accept or reject the Search Committee's recommendation(s). If the CEO rejects the Search Committee's recommendation(s), he/she shall discuss the matter with the Search Committee and request that they submit additional candidates for consideration. The CEO has the ultimate authority to appoint the Chair of the Department following receipt of a recommendation from the Search Committee. The Chair of the Department shall be installed for a renewable four (4) year term.

10.6-3 DUTIES

Each Chair shall have the following authority, duties and responsibilities.

a. Act as presiding officer at departmental meetings.

b. Report to the medical executive committee and to the Chief Medical Officer regarding all professional and administrative activities within the department;

c. Generally and continuously monitor the quality of patient care and professional performance rendered by members with clinical privileges

in the department through a planned and systematic process; oversee and maintain the effective conduct of the patient care, evaluation, and monitoring functions delegated to the department by the medical executive committee in coordination and integration with organization-wide quality assessment and improvement activities.

d. Develop and implement departmental programs for patient care review, ongoing monitoring of practice, credentials review and privileges delineation, medical education, utilization review, and quality assessment and improvement and all other clinically related activities of the department.

e. Be a member of the Medical Executive Committee, be responsible for all clinically related activities of the department, give guidance on the overall medical policies of the Medical Staff and Medical Center and make specific recommendations and suggestions regarding his/her department.

f. Recommend criteria for clinical privileges to the Credentials Committee and Medical Executive Committee, and timely transmit to the Credentials Committee recommendations concerning practitioner appointment and classification, renewal of membership, criteria for clinical privileges, and monitoring of specific services and corrective action with respect to persons with clinical privileges in the department.

g. Endeavor to enforce the Medical Staff Bylaws, Rules and Regulations, within the department.

h. Implement within the department appropriate actions taken by the Medical Executive Committee.

i. Participate in every phase of administration of the department, including maintaining a quality control program, as appropriate, recommending a sufficient number of qualified and competent persons to provide care, treatment and services, and space and other resources needed by the department; cooperation with nursing service and the hospital administration in matters such as personnel (including assisting in determining the qualifications and competence of department/service personnel who are not licensed independent practitioners and who provide patient care services), supplies, orientation, special regulations, standing orders and techniques.

j. Assist in the preparation of such annual reports, including budgetary planning, pertaining to the department as may be required by the Medical Executive Committee.

k. Assess and recommend to the Credentials Committee and/or Medical Executive Committee, off-site sources for needed patient care, treatment, and services not provided by the department of the medical center.

l. Integrate the department or service into the primary functions of the Medical Center and coordinate and integrate interdepartmental and intradepartmental services.

n. Develop and implement department policies and procedures that guide and support the provision of care, treatment and services in the department.

o. Make recommendations for a sufficient number of qualified and competent persons to provide care or service and recommend delineated clinical privileges for each member of the department.

q. Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff, Chief Medical Officer or the CEO.

10.6-4 EVALUATION, TERM OF OFFICE AND REMOVAL OF DEPARTMENT CHAIR

a. The Chair of the Department term of office shall be four (4) years, at which time reappointment by the CEO shall be necessary for continued function as Chair of the Department.

b. Biennial evaluations to assess the Chair's performance of duties enumerated in Section 10.6-3 are conducted jointly by the Chief of Staff and the Chief Medical Officer and reported to the Chief Executive Officer with a recommendation to the CEO for appropriateness for further service.

c. Removal of a Chair of a Department may be effectuated at any time by the Chief Executive Officer in consultation with the Medical Executive Committee. Grounds for removal during the term of office include, but are not limited to:

1. development of a significant conflict of interest;

2. for cause, including but not limited to neglect or malfeasance in office, serious acts of moral turpitude, or failure to discharge satisfactorily the duties of the office as set forth in these Medical Staff Bylaws;

3. chair ceases to be Active or Provisional Medical Staff member.

d. A Chair of a Department may be removed by action of the CEO or by a vote of no confidence by a 2/3 majority vote of the Active Staff members of the applicable department and ratification by a simple majority vote of the Medical Executive Committee.

c. Removal is not subject to hearing procedures described in Article VIII of these Bylaws.

10.7 DIVISION CHIEFS

10.7-1 QUALIFICATIONS

Each Division shall have a Chief who must be an Active Staff member or a Provisional Staff member and a member of the appropriate division. The Division Chief must be qualified by training, experience, and demonstrated current ability in the clinical area covered by the Division. All Division Chiefs appointed after May 1, 2003 shall be:

a. board certified by an appropriate specialty board approved by the American Board of Medical Specialties or American Osteopathic Association, **or** have successfully completed an Accreditation Council for Graduate Medical Education or American Osteopathic Association approved residency training program and achieve board certification within three (3) years of board eligibility; or

b. be board certified by the American Board of Podiatric Surgery **or** have completed a podiatric residency program approved by the Council on Podiatric Medical Education and achieve board certification within three (3) years of board eligibility; or

c. be board certified by the American Board of Oral and Maxillofacial Surgery as recognized by the American Dental Association **or** have successfully completed a residency program in an accredited oral and maxillofacial surgery program recognized by the American Dental Association and achieve board certification within three (3) years of board eligibility.

A Division Chief shall be appointed by the Chair of the Department after careful review of the candidate's qualifications. Such appointments shall be made with the advice and approval of the Chief Medical Officer and the Chief of Staff, whose approval shall not be unreasonably withheld, and reported to the Medical Executive Committee.

10.7-2 APPOINTMENT

A Division Chief shall serve for a two (2) year term unless the Division Chief is removed for one of the following reasons:

a. He/She resigns:

b. He/She is no longer an Active or Provisional Staff member.

c. He/She is removed by the Chair of the Department with the concurrence of the Medical Executive Committee. Such removal shall have no effect on the individual's clinical privileges or Medical Staff membership and is not subject to hearing procedures described in Article VIII of these Bylaws.

d. The Division Chief's performance shall be reviewed by the Chair of the Department and reported to the Medical Executive Committee, and the appointment renewed for an additional two (2) year term, if performance is satisfactory and the Chair so recommends.

10.7-3 DUTIES

Each Division Chief shall:

a. act as presiding officer at Division meetings;

b. assist in the development and implementation, in cooperation with the Chair of the Department, of programs to carry out the quality review, and evaluation and monitoring functions assigned to the Division;

c. evaluate the clinical work performed in the Division;

d. conduct investigations and submit reports and recommendations to the Chair of the Department regarding the clinical privileges to be exercised within the division by members or applicants to the Medical Staff;

e. recommend to the Chair of the Department, specific clinical privileges for each Medical Staff member holding or requesting clinical privileges in the department both at the time of initial appointment and reappointment; and

d. perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chair of the Department, the Chief of Staff or the Medical Executive Committee.

ARTICLE XI
COMMITTEES

11.1 DESIGNATION

The committees described in this Article shall be the standing committees of the Medical Staff. Unless otherwise specified, the Chair and members of all committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with and approval by the Medical Executive Committee. Medical Staff committees shall be responsible to the Medical Executive Committee. An Ad Hoc or special Medical Staff Committee may be established and members may be appointed by any Medical Staff committee chairperson, the Chief of Staff, or the Medical Executive Committee. All ad hoc or special committees shall report to the chairperson of the committee which appointed the ad hoc committee or to the Chief of Staff. All ad hoc or special committees will ultimately report to the Medical Executive Committee.

11.2 GENERAL PROVISIONS

11.2-1 TERMS OF COMMITTEE MEMBERS

Unless otherwise specified, committee members shall be appointed for a term of two years, and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee. There shall be no set term of appointment for members of the Physician Support Committee.

11.2-2 REMOVAL

If a member of a committee ceases to be a member in good standing of the Medical Staff, suffers a loss or significant limitation of clinical privileges, or if any other good cause exists, that member may be removed by the Chief of Staff, subject to consultation with and approval by the Medical Executive Committee.

11.2-3 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 Medical Executive Committee.

11.3 MEDICAL EXECUTIVE COMMITTEE

11.3-1 COMPOSITION

All members of the Medical Staff of any discipline or specialty are eligible for membership on the Medical Executive Committee. The majority of voting Medical Executive Committee members shall be fully licensed Physicians

actively participating in the Medical Center. The Medical Executive Committee shall consist of the following:

a. Officers of the Medical Staff

b. Chairs of the Departments

c. Six (6) at-large members of the Active Medical Staff, three from the Highland campus, one from the Fairmont campus, one from the John George Pavilion campus, and one from the freestanding ambulatory clinics, who shall be nominated and elected for a two-year term in the same manner and at the same time as provided in Sections 9.1-4 through 9.1-5 for the nomination and election of officers

d. Graduate Medical Education Designated Institutional Official (DIO)

e. The Immediate Past-Chief of Staff and Chief Medical Officer shall be ex-officio members. The Immediate Past-Chief of Staff shall be a voting member, but the Chief Medical Officer shall not have voting privileges.

f. The Chief Executive Officer and representatives of the House Staff and Nursing Administration shall serve as ex-officio members without vote.

11.3-2 DUTIES

The duties of the Medical Executive Committee, as delegated by the medical staff are:

a. representing and acting on behalf of the Medical Staff, through authority delegated to the Medical Executive Committee by the Medical Staff, in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;

b. developing, coordinating and implementing the professional and organizational activities and policies of the Medical Staff;

c. receiving and acting upon reports and recommendations from Medical Staff departments, divisions, committees, and assigned activity groups;

d. recommending action to the Board of Trustees on matters of medical-administrative nature;

e. establishing appropriate criteria for cross-specialty privileges in accordance with Section 5.2

f. establishing and making recommendations directly to the Board of Trustees regarding the structure of the Medical Staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of performance improvement activities and mechanisms of the Medical Staff, termination of Medical Staff membership and fair hearing procedures, as well as other matters relevant to the operation of an organized Medical Staff;

g evaluating the medical care rendered to patients in the Medical Center by practitioners with clinical privileges and others who are credentialed by the Medical Staff;

h. participating in the development of all hospital policy, practice and planning

i reviewing the qualifications, credentials, performance and professional competence and character of applicants and Staff members and making recommendations to the Board of Trustees regarding Medical Staff appointments and reappointments, assignments to departments, clinical privileges, and corrective action;

j. 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;

k. taking reasonable steps to develop continuing education activities and programs for the Medical Staff;

l. designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the Chief of Staff;

m. reporting to the Medical Staff at each regular staff meeting;

n. assisting in the obtaining and maintaining of accreditation;

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

p. appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff;

q. reviewing the quality and appropriateness of medical care services provided by all practitioners in the Medical Center;

r. reviewing and approving outside sources where patient care contracted services are provided where Licensed Independent Practitioners (LIPs) are providing medical care services;

s. fulfilling the Medical Staff organization's accountability to the Board of Trustees for the medical care rendered to patients of the Medical Center, including the organization of the quality assessment and performance improvement activities of the Medical Staff and the mechanism to conduct, evaluate and revise such activities; -

t. designating Members of the Medical Staff who have independent privileges to provide oversight of care, treatment, and services provided by Practitioners who are credentialed by the Medical Staff;

u. assuring that the care, treatment, and services provided to Medical Center patients meets a uniform standard of quality;

v determining the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to Medical Staff Members;

w. determining the mechanism for establishing and maintaining patient care standards and credentialing and delineation of clinical privileges;

x. assuring that Medical Staff members participate in organizational performance improvement activities;

y. assuring accountability of the Medical Staff to the Board of Trustees for the quality of medical care, treatment, and services provided to the Medical Center's patients; and

z. assuring that an effective peer review structure is in place to perform Focused Practitioner Specific Evaluations when a concern is raised regarding the performance of an existing credentialed provider or there is doubt about an applicant's ability to perform the privileges requested.

By adopting these Bylaws, the Medical Staff has delegated to the Medical Executive Committee the authority to perform on behalf of the Medical Staff the duties and functions described in these Bylaws, including but not limited to those described in this section 11.3-2.

11.3-3 MEETINGS

The Medical Executive Committee shall meet monthly, at least ten (10) times per year, or when convened by the Chief of Staff and shall maintain a record of its proceedings and actions. Quorum requirements are set forth in Section 12.3.

11.3-4 REMOVAL OF MEDICAL EXECUTIVE COMMITTEE MEMBERS

Members of the Medical Executive Committee are appointed either because of title or position or are elected as at-large members. Members of the Medical Executive Committee who are appointed by title or position shall be removed from the Medical Executive Committee when they lose the title or position that granted them membership. At-large members and the Immediate Past Chief of Staff may be removed from the Medical Executive Committee through the same mechanism as described in Section 9.1.6 related to the removal of officers.

11.4 CREDENTIALS COMMITTEE

11.4-1 COMPOSITION

The Credentials Committee shall consist of members of the Active Staff, selected on a basis that will ensure, insofar as feasible, representation of major clinical specialties and each of the departments.

11.4-2 DUTIES

The duties of the Credentials Committee shall be:

a. review and evaluate the qualifications of each practitioner applying for initial appointment;

b. review and evaluate selected applicants for reappointment as requested by the Chair of the Department or otherwise defined in **Medical Staff Policy and Procedure: Reappointment Levels**;

c. submit required reports and information on the qualifications of each practitioner applying for Medical Staff membership including recommendations with respect to appointment, membership category, department affiliation, clinical privileges and special conditions;

d. investigate, review and report on matters referred by the Chief of Staff or the Medical Executive Committee regarding the qualifications, conduct, professional character or competence of any applicant or Medical Staff member;

e. submit periodic reports to the Medical Executive Committee on its activities.

11.4-3 MEETINGS

The Credentials Committee shall meet as often as necessary but at least quarterly or at the call of its Chair. The committee shall maintain a record of its proceedings and actions and shall report to the Medical Executive Committee.

11.5 JOINT CONFERENCE COMMITTEE

11.5-1 COMPOSITION

As necessary, the Chief of Staff shall convene an ad hoc Joint Conference Committee to address a particular issue. The committee shall be composed of a total number of six (6) voting members: three (3) members of the Board of Trustees, and three (3) members of the Medical Executive Committee -the Chief of Staff, Immediate Past Chief of Staff and Vice Chief of Staff of the Medical Staff. The Chief Executive Officer and Chief Medical Officer shall be additional non-voting ex-officio members, for a total of 8 members. The Chair of the Joint Conference Committee shall be the Chief of Staff. A quorum shall be no less than four (4) voting members.

11.5-2 DUTIES

The Joint Conference Committee shall constitute a forum for the discussion of matters between the Board of Trustees and Medical Staff when other mechanisms have not resulted in resolution of the matter. The Joint Conference Committee shall also meet if any conflicts arise related to the Medical Staff Bylaws, Rules and Regulations, and policies.

11.5-3 MEETINGS

The Joint Conference Committee shall meet as needed and shall transmit written reports of its activities to the Medical Executive Committee to Medical Center Administration and to the Board of Trustees. The Joint Conference Committee will convene on request of the Chief of Staff.

11.6 OTHER MEDICAL STAFF COMMITTEES

There shall be other designated standing committees of the Medical Staff to oversee critical Medical Staff duties and functions. The composition, duties, and meeting frequency of these Medical Staff committees shall be defined and contained in the Medical Staff Rules and Regulations of the Alameda Health System.

11.7 CONFLICT MANAGEMENT

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

   1. upon written petition signed by either:

      i. at least 33% of the voting members of the Medical Staff, or

      ii. at least two-thirds (2/3) of the members of any Department of the Medical Staff; or

   2. upon the MEC's own initiative at any time; or

   3. as otherwise specified in these Bylaws.

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

c. A petition to initiate the conflict management process shall designate two Active Medical Staff members to serve as representatives of the petitioners, describe the nature of the conflict, and state the reasons why the conflict management process should be utilized to address it.

d. With respect to each particular conflict, the MEC shall determine and specify a process that the MEC deems most appropriate to the issues and circumstances. At a minimum, the conflict management process shall do all of the following:

   1. provide a reasonably timely, efficient, and meaningful opportunity for the parties to express their views;

   2. require good-faith participation by representatives of the parties; and

   3. provide for a written decision or recommendation by the MEC on the issues within a reasonable time, including an explanation of the MEC's rationale for its decision or recommendation.

e. At the MEC's discretion, the process for management of a conflict between the MEC and Medical Staff members may include the involvement of a third party to facilitate or mediate the conflict management efforts.

f. The conflict management process described in this Article 11.7 shall be a necessary prerequisite to any proposal to the Board by Medical Staff members for adoption

or amendment of a Bylaw, Rules and Regulations provision, or Policy not supported by the MEC, including (but not limited to) a proposed Bylaws amendment intended to remove from the MEC some authority that has been delegated to it by the Medical Staff.

g. Nothing in this Article 11.7 is intended to prevent Medical Staff members from communicating with the Board about Medical Staff Bylaws, Rules and Regulations, or Policies, according to such procedures as the Board may specify.

ARTICLE XII
MEETINGS

12.1 MEETINGS

12.1-1 ANNUAL MEETING OF THE MEDICAL STAFF

There shall be an annual meeting of the Medical Staff. The Chief of Staff, or such other officers, department or division chairs, or committee chairs, as the Medical Executive Committee may designate, shall present reports on actions taken and goals accomplished during the preceding year and on other matters of interest and importance to the membership. Goals may be set for the next Medical Staff year. Notice of this meeting shall be given to the membership at least ten (10) days prior to the meeting. Medical Staff elections shall be held at the annual meeting of the Medical Staff in each even-numbered year.

12.1-2 REGULAR MEETINGS

Regular meetings of the members may be held semi-annually. The date, place and time of the regular meetings shall be determined by the Medical Executive Committee, and notice shall be given to the membership at least ten (10) days prior to a regular meeting.

12.1-3 AGENDA

The order of business at meetings of the Medical Staff shall be determined by the Chief of Staff and the Medical Executive Committee. The agenda shall include, insofar as feasible:

a. reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;

b. administrative reports from the Chief of Staff, departments, committees, Chief Medical Officer, and the Chief Executive Officer;

c. election of officers when required by these Bylaws;

d. reports by responsible officers, committees and departments on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the Medical Staff, and on the fulfillment of other required Medical Staff functions;

e. continuing business; and

f. new business.

12.1-4 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Chief of Staff of the Medical Executive Committee, or shall be called on the written request of ten 10% of the members of the Active Medical Staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The Medical Executive Committee shall schedule the meeting within thirty (30) days after receipt of such request. No later than ten (10) days prior to the meeting, notice shall be mailed or delivered to the members of the Medical Staff which includes the stated purpose, the place, day and hour of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

12.1-5 VOTING

Voting in any regular or special Medical Staff meeting may occur in person at the meeting, by mail in ballot or e-mail ballot or other electronic means, including but not limited to attendance and voting by telephone conference.
In addition, for amendment of the Medical Staff Bylaws, voting may be conducted without a regular or special meeting of the Medical Staff, provided that written notice of the proposed changes is provided to the Medical Staff, by mail or email, at least thirty (30) days prior to the closing of voting. Such notice shall be supplemented by posting of the notice in appropriate places, which shall at least include the Medical Staff Office and may be further supplemented through newsletters and other appropriate media. The notice shall include the exact wording of the existing language, if any, and the proposed amendment, if applicable. In addition, for all members of the Active Staff, the notice shall include ballots for such voting and a description of the required method for returning the ballot. Proxy voting is not permitted.

12.2 COMMITTEE AND DEPARTMENT MEETINGS

12.2-1 REGULAR MEETINGS

Except as otherwise specified in these Bylaws, the chair of committees, departments and divisions may establish the times for the holding of regular meetings. The chair shall make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

12.2-2 SPECIAL MEETINGS

A special meeting of any Medical Staff committee, department or division may be called by the chair thereof, the Medical Executive Committee, or the Chief of Staff, and shall be called by written request of one-third of the current members eligible to vote, but not less than two (2) members. Special meetings may be conducted by telephone conference. Good faith efforts must be made to give advance notice of special meetings to all members of the committee, department or division through an appropriate means.

12.3 QUORUM

12.3-1 STAFF MEETINGS

The presence of fifty (50%) percent of the total members of the Active Medical Staff at any regular or special meeting in person, by mail in ballot or e-mail ballot shall constitute a quorum for the purpose of the election or removal of Medical Staff Officers, and for actions described in Sections 1.3 and 11.3-5. Except as otherwise provided in these Bylaws, the presence of twenty-five percent (25%) of such members shall constitute a quorum for all other actions.

12.3-2 DEPARTMENT AND COMMITTEE MEETINGS

A quorum of fifty percent (50%) of the voting members shall be required for the Medical Executive Committee meeting. For department, division and committee meetings, a quorum shall consist of twenty-five percent (25%) of the voting members but in no event less than two (2) voting members.

12.3-3 MANNER OF ACTION

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

Committee action may be conducted by electronic facsimile transmission or electronic mail, which shall not be deemed to constitute a meeting. Valid action may be taken without a meeting by a committee if it is acknowledged by a written record setting forth the action so taken which is signed by two-thirds (2/3) of the members entitled to vote.

12.3-4 MINUTES AND RECORDS

Except as otherwise specified herein, minutes of meetings and records of all votes conducted without meetings pursuant to Section 12.3-3, shall be prepared and retained. Minutes shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters. A copy of the minutes shall be signed by the presiding officer of the meeting and forwarded to the Medical Executive Committee.

12.4 ATTENDANCE REQUIREMENTS

12.4-1 REGULAR ATTENDANCE

a. When attendance is required at a specific Medical Staff meeting, members will be notified according to the Medical Staff Bylaws Article XII, Sections 12.1-1, 12-1-2 and 12.1-4.

b. Mandatory attendance at division and/or department meetings will be at the Chair of the Department or Division Chief's discretion with the approval of the Chief of Staff.

Each member of the Consulting or Courtesy staff, and members of the Provisional Medical Staff, who qualify under criteria applicable to Courtesy or Consulting members, may be required to attend such other meetings as may be determined by the Medical Executive Committee. Persons granted temporary clinical privileges are excluded from meeting attendance requirements.

12.4-2 ABSENCE FROM MEETINGS

Any member who is compelled to be absent from any Medical Staff department, division, or committee meeting for which attendance was mandatory shall promptly provide to the regular presiding officer thereof the reason for such absence. Unless excused for good cause by the presiding officer of the department, division or committee, or the Secretary/Treasurer for Medical Staff meetings, failure to meet the attendance requirements may be grounds for removal from such committee or for corrective action.

12.4-3 SPECIAL ATTENDANCE

At the discretion of the Chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a department, division, or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice or professional behavior is involved, the notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at any meeting with respect to which he was given such notice, unless excused by the Chief of Staff or Medical Executive Committee upon a showing of good cause, shall result in automatic administrative suspension of the member’s privileges until such time as the member shall appear for a subsequent meeting (or shall agree to so appear, to the satisfaction of the Chair or presiding officer who requested the member’s attendance). Such failure to appear may also be grounds for corrective action.

12.5 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order. However, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

ARTICLE XIII
CONFIDENTIALITY, IMMUNITY AND RELEASES

13.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising clinical privileges within this Medical Center, an applicant:

a. authorizes representatives of the Medical Center and the Medical Staff to solicit, provide, and act on information bearing on, or reasonably believed to bear on, the applicant's professional ability and qualifications;

b. authorizes persons and organizations to provide information concerning such practitioner to the Medical Staff;

c. agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Medical Center or a third party who acts in accordance with the provisions of this Article; and

d. acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges at this Medical Center.

13.2 CONFIDENTIALITY OF INFORMATION

13.2-1 GENERAL

The minutes, files, records and proceedings of the Medical Staff and all departments, divisions, standing, special or ad hoc committees, including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential and protected from disclosure pursuant to California Evidence Code 1157. Dissemination of such information and records shall only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff or, where no officially adopted policy exists, only with the express approval of the Medical Executive Committee or its designee.

13.2-2 BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff departments, divisions, or committees, except in conjunction with the peer review activities of other hospitals, peer review bodies, professional societies, or licensing authorities, is outside appropriate standards of conduct for this Medical Staff, violates these bylaws, and will be deemed disruptive to the operations of the Medical Center. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

13.2-3 MEDICAL STAFF RECORDS

Access to medical staff records shall be limited to duly appointed officers and committees of the medical staff for the sole purpose of discharging medical staff responsibilities and subject to the requirements that confidentiality be maintained.

13.3 IMMUNITY FROM LIABILITY

13.3-1 FOR ACTION TAKEN

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

13.3-2 FOR PROVIDING INFORMATION

Each representative of the Medical Staff and Medical Center and all third parties shall be immune, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the Medical Staff or Medical Center, or to another health care facility or organization, concerning such person who is, or has been, an applicant to or member of the Staff or who did, or does, exercise clinical privileges or provide services at this Medical Center.

13.4 ACTIVITIES AND INFORMATION COVERED

The confidentiality, Evidence Code 1157 protection and immunity provided by this Article shall apply to all acts, communications, reports (minutes, records), recommendations or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

a. applications for appointment, reappointment, clinical privileges or specified services;

b. corrective action;

c. hearings and appellate reviews;

d. utilization reviews;

e. other department, division, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct;

f. reports and queries to peer review organizations, the Medical Board of California, National Practitioner Data Bank, and similar reports and queries; and

g. all other performance improvement activities, minutes, records, and documents of Medical Center departments, divisions, administration, the Medical Executive Committee, or any other committees, groups, or individuals as designated and charged by the Medical Staff Chief of Staff or Medical Executive Committee.

13.5 RELEASES

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

13.6 INDEMNIFICATION

a. Subject to the conditions described below, the Medical Center shall indemnify, defend and hold harmless, members of the Medical Staff from and against losses

and expenses incurred by reason of any action, suit, proceeding or investigation arising out of actions or activities undertaken within the scope of peer review activities authorized by these bylaws and carried out in good faith and without malice, as follows.

1. Attorneys' fees authorized in writing by the Medical Center;

2. Settlements and other costs authorized or agreed to by the Medical Center; and

3. Reasonable compensation (not to exceed $100.00 per hour) for lost income attributable to time spent at depositions or court appearances.

b. Such defense and indemnification is expressly conditioned upon the following:

1. the member shall provide notice to the Medical Center within fourteen (14) days of receipt of notice of any such suit, action, proceeding or investigation; and

2. Medical Center shall have sole authority to retain legal counsel for, to control litigation in and to settle such disputes.

ARTICLE XIV
GENERAL PROVISIONS

14.1 RULES AND REGULATIONS AND MEDICAL STAFF POLICIES AND PROCEDURES

14.1-1 APPROVAL BY THE MEDICAL EXECUTIVE COMMITTEE

a. The Medical Executive Committee shall initiate and adopt general Rules and Regulations that provide associated details, to implement more specifically the general principals established in these Bylaws, for the proper conduct of its work and shall periodically review and revise its Rules and Regulations to comply with current Medical Staff practice. Additions or recommended changes to the general Medical Staff Rules and Regulations shall be generated by or submitted to the Medical Executive Committee for review and approval.

b. The Medical Executive Committee shall adopt Medical Staff policies and procedures as may be necessary for proper conduct of work and shall periodically review and revise such Medical Staff policies and procedures to comply with current Medical Staff practices. Recommended adoptions and/or changes to Medical Staff policies and procedures shall be generated by or submitted to the Medical Executive Committee for review and approval.

c. The Medical Staff Bylaws, Rules and Regulations, and policies shall not conflict with the Board of Trustees Bylaws.

d. Proposals for new Rules and Regulations or Policies , or amendments to existing Rules and Regulations or Policies, may be submitted to the MEC by any voting member(s) of the Medical Staff or by the Hospital CEO or his/her designee on behalf of Hospital Administration, or proposed by the MEC on its own initiative.

e. A proposal bearing the signatures of 33% or more of the voting members of the Active Medical Staff (which will constitute notice of the proposal to the MEC) must identify two Active medical Staff members who will serve as representatives and act on behalf of the proposal signers in the processes described below (including any conflict management processes):

    1. If the MEC supports a Rules and Regulations proposal as submitted, the proposal will be disseminated to the Medical Staff for comment as described below, before the MEC submits the proposal to the Board for approval. The MEC is not required to submit proposed Policies or proposed Policy amendments to the Medical Staff for comment.
    2. If the MEC does not support the proposal, it will notify the designated representatives in writing, and they will have 30 days from receipt of the notice to invoke the conflict management process described in Article 11.7 of these Bylaws. If the conflict management process is not invoked within 30 days, it will be deemed waived and the proposal will be deemed withdrawn.
    3. If the conflict is not resolved by withdrawal of the proposal, or by MEC support of the proposal as modified in the conflict management process, then the proposal will be submitted (in original form or, if the original proposal has been modified in the conflict management process, then as modified) to the Medical Staff for comment as described below before the proposal is submitted to the Board for approval.

f. With respect to any Rules and Regulations proposal that does not bear the signatures of 33% of Active Medical Staff members), the MEC has discretion to do any of the following:

    1. disseminate the proposal, as submitted, to the Medical Staff for comment;

    2. modify the proposal and disseminate it, as modified, to the Medical Staff for comment; or

    3. reject the proposal and not disseminate it to the Medical Staff for consideration.

g. With respect to any Policy proposal that does not bear the signatures of **33%** of Active Medical Staff members, the MEC may accept, modify or reject the proposal without disseminating it to the Medical Staff for comment.

h. Except as otherwise provided in this Article, before the MEC submits any proposal for adoption or amendment of Rules and Regulations to the Board for approval, the MEC shall disseminate the proposal to the Medical Staff in a reasonable manner, which may include posting it in a newsletter or bulletin, distributing it at a general Medical Staff meeting, or any other method regularly used by the Medical Staff Office to provide notices to members. Members of the Medical Staff shall be given an opportunity to submit written comments, through the Medical Staff Office, for a period of not less than **15** days.

i. After considering any comments that have been received within the allotted period, the MEC may modify the proposal in light of the comments. The MEC will disseminate any such modified proposal to the Medical Staff, and may, in the MEC's discretion, solicit further comments in the manner described above.

j. If a proposal did not include the signatures of **33** % or more of the voting members of the Active Medical Staff, but the MEC disseminated the proposal to the Medical Staff for comment, then after the comment period ends the MEC in its discretion may do either of the following:

1. submit the proposal to the Board for approval, in its original form or as modified in light of the comments; or

2. reject the proposal and not submit it to the Board .

k. Upon approval by the Board, new Rules and Regulations, Policies, or amendments to existing Rules and Regulations or Policies, shall be announced promptly to the Medical Staff in a reasonable manner, as described above.

l. Duly adopted Rules and Regulations and Policies shall be binding on all applicants to and members of the Medical Staff, as well as any practitioners who are granted temporary clinical privileges.

m. If a proposal is not approved by the Board, then the MEC (or the designated representatives of the group of Medical Staff members who submitted a non-MEC-supported proposal that went directly to the Board) may invoke the conflict management process set forth in

[Section 11.7 of these Bylaws within 15 days of receiving notice that the proposal was not approved by the Board.

n. If the MEC receives documentation of an urgent need to amend the Medical Staff Rules and Regulations to comply with law or regulation, the MEC may adopt the necessary amendment provisionally and submit it to the Board for provisional approval, without prior notification of the Medical Staff. Immediately following the MEC's adoption of such an urgent provisional amendment to the Rules and Regulations, the MEC will notify the Medical Staff (by an acceptable method of providing such notice as described above), and offer an opportunity for any interested Medical Staff member to submit written comments to the MEC within **15** days of the date of the notice. The amendment will become final at the end of the comment period if the comments indicate there is no substantial conflict regarding the provisional amendment. (There is no substantial conflict unless at least 33% of voting Active Medical Staff members express opposition to the amendment in writing.)

o. If the comments indicate a substantial conflict over the provisional amendment, then the MEC will implement the conflict management process set forth in Section 11.7 of these Bylaws, and may submit a revised amendment to the Board for approval if necessary.

p. In the event of a conflict between these Bylaws and any provision of the Medical Staff Rules and Regulations or Policies, as determined by the MEC, the Bylaws shall prevail.

14.1-2 ADOPTION BY THE BOARD OF TRUSTEES

Following Medical Executive Committee approval of Medical Staff General Rules and Regulations or Medical Staff policies as noted above, such Rules and Regulations or policies shall be come effective following approval by the Board of Trustees. Board of Trustees approval shall not be withheld unreasonably.

14.2 DUES OR ASSESSMENTS

The Medical Executive Committee shall have the power to determine the amount of annual dues or assessments, if any, for each category of Medical Staff membership or affiliation and to determine the manner of expenditure of such funds received.

All members of the Medical Staff shall pay annual dues with the exception of Honorary and Emeritus status. Members who provide voluntary services may be exempt at the recommendation of Chair of the Department and the discretion of the Medical Executive Committee.

14.2-1 MEDICAL STAFF FUNDS

Medical Staff funds, regardless of what source (i.e., medical staff dues, Medical Center funds) shall be under the sole control of the Medical Staff.

14.3 CONSTRUCTION OF TERMS AND HEADINGS

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

14.4 AUTHORITY TO ACT

Any member or members who act in the name of this Medical Staff without proper authority shall be subject to such corrective action as the Medical Executive Committee may deem appropriate.

14.5 DIVISION OF FEES

Any division of fees by members of the Medical Staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff.

14.6 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, or requests required or permitted to be mailed shall be in writing properly sealed, and shall be sent through United States Postal Service, first class postage prepaid. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained. Notice to the Medical Staff or to officers or committees thereof, shall be addressed as follows:

Name and proper title of addressee, if known or applicable, or:

Chief of Staff,
c/o Medical Staff Services Department
Alameda Health System
1411 E. 31st St.
Oakland, CA 94602

Mailed notices to a member, applicant or other party, shall be to the addressee at the address as it last appears in the official records of the Medical Staff or the Medical Center.

14.7 DISCLOSURE OF INTEREST

All nominees for election or appointment to the Medical Staff Services Departments, Chairs of the Departments, or the Medical Executive Committee, shall, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeable result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

14.8 NOMINATION OF MEDICAL STAFF REPRESENTATIVES TO OUTSIDE ORGANIZATIONS

Candidates for positions as Medical Staff representatives to local, state, and national hospital medical staff sections should be filled by such selection process as the Medical Staff may determine. Nominations for such positions shall be made by a nominating committee appointed by the Medical Executive Committee.

14.9 CONFIDENTIALITY OF THE CREDENTIAL FILE

Medical Staff members or other individuals exercising clinical privileges shall be granted access to his/her own credentials file, subject to the following provisions:

a. The records of the medical staff and its departments and committees responsible for the evaluation and improvement of the quality of patient care rendered in the Medical Center shall be maintained as confidential.

b. Access to such records shall be limited to duly appointed officers and committees of the medical staff for the sole purpose of discharging medical staff responsibilities and subject to the requirement that confidentiality be maintained.

c. Information which is disclosed to the governing body of the Medical Center or its appointed representatives—in order that the governing body may discharge its lawful obligations and responsibilities—shall be maintained by that body as confidential.

d. Information contained in the credentials file of any member may be disclosed with the member’s consent, or to any medical staff or professional licensing board, or as permitted by these Bylaws

e. A medical staff member shall be granted access to the individual’s credentials file, subject to the following provisions:

    1. timely notice of such shall be made by the member to the chief of staff or the chief of staff’s designee;

    2. the member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information—including peer review committee findings, letters of

reference, proctoring reports, complaints, etc.—shall be provided to the member, in writing, by the designated officer of the medical staff, (at the time the member reviews the credentials file)/(within a reasonable period of time, as determined by the medical staff). Such summary shall disclose the substance, but not the source, of the information summarized. Notwithstanding the foregoing, the medical Staff shall have the discretion to permit a member to review and make his/her own summary of information from his or her file, provided that the Chief of Staff determines that this would be appropriate for the information in question and that, where the information was provided in confidence, the information disclosed does not reveal the source of such information;

3. the review by the member shall take place in the medical staff office, during normal work hours, with an officer or designee of the medical staff present.

14.10 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

The Medical Executive Committee may request an opportunity to review and make recommendations to the Board of Trustees regarding quality of care issues related to exclusive arrangements for physician and/or professional services, prior to any decision being made, in the following situations:

a. the decision to execute an exclusive contract in a previously open department or service;

b. the decision to renew or modify an exclusive contract in a particular department or service;

c. the decision to terminate an exclusive contract in a particular department or service.

14.11 MEDICAL STAFF REPRESENTATION BY LEGAL COUNSEL

Upon the authorization of the Medical Staff, or of the Medical Executive Committee acting on its behalf, the medical staff may retain and be represented by independent legal counsel.

ARTICLE XV
ADOPTION AND AMENDMENT OF BYLAWS

15.1 PROCEDURE

On the request of the Chief of Staff, the Medical Executive Committee, the Bylaws Committee, or on timely written petition signed by at least ten (33%) percent of the members of the Medical Staff in good standing who are entitled to vote, consideration

shall be given to the adoption, amendment, or repeal of these Bylaws. Any proposed change(s) to the bylaw language will be mailed or e-mailed to each member of the Active Medical Staff at least thirty (30) days prior to a request for a Bylaws vote. Voting regarding bylaw change(s) shall occur pursuant to Section 12.1-5 Article XII Generally, proposals to adopt, amend or repeal Bylaws will emanate from or be endorsed by the Medical Executive Committee in accordance with its overall responsibility to represent and act on behalf of the Medical Staff and discharge its various functions as described in Section 11.3 of these Bylaws. However in addition to the mechanisms set forth above by which the Medical Staff may adopt MEC-proposed amendments to these Bylaws, the Medical Staff may adopt and propose Bylaw amendments directly to the Board for its approval, but only in accordance with the following procedure:

a. A proposal to amend the Bylaws may be initiated by submitting to the Medical Staff Office a petition signed by at least 33 % of voting Active Medical Staff members proposing a specific Bylaws amendment or amendments (which will constitute notice of the proposed Bylaws amendment(s) to the MEC). Any such petition must identify two Active Medical Staff members who will serve as representatives and act on behalf of the petition signers in the processes described below (including any conflict management processes).

b. Upon submission of such a petition, the MEC will determine whether it supports the proposed Bylaws amendment(s), and if so, the Medical Staff Office will arrange for a vote on the proposed Bylaws amendment(s) by the voting members of the Active Medical Staff according to the process described above for voting on MEC-proposed Bylaws amendments.

   1. If the Medical Staff adopts the proposed Bylaws amendment(s) by a vote of the Medical Staff conducted according to the process described above, then the proposed Bylaws amendment(s) will be submitted to the Board for approval.

   2. If the Medical Staff does not adopt the proposed Bylaws amendment(s) by vote, then the proposed Bylaws amendment(s) will be deemed withdrawn.

c. If the MEC does not support the proposed Bylaws amendment(s), the MEC will notify the designated representatives in writing, and they will have 30 days from receipt of the notice to invoke the conflict management process described in Article 11.7 of these Bylaws. If the conflict management process is not invoked within 30 days, it will be deemed waived and the proposed Bylaws amendment(s) will be deemed withdrawn.

d. If the conflict is not resolved by withdrawal of the proposed Bylaws amendment(s), or by MEC support of the proposed Bylaws amendment(s) as modified in the conflict management process, then the proposed Bylaws amendment(s) will be submitted (in original form or, if the original proposed Bylaws amendment(s) has/have been modified in the conflict management

process, then as modified) to the Medical Staff for a vote. The proposed Bylaws amendment(s) will be submitted to the Board if a majority of the Active Medical Staff members who are eligible to vote cast their ballots in favor of the proposed Bylaws amendment(s).

e. A copy of the MEC's written statement of its decision and reasons issued at the conclusion of the conflict management process shall be provided to the Board along with any proposed Bylaws amendment(s) submitted to the Board after such process.

f. Such proposed Bylaws amendment(s) will become effective immediately upon Board approval, which shall not be withheld unreasonably.

g. If the Board does not approve the proposed Bylaws amendment(s), then the matter will be referred to the conflict management process set forth in Section 11.7of these Bylaws for management of conflicts between the Board and the Medical Staff.

15.2 ACTION ON BYLAW CHANGE

Provided that notice of the procedure described in Section 15.1 has been followed, revision of the Bylaws may be approved by an affirmative vote of the majority of voting members voting in person, by mail-in ballot or e-mail ballot.

15.3 APPROVAL

Bylaw changes adopted by the Medical Staff shall become effective following approval by the Board of Trustees, which approval shall not be withheld unreasonably. Neither the Board of Trustees nor the Medical Staff may unilaterally amend the Medical Staff Bylaws. Should the Board of Trustees take no action for approval or disapproval of any Bylaws changes within forty-five (45) days of submission by the Medical Staff, the the Medical Staff Chief of Staff shall present the Bylaws changes as adopted by the Medical Staff at a special Joint Conference Committee meeting for discussion and resolution.

15.4 EXCLUSIVITY

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

15.5 REVIEW

These Bylaws shall be reviewed at least every two (2) years and revisions made according to the described amendment procedure.

a. TECHNICAL AND EDITORIAL REVISIONS

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

Medical Staff of Alameda Health System

Board of Trustees