

# ALAMEDA HOSPITAL

# MEDICAL STAFF BYLAWS

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## **PREAMBLE**

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

**Whereas, the city of Alameda HealthCare District owns Alameda Hospital and Alameda Health System operates Alameda Hospital; and**

**Whereas, the purpose of Alameda Hospital is to, among others, provide acute care general hospital services, skilled nursing facilities and sub-acute services.**

**Whereas, it is recognized that the Alameda Hospital Medical Staff is responsible for the quality of medical care and education in the hospital and must accept and discharge this responsibility subject to the ultimate authority of the Board of Trustees, 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 hospital to its patients.**

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

## DEFINITIONS

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1. The term “**Hospital**” means the Alameda Hospital, including its Skilled Nursing Facilities and others as applicable.
2. The term “**Practitioner**” or “Licensed Independent Practitioner” means a California licensed physician (medical or osteopathic), podiatrist, dentist, oral maxillofacial surgeon, or clinical psychologist.
3. The term “**Medical Staff**” means the organization of those medical physicians, osteopathic physicians, dentists, or podiatrists 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 their licensure that has been granted and maintains Medical Staff membership.
5. The term “**Board of Trustees**” (BOT) means the Alameda Health System Authority Board of Trustees, which is the governing body of the Health System.
6. The term “**Chief Medical Officer**” (CMO) means a physician and surgeon appointed by the Chief Executive Officer and approved by the Medical Executive Committee to provide all necessary administrative support for the medical staff, communicate the views of the Health System administration to the medical staff, and serve as a liaison between the medical staff and the administration on particular issues. This position standing alone does not entitle its holder to vote on any matters of the Medical Staff or committees of the Medical Staff.
7. The term “**Inquiry**” means a preliminary fact-finding and review process to determine whether to commence an investigation.
8. The term “**Investigation**” means a process formally commenced by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a member and individuals who hold clinical privileges of the Medical Staff. An investigation is ongoing until either formal action is taken, or the investigation is closed. An investigation does not include activity of the Medical Staff Wellbeing Committee. A routine or general quality review of cases or a routine review of a particular physician is not an investigation. An investigation is closed when the MEC completes its review, which includes but is not limited to not taking action but tracking and trending or monitoring to assure no further issues.
9. The term “**Just Culture**” refers to a safety-supportive system of shared accountability where medical staff members are accountable to the systems they have designed and for supporting the safe choice of patients, visitors, and staff.
10. The term “**Zero Tolerance**” refers to the Medical Staffs culture that disruptive behavior is

never justified.

11. The term “**Medical Executive Committee**” (MEC) means the Executive Committee of the Medical Staff.

12. The term “**Quality Professional Services Committee**” (QPSC) means the subcommittee of the Alameda Health System Board of Trustees, which has the authority to render initial appointment, reappointment and renewal or modification of clinical privilege decisions of the Medical Staff.

13. The term “**Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE)**” are terms used for evaluation of a practitioner’s performance. OPPE is the continuous evaluation of a practitioners’ performance FPPE is a process whereby the organization evaluated the privilege-specific competence of the practitioner when new privileges are granted, when clinical activity is insufficient to evaluate competence or there is a particular question regarding a practitioner’s care or professional conduct.

14. The term “**Chief Executive Officer**” means the individual appointed by the Board of Trustees to act in its behalf in overall management of the Health System.

15. The term “**Department**” refers to a clinical unit of the Medical Staff that represents a clinical specialty and its subspecialties.

16. The term “**Department Chair**” refers to the individual who is chief of a department who is selected in accordance with these Bylaws.

17. The term “**Vice Chair**” refers to the individual appointed by the Department Chair and approved by the Chief of Staff in accordance with these Bylaws.

18. The term “**Advanced Practice Provider**” or “**APP**” means an individual who practices in an APP category approved by the Board of Trustees and who meets the requirements contained in the APP Policies and Procedures and other applicable Medical Staff documents.

19. The term “**Medical Staff Year**” refers to the period from January 1<sup>st</sup> to December 31<sup>st</sup> of the same year.

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

21. The term “**Good Standing**” means a member is currently not the subject of a recommendation or action that is cause for requesting a hearing or serving with any limitation of prerogative imposed by operations of the bylaws, rules and regulations or policies and procedures of the medical staff.

22. The term “**Chief of Staff**” means the chief officer of the medical staff elected by members of the Medical Staff pursuant to these Bylaws.

23. The term, “**Telemedicine**” refers to the provision of clinical services to patients by physicians and practitioners from a distance via electronic communications. The use of medical information exchanged from one site to another via electronic communication to improve patients’ health status. Telemedicine is a subcategory of telehealth.
24. The term, “**Telemedicine Entity**” refers to a Provider of telemedicine services in a manner that allows the originating site hospital or critical access hospital to comply with all applicable CoPs and standards. This is not a Medicare- participating hospital.
25. The term, “**Distant Site**” refers to the location where the physician or licensed practitioner who is delivering the services via telemedicine.
26. The term, “**Originating Site**” refers to the location of the patient at the time the service is being furnished via telemedicine. This must be a designated healthcare facility.

# ALAMEDA HOSPITAL MEDICAL STAFF BYLAWS

## ARTICLE 1: NAME AND PURPOSES

### 1.1 NAME

The name of this organization is **ALAMEDA HOSPITAL MEDICAL STAFF**.

### 1.2 PURPOSES AND RESPONSIBILITIES

The Medical Staff's purposes are:

- a. to take reasonable measures to assure that all patients admitted to or treated at Alameda Hospital receive care at a level of quality and efficiency consistent with generally accepted standards attainable within the Health System's means and circumstances, and that patient care services are provided only by members of the Medical Staff or under supervision or direct order of members of the Medical Staff, or provided by an individual who has been granted temporary privileges, and that such services are and within the scope of the clinical privileges granted to those members in accordance with these Bylaws;
- b. to organize and support professional education and community health education and support services;
- c. to initiate and maintain AH Medical Staff Bylaws, Rules and Regulations and policies that govern how the Medical Staff carries out its responsibilities for the professional work performed in the hospital;
- d. to provide a means for the Medical Staff, Board of Trustees and Administration to discuss issues of mutual concern;
- e. 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 clinical privilege holders;
- f. the Medical Staff shall strive to reflect the diversity of the community and patients we serve.

### 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 Health System-wide policy involving the oversight of care, treatment, and services provided by members and others at Alameda Hospital. The Medical Staff is also responsible for and involved with all aspects of delivery of

## ALAMEDA HOSPITAL MEDICAL STAFF BYLAWS

health care within the hospital 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 Hospital depends on the mutual accountability, interdependence, and responsibility of the Medical Staff and the Health System governing board for the proper performance of their respective obligations. To that end, the Medical Staff acknowledges that the Board of Trustees must act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the Hospital. In adopting these Bylaws, the Medical Staff commits to exercise its responsibilities with diligence and good faith, and in approving these Bylaws, the Board of Trustees commits to supporting the Medical Staff's self-governance and independence in conducting the affairs of the Medical Staff. Accordingly, the Board of Trustees will not assume a duty or responsibility of the Medical Staff precipitously, unreasonably, or in a bad faith; and will do so only in the reasonable and good faith belief that the Medical Staff has failed to fulfill a substantive duty or responsibility in matters pertaining to the quality of patient care.

### **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, and other sections in these Bylaws including the ability to recommend to the Medical Staff changes to the Bylaws and Rules and Regulations and formulate and approve Medical Staff Rules and Regulations and policies in accordance with the procedures described in these Bylaws. 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. The process for Medical Staff amendment of Rules and Regulations and Bylaws is described in Section 16.1.

Although the Medical Staff has delegated to the Medical Executive Committee the ability to recommend to the Board of Trustees changes to the Rules or policies in accordance with Section 16.1, adoption or amendment of Medical Staff rules and regulations and/or policies also can be recommended by the voting Medical Staff Members following the same process as described in Section 17.1. with or without the prior recommendation of the Medical Executive Committee. Other delegated duties authorities of the Medical Executive Committee may be recalled by voting Medical Staff Members as described in Section 12.3-5.

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## ARTICLE 2: MEMBERSHIP

### 2.1 NATURE OF MEMBERSHIP

No Physician, Dentist, or Podiatrist, including those in a medical administrative position by virtue of a contract or employment with the Health System, shall admit or provide medical or health-related services to patients in the hospital unless they are a member of the Medical Staff who have been granted clinical privileges for admission and treatment or has been granted 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 on the professional training, experience and other criteria as determined by the Medical Executive Committee or 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 Administrative, 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 valid, unsuspended California license which is unrestricted and not subject to a pending accusation, or any probation for any Medical Board 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.

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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.
  1. From and after January 1, 2017, all initial applicants for medical staff membership must be board certified or progressing towards board certification (as determined by the respective specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association Board, the American Board of Oral and Maxillofacial Surgery, the American Board of Foot and Ankle Surgery, or the American Board of Podiatric Medicine) in the specialty area to which the applicant is seeking appointment at the time of initial appointment and at the time of such applicant's subsequent reappointments.
  2. Failure to meet the qualifications for medical staff membership and privileges based on the standards in this Section 2.2-2 b. does not give rise to the procedural rights outlined in Article 9.
  3. Exception may be made for "moonlighting practitioners" pursuant to the Medical Staff Policy "Moonlighting Practitioners" and in accordance with these Bylaws. There is no right to an exception.

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.

- c. 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, per individual;
  2. Be a member, employee, or subcontractor of a group or person that has a contract in departments operated under an exclusive contract, where applicable;
  3. Not be currently excluded from any health care program funded in whole or in part by the federal government,

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including Medicare or Medicaid (Medi-Cal); and

4. Meet basic qualifications in Article 3 Categories for Membership. If such qualifications are not met solely due to clinical activity the reappointment application will be reviewed at Credentials Committee to determine whether there is good cause for a reappointment application to be offered. The recommendation will be referred to the Medical Executive Committee. There is no right to be offered a reappointment application if clinical activity requirements are not satisfied.
5. 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 9 of these Bylaws.

### **2.2-3 QUALIFICATIONS FOR MEMBERSHIP**

In addition to meeting the basic standards, the practitioner must document their:

- (a) (1) a current California license which is unrestricted and not subject to a pending accusation, or any probation for any Medical Board, (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and (5) current adequate physical and medical health status, so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;
- (b) Commitment (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care, (3) to keep as confidential, as required by law, all information or records received in the physician-patient relationship, and (4) to be willing to participate in and properly discharge those responsibilities determined by the medical staff;

### **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;

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- 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. is certified by a particular specialty board; or
- e. 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, gender identity, sexual orientation, race, age, religion, 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.

### **2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP**

Except for the Honorary, Emeritus and Administrative Staff, the ongoing responsibilities of each member of the Medical Staff and/or clinical privilege holder include:

- a. All initial appointees to the Medical Staff who are granted clinical privileges and all members granted new clinical privileges shall be subject to a period of FPPE/proctoring.
- b. Providing patients with the quality of care meeting the professional standards of the Medical Staff of this hospital;
- c. Abiding by the Medical Staff Bylaws, Rules & Regulations and Policies and Procedures;
- d. 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;
- e. Timely preparing and completing medical records for all patients to whom the member provides care in the Health System;
- f. Abiding by the ethical principles of the California Medical Association or other applicable professional association;
- g. Working cooperatively with members, nurses, Health System administration and others so as to create a working environment conducive to quality patient care;

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- h. Providing continuing coverage for their patients and making appropriate arrangements for clinical coverage for their 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 these Bylaws, or which is the subject of a hearing pursuant to Article 9;
- p. Notify the Chief of Staff in writing no later than seven (7) calendar days from the occurrence of any of the following and providing such additional information as may be requested, regarding each of the following:
  - 1. The revocation, limitation, or suspension of their professional license or DEA registration, any court order to cease or restrict their professional practice, any reprimand or other disciplinary action taken by any state or federal governmental agency relating to their professional license.
  - 2. Loss, summary suspension or summary restriction or denial of staff membership or privileges at any hospital or other health care institution, whether temporary or permanent.
  - 3. Change in employment status such as termination and/or administrative leave.
  - 4. To maintain quality and safety for our patients, if the individual Staff member or APP has been unable to provide clinical care for more than thirty (30) consecutive days they must notify the Department Chair, Chief of Staff, and the Medical Staff Office via written communication

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five (5) working days in advance of resuming clinical care within our health system.

5. Lapse, cancellation or change of professional liability coverage including any change of carrier or amount of coverage.
6. 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 taken by a Medicare peer review organization, the Department of Health Human Services, or any health regulatory agency of the United States or the State of California.
7. Receipt of notice of the filing of any suit against the practitioner alleging professional liability in connection with the treatment of any patient.
8. The development of any mental or physical condition or other situation that could compromise the practitioner's ability to perform the functions associated with their clinical privileges in a safe and effective manner.
9. The filing, conviction, pleading guilty, no contest or its equivalent in any jurisdiction to a felony, requires written communication to MEC.
10. The conviction, pleading guilty, no contest or its equivalent in any jurisdiction to a misdemeanor, requires written communication to MEC.

q. To immediately submit to an appropriate evaluation, which may include diagnostic testing (such as a blood and/or urine test), and/or to a complete physical, mental, and/or behavioral evaluation, if at least two Medical Staff Officers are concerned with the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff Officers. The Medical Staff member must execute all appropriate releases to permit the sharing of information with the Medical Staff Officers and pay for the cost of the requested evaluation(s) and/or testing.

r. 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

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### 2.6 MEMBER'S CONDUCT REQUIREMENTS

As a condition of membership and privileges, medical staff members, APP's and non-members with clinical privileges shall continuously meet the requirements for a culture of safety, quality of care, and professional conduct established in these Bylaws and the Medical Staff's Rules and Regulations and policies. Allegations of harassment, discrimination, unprofessional or disruptive conduct shall be reviewed and addressed if verified. Professionalism also includes promoting Just Culture principles, which helps to assure a safe clinical practice and appropriate care and treatment for patients.

Medical Staff members and clinical privilege holders are expected to:

- a. to adhere to the ethics of their respective professions;
- b. to be able to work cooperatively with others so as not to adversely affect patient care;
- c. behave in a way that promotes a Just Culture.

Notwithstanding any other provision of these Bylaws, the Medical Staff's Rules and Regulations or policies, documentation relating to such reviews, their conclusions and any resulting remedial or disciplinary action shall be maintained by the Medical Staff as peer review documents.

## ARTICLE 3: CATEGORIES OF MEMBERSHIP

### 3.1 CATEGORIES

The categories of the Medical Staff include the following: Active, Courtesy, Consulting, , Office Based, Honorary and Emeritus, Administrative and Telemedicine. 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 Health System to provide appropriate continuity of quality care;
- c. regularly care for patients at Alameda Hospital and are considered by the Credentials Committee as having Alameda Hospital a major part of their hospital practice. “Regularly care for patients” shall mean are involved

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in at least forty (40) inpatient or outpatient care activities in two (2) years at Alameda Hospital. These patient care activities may consist of admissions (inpatient or outpatient), assisting in surgery, consultations and/or performing other patient care procedures-but do not include laboratory orders. Exceptions to this requirement may be made for good cause by the Medical Executive Committee; and

### **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 these Bylaws ;
- b. attend and vote on matters presented at general and special meetings of the Medical Staff and of the Department and Committees of which they are a member; and
- c. hold staff, 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 Hospital 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, their Medical Staff membership shall automatically terminate. No such transfer or termination shall be subject to the provisions of Article 9.

## **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 Hospital per two (2) year period. These patient care activities may consist of admissions

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(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

### 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 these Bylaws;
- 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, their medical staff membership shall automatically terminate. No such transfer or termination shall be subject to the provisions of Article 9.

## 3.4 CONSULTING STAFF

### 3.4-1 QUALIFICATIONS

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

- a. are not otherwise members of the Medical Staff but 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

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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 Hospital 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 hospital 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 these Bylaws ;
- 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,

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their medical staff membership shall automatically terminate. No such transfer or termination shall be subject to the provisions of Article 9.

### **3.5 HONORARY AND EMERITUS STAFF**

#### **3.7-1 QUALIFICATIONS**

##### **a. Honorary Staff**

The Honorary Staff shall consist of physicians, dentists, podiatrists, and clinical psychologists who do not actively practice at the hospital 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 hospital, and who continue to exemplify high standards of professional and ethical conduct. Honorary Staff members are not required to pay dues.

##### **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.

#### **3.7-2 PREROGATIVES**

Honorary and Emeritus staff members are not eligible to admit patients to the hospital, or to exercise clinical privileges in the hospital, 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. They are not required to pay dues.

### **3.6 ADMINISTRATIVE STAFF**

#### **3.8-1 QUALIFICATIONS**

The Administrative Staff shall consist of physicians, dentists, podiatrists, or clinical psychologists, who do not have any clinical privileges at the Health System but are important resource individuals for Medical Staff. The functions that Administrative Staff may perform for the medical staff include all phases of quality assessment and peer review, including but not limited to observing procedures, proctoring, performing chart review, participating in investigations, and participating in hearings. Administrative Staff may be appointed to the Administrative Staff by the Chief of Staff or the Medical Executive Committee and are not required to complete the application process in Article 4 or pay Medical Staff dues. Such persons shall be qualified to perform the quality assessment and peer review functions for which they are made Administrative Staff. They may be excused from having a California license, professional liability insurance, and any other requirements the Chief of Staff or designee determines are in the best interests of the Medical Staff given the functions they will be performing. They may not vote or hold office.

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### **3.8-2 PREROGATIVES**

Administrative Staff members shall be afforded the following prerogatives:

- a. Attend committee meetings to which they have been appointed for the limited purpose of carrying out the functions for which they were made members of the Administrative Staff. Attend other department and committee meetings, upon request.

### **3.8-3 APPOINTMENT TERM**

Membership on the Administrative Staff may be time limited or limited based upon their assignment, as dictated by the Medical Staff Administrative Agreement Form as signed by Department Chair and Chief of Staff/designee. At the end of the appointment period, Administrative Staff membership will automatically expire without any right to the hearing or appeals processes in these Bylaws.

## **3.7 TELEMEDICINE STAFF**

### **3.9-1 QUALIFICATIONS**

The Telemedicine Staff shall consist of practitioners who only provide diagnostic services via telemedicine link from a site other than the hospital. Telemedicine Staff must apply for appointment and reappointment. Telemedicine privileges are limited to those services recommended by the Medical Executive Committee and approved by the Board of Trustees.

### **3.9-2 PREROGATIVES**

- a. Telemedicine Staff shall exercise only such telemedicine privileges as are granted to them pursuant to these Bylaws.
- b. Telemedicine Staff shall be required to meet the general and basic qualifications for membership in and the basic responsibilities specified in these Bylaws however, practitioners from a distant site who only have Telemedicine clinical privileges may be excused from requirements to attend meetings and provide coverage of the Emergency Department, and immunizations.
- c. Telemedicine Staff shall not be eligible to vote or hold office in this Medical Staff organization.
- d. Telemedicine Staff are obligated to be licensed in the State of California and have malpractice insurance.

## **3.8 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.

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### **3.9 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.

### **3.10 MODIFICATION OF MEMBERSHIP CATEGORY**

On its own, on recommendation of the Credentials Committee, or pursuant to a request by a member the Medical Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of the Bylaws.

## **ARTICLE 4: APPOINTMENT AND REAPPOINTMENT**

### **4.1 GENERAL**

Except as otherwise specified herein, no person (including persons engaged by the Health System in administratively responsible positions), shall exercise clinical privileges in the hospital unless and until they apply for and receive 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 policies and procedures and hospital policies and procedures approved by the Medical Staff and agrees that throughout any period of membership they 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 Advanced Practice Provider Staff, as applicable under the circumstances.

### **4.2 BURDEN OF TIMELY PRODUCING INFORMATION**

- a. 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

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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.

- b. An application automatically shall be deemed voluntarily withdrawn if an applicant does not provide any required information and/or documentation within thirty (30) days after it is requested, unless the applicant submits within said thirty (30) days information that the Department Chair or designee deems "good cause" for the additional time to respond. Failure to provide the required information or documentation within such additional time shall result in the application being automatically deemed resigned. An applicant whose application is not completed within six (6) months after it was received by the Medical Staff Office shall be automatically deemed voluntarily withdrawn unless the Department Chair or designee determines the delay should be excused for good cause as beyond the control or responsibility of the applicant; provided, however, the applicant then may be required to confirm via written communication that all of the information on the application continues to be complete and correct and must complete the application within such additional time as specified by the Department Chair or designee.

### **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 complete 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 Staff. 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

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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 assured that the Medical Staff has received written evaluations for those listed by the applicant as references and from other potential sources of relevant information and has signed special releases or similar documents, as requested. The Medical Staff may adopt a policy for the processing of applications that directs that applications be deemed incomplete and automatically withdrawn if persons identified by the applicant decline to reply after receiving such release or similar document.

### **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:

1. 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
2. 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 provision of Article 9.

### **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

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information provided or of any new information that might reasonably have an effect on the applicant's candidacy. Absent good cause to excuse the failure to notify, the failure to meet this responsibility will automatically result in 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 PRE-APPLICATION AND APPLICATION FOR INITIAL APPOINTMENT**

#### **4.6-1 PRE-APPLICATION**

- a. The Medical Executive Committee may adopt a policy to implement a pre-application process that requires individuals to complete a pre-application form that is developed by the Medical Executive Committee. The pre-application form would require that potential applicants provide information and documents that demonstrate the individual meets both (i) the criteria specified in the bylaws, rules and policies to be eligible to be considered for medical staff or APP membership, and (ii) the applicable criteria established by the medical staff to be eligible to apply for clinical privileges in the individual's proposed area of practice. No application for appointment will be provided to a potential applicant, nor will an application be accepted from a potential applicant, until the pre-application process confirms the individual is eligible to apply for membership and eligible to apply for the applicable clinical privileges in the individual's proposed area of practice. The Medical Executive Committee may establish administrative procedures to implement the pre-appointment process, including but not limited to pre-application fees, timely completion of the pre-application process, and requirements for timely submitting an application for appointment after the medical staff provides the application for appointment. Failure to meet the criteria to receive an application is not an assessment of the individual's competence and not basis for the procedures in Article 9. The completed pre-application form and the information and documents collected as part of the pre-application process are the medical staff's confidential peer review materials, not to be retained in any administrative files nor used for any administrative purposes.

If the applicant does not meet criteria, an application will not be released. Not meeting criteria to receive an application is not grounds for the procedures in

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Article 9 hereof. If a potential applicant would believe that they meet the criteria, that individual must submit via written communication to the Medical Staff within thirty (30) days after notice that the individual did not meet criteria a letter via written communication that includes all information and documents that substantiate the individual meets the criteria.

### **4.6-2 APPLICATION FORM**

- a. Application forms shall be developed by the Medical Executive Committee. The completed Medical Staff application forms and all materials received as part of the application process 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:
  - i. 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;
  - ii. specialty or subspecialty board certification and eligibility;
  - iii. the applicant's qualifications, including but not limited to, professional training and experience, current licensure, current DEA registration, special certification, ability to perform privileges requested and continuing medical education information related to the clinical privileges to be exercised by the applicant;
  - iv. peer references familiar with the applicant's professional competence and ethical character;
  - v. requests for membership categories, department assignments, and clinical privileges;
  - vi. 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;
  - vii. final judgments or settlements made against the applicant in professional liability cases and any filed and served cases pending;
  - viii. all past and present out of-state medical licenses;
  - ix. past practice history;
  - x. current and past hospital affiliations;
  - xi. 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;
  - xii. 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

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- health care facility;
- xiii. 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;
- xiv. 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
- xv. information as to whether the applicant has ever been subject to criminal conviction (nolo contendre and guilty plea are deemed a conviction) or whether any such action is pending.

Each application for initial appointment to the Medical Staff shall be via written communication, 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 in such a manner or format as determined by the Medical Executive Committee.

### **4.6-3 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 their willingness to appear for interviews in regard to the application;
- b. authorizes consultation with others who have been associated with them and who may have information bearing on their 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 their qualifications and ability to exercise clinical privileges requested, agrees to provide such records and documents as the Medical Staff deems relevant to its review of the applicant's qualifications, 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;

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- 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. upon signed release, consents to the disclosure to other hospitals, medical associations, and licensing boards, and to other similar organizations as required or permitted by law, any information regarding their 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, assessments, or fines, acknowledges responsibility for timely payment;
- h. agrees to provide for continuous quality care for their patients;
- i. agrees to maintain an ethical practice, including refraining from illegal inducements for patient referral, to provide continuous care of their patients, to seek consultation whenever necessary, to refrain from providing "ghost" surgical or medical services, and to refrain from delegating patient care responsibility to non-qualified or inadequately supervised practitioners; and
- j. agrees to be bound by the Medical Staff Bylaws, Rules and Regulations and Medical Staff policies and Health System organizational policies and procedures.
- k. agrees that if membership and privileges are granted, then for the duration of medical staff membership, the member has an ongoing and continuous duty to report to the medical staff office within seven (7) days any and all information that would otherwise correct, change, modify or add to any information provided in the application or most recent reapplication when such correction, change, modification, or addition may reflect adversely on current qualifications for membership or privileges.

### 4.6-4 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 9. 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

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obligation to timely provide the required information. The application will not be submitted to the Department Chair or Credentials Committee until it is complete and all necessary information has been verified. When collection and verification is accomplished, all such information shall be transmitted to the Department Chair and Credentials Committee for action.

### **4.6-5 DEPARTMENT ACTION**

After receipt of the application, 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 their discretion. 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 Chair of the Department may also request that the Medical Executive Committee defer action on the application.

### **4.6-6 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 determine additional information or documents are required and return the application as incomplete to the Medical Staff Service Department. At any time, the Credentials Committee may request that the Medical Executive Committee defer action on the application.

### **4.6-7 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 determine additional information or documents are required and return the application as incomplete to the Medical Staff Services Department, 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

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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 Medical Executive Committee may also defer action on the application. The reasons for each recommendation shall be stated.

### **4.6-8 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 Quality Professional Services Committee, where applicable, and Board of Trustees
- b. **Adverse Recommendation:** When a final recommendation of the Medical Executive Committee is adverse to the applicant, the Medical Executive Committee shall notify the applicant of the adverse recommendation. If the adverse recommendation is grounds for the procedures in Article 8, the applicant will be notified in accordance with the procedures in Article 8 of the procedural rights in Article 8. The Board of Trustees will take no action until the applicant has waived or exhausted the hearing rights in Article 8, if the applicant has waived his right to a hearing and the MEC's decision is supported by substantial evidence, the MEC's decision shall be adopted by the Quality Professional Services Committee, where applicable, and Board of Trustees as the final decision.

### **4.6-9 ACTION ON THE APPLICATION**

The Quality Professional Services Committee, where applicable, and 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 9 of the Bylaws, the Chief of Staff or their designee shall promptly inform the applicant that he or she shall be entitled to the procedural rights as provided by Article 9. In the case of an adverse Medical Executive Committee recommendation or an adverse Board of Trustees decision, the Quality Professional Services Committee, where applicable, and Board of Trustees shall take final action in the matter only after the applicant has exhausted or has waived their Bylaws Article 9 procedural rights.

### **4.6-10 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.

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- 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 they are assigned;
  3. clinical privileges granted; and
  4. special conditions attached to the appointment.

### **4.6-11 REAPPLICATION AFTER ADVERSE APPOINTMENT OR CLINICAL PRIVILEGE DECISION**

An applicant who has received a final adverse decision regarding appointment or clinical privileges that was grounds for requesting a hearing pursuant to Article 9 shall not be eligible to reapply to the Medical Staff or to request such clinical privileges for a period of three (3) years after the date of the final adverse decision, or for a time period at the discretion of the MEC. This time period shall be determined at the time of final action by the MEC. Any such reapplication or request for clinical privileges 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. For purposes of this Section, the date of the final adverse action is the date all hearings, appeals and any court proceedings related to the adverse decision have been exhausted, complete and final or have been waived. If an individual withdraws an application for membership or privileges, agrees to a restriction or limitation, or relinquishes their membership or clinical privileges following an adverse recommendation or action by the Medical Executive Committee or Board of Trustees that was grounds for requesting a hearing pursuant to these Bylaws, after the individual is on notice of a pending adverse recommendation, or during an investigation, the individual also may not apply for appointment or such clinical privileges until at least three (3) years or the time frame approved by the MEC, after such withdrawal, agreement or relinquishment.

### **4.6-12 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

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complete and includes all necessary supporting documentation.

- b. Review and recommendation by the Department Chair 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 forty-five (45) 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 9.

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. At least one hundred and twenty days (120) prior to the expiration date of the current staff appointment (except for temporary appointments), a reapplication form developed by the Credentials Committee and approved by the Medical Executive Committee shall be mailed or delivered to the Member. If a completed application for reappointment is not received at least sixty (60) days prior to the expiration date, notice shall be promptly sent to the applicant advising that the completed application has not been received and that the Member will have only an additional thirty (30) days to submit a completed application. The reapplication form shall be accompanied by payment of any applicable fees and include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 4.6-2, as well as other relevant matters.
- 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 but may not be filed three (3) years if Section 4.6-10 applies. 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. Such applicant shall have the burden of producing

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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. If the request is incomplete, the incomplete request automatically shall be withdrawn and not processed.

### **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 Level 1 and Level 2 criteria and the process for their reappointment are described in Medical Staff Policy and Procedure: Application 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 4.6-2 through 4.6-12. In each such instance, the member's eligibility for Medical Staff membership as set forth in Article 2, and the member's eligibility for assignment to a category of the Medical Staff as set forth in Article 3, 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 these Bylaws.

### **4.7-5 FAILURE TO FILE REAPPOINTMENT APPLICATION**

Failure to file a complete application with any assessed fees for reappointment with all supporting or requested documentation at least 85 days prior to the expiration of the provider's current appointment shall result in the automatic expiration of medical staff membership and/or privileges at the end of the current appointment unless otherwise extended for good cause by the Medical Executive Committee so long as there is adequate time for processing the provider's application, including

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MEC and Board approval, prior to the expiration of the privileges. Otherwise, the provider shall be deemed to have resigned membership and/or privileges. In the event membership and/or privileges expire for the reasons set forth herein, the procedures set forth in Article 9 shall not apply. A provider who requests reappointment within sixty (60) days following an automatic termination under this Section shall not be required to complete a new application form.

### **4.8 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 9.

### **4.9 LEAVE OF ABSENCE**

#### **4.9-1 LEAVE STATUS**

A medical staff member may take a voluntary leave of absence from the medical staff for health reasons, to fulfill military or family obligations, to obtain further education or training, for vacation or any other purpose, upon submitting a written notice to the medical executive committee three (3) weeks in advance of the beginning of the leave (unless there are unexpected circumstances), stating the approximate period of leave desired, which may not exceed one (1) year. The member will be provided with a written statement in advance of the leave disclosing whether the leave will give rise to a report and providing the member the opportunity to cancel the leave to avoid reporting.

- a. During the period of the leave, the member or clinical privilege holder shall not exercise clinical privileges at the Hospital, and membership rights and responsibilities shall be inactive.
- b. During the period of a leave, if the member is an APP's sole supervising physician, the staff member's and the APP's privileges and prerogatives shall be suspended. The member or APP has an obligation to pay dues and to timely submit an application for reappointment to retain the same reappointment deadlines and cycle during the member's leave of absence, except for members and APP's on military leaves of absence who are excused from paying dues or submitting applications for reappointment while on military leave. Except for members and APP's on military leaves of absence, failure to timely pay dues and comply with reappointment deadlines shall result in the automatic deemed resignation of the member.

#### **4.9-2 TERMINATION OF LEAVE**

- a. At least thirty (30) days prior to the termination of the leave of absence, or at

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any earlier time, the Medical Staff member or APP may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee.

- b. The Medical Staff will notify the member or APP of any materials required from the member to make the credential file complete before the request for return from a leave of absence can be processed. The request will be reviewed by Medical Staff Department and the Medical Executive Committee.
- c. 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 or clinical privilege holder shall submit a summary of relevant activities during the leave. At the request of the Medical Executive Committee, all members may be subject to a fitness for duty evaluation, and/or a routine focus review upon their return from a leave of absence.
- d. If the member or clinical privilege holder would have been required to submit an application for reappointment during such a leave, the member must submit a completed application for reappointment.
- e. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the member's or clinical privilege holder's privileges and prerogatives following the procedure provided in Sections 4.1 through 4.5-11.
- f. Clinical privileges will only be reinstated after approval by the Medical Executive Committee and the Board of Trustees.

### 4.9-3 FAILURE TO REQUEST REINSTATEMENT

Failure without good cause to request reinstatement or to submit information or documents requested to process the request shall result in automatic termination of membership, privileges, and prerogatives. In the event membership, privileges, or prerogatives terminate for the reasons set forth in this paragraph, the procedures set forth in Article 9 shall not apply. A request for Medical Staff membership subsequently received from a member, privileges, or prerogatives so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

### 4.9-6 OBSERVATION REQUIREMENT

Depending on the length of leave and the activities performed during this leave, reinstatement may, in the discretion of the Medical Executive Committee, be made subject to an observation requirement for a period of time during which the member's or clinical privilege holder's clinical care is proctored or monitored by the Department Chair or his/her designee to determine the member's or clinical

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privilege holder's continued ability. Such required proctoring or monitoring is part of the routine proctoring processes, not based on an assessment of the professional competence, and will not be deemed disciplinary action or cause for a hearing pursuant to Article 9.

## ARTICLE 5: CLINICAL PRIVILEGES

### 5.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws, individuals providing clinical services at this Hospital shall be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be Medical Staff 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 Health System Policies and Procedures and Health System policies and procedures that have been approved by the Medical Executive Committee. If an individual holds clinical privileges but is not credentialed as a Member or APP, the holder of clinical privileges shall comply with these Bylaws, the Rules, and policies to the extent they may logically apply to individuals who hold clinical privileges.

### 5.2 DEVELOPMENT OF CRITERIA FOR CLINICAL PRIVILEGES

Subject to the approval of the Medical Executive Committee and the Board of Trustees, each Department will be responsible for developing criteria for granting clinical privileges. The criteria shall be designed to facilitate uniform quality patient care, treatment and services. Advanced Practice Providers shall participate in developing the criteria for privileges to be exercised by APPs. Each Department approved criteria for granting privileges shall be on the privilege form.

#### 5.2-3 CRITERIA FOR “CROSS-SPECIALTY” PRIVILEGES WITHIN THE MEDICAL STAFF

Any request for clinical privileges that are either new to the Medical Staff 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 Medical Staff credentialing criteria for new or cross-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.

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### **5.3 DELINEATION OF PRIVILEGES IN GENERAL**

#### **5.3-1 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 Advanced Practice Providers who seek to exercise independent clinical privileges must specifically delineate the privileges requested. Subject to applicable waiting periods specified in the Article 4, 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. The burden of providing sufficient information to evaluate a request for privileges rests with the applicant.

#### **5.3-2 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 Medical Staff despite the member's qualifications or ability to perform the requested privilege.

### **5.4 FOCUSED PROFESSIONAL PRACTICE EVALUTION (FPPE) / PROCTORING**

#### **5.4-1 GENERAL PROVISIONS**

All initial appointees to the Medical Staff and all members granted new clinical privileges shall be subject to a period of FPPE/proctoring. In addition, the Medical Executive Committee may require members to be observed or otherwise evaluated 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. Such required observation or evaluation that is not based upon identified concerns with a member's competence or conduct, but the lack of information to assess the

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member's competence or conduct, is not grounds for the procedures in Article 9. 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. The member shall continue to comply with FPPE/Proctoring requirements until the member is notified via written communication that the member no longer is subject to FPPE/Proctoring.

### 5.4-2 FAILURE TO COMPLETE FPPE/PROCTORING

- a. If an initial appointee fails to complete the FPPE/proctoring requirement those specific clinical privileges shall continue at reappointment with the existing proctoring requirements.
- b. If a member exercising new clinical privileges fails to complete the FPPE/proctoring requirement those specific clinical privileges shall continue with the existing proctoring requirements. 9.
- 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 9 shall apply.

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### **5.5 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS**

#### **5.5-1 ADMISSIONS**

Every patient admitted to the Hospital shall have a history and physical examination completed by a physician, Advanced Practice Provider 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, and podiatrists 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 documents and conducts or directly supervises the admitting history and physical examination (except the portion related to dentistry, oral surgery, or podiatry) 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 Advanced Practice Provider 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.

#### **5.5-2 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.

#### **5.5-3 MEDICAL APPRAISAL**

All patients admitted for care in the Hospital by a dentist, oral surgeon or podiatrist 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 Chair(s).

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### 5.6 HISTORY AND PHYSICAL – COMPLETION OF:

- a. Histories and physicals can be conducted or updated and documented only pursuant to specific privileges granted upon request to qualified physicians, advanced practice providers, and other practitioners who are members of the medical staff or have temporary privileges, acting within their scope of practice.
- b. Oral maxillofacial surgeons who have successfully completed a postgraduate program in oral maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Office of Education and have been determined by the medical staff to be competent to do so, may be granted the privileges to perform a history and physical examination related to oral maxillofacial surgery. For patients with existing medical conditions or abnormal findings beyond the surgical indications, a physician member of the medical staff with history and physical privileges must conduct or directly supervise the admitting history and physical examination, except the portion related to oral maxillofacial surgery, and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the oral maxillofacial surgeon's lawful scope of practice.
- c. 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 (or registration if an outpatient procedure) for the same diagnosis is on record, in which case that history and physical will be updated within twenty-four (24) hours of admission. Every patient admitted for surgery must have a history and physical upon admission, 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 prior to surgery or a procedure requiring anesthesia.
- d. Every patient receives a history and physical no more than thirty (30) days prior to, or within twenty-four (24) hours of inpatient admission or registration, but prior to surgery or a procedure requiring anesthesia. For a medical history and physical examination that was completed within thirty (30) days prior to inpatient admission or registration, an update documenting any changes in the patient's condition is completed within twenty-four (24) hours after inpatient admission or registration, but prior to surgery or a procedure requiring anesthesia.

### 5.7 TEMPORARY PRIVILEGES

#### 5.7.1 REQUIREMENT OF NEED AND DEFINITION OF CIRCUMSTANCES

Temporary privileges are allowed under two circumstances only: to address a patient care need and to permit patient care to be provided while an application is

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pending. Temporary privileges for applicants may be granted for no more than 120 days.

### **5.7.2 APPLICATION AND REVIEW**

- a. Upon request of temporary privilege application and receipt of all required fees and supporting documentation from a physician, dentist or podiatrist 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 these Bylaws , but only after the following has occurred.
  1. Primary source verification via written communication or through a documented telephone conversation of licensure status, current competence relevant to the privileges requested, and insurance status is obtained.
  2. A National Practitioner Data Bank query.
  3. An OIG sanction report and GSA List query to ensure that applicant is not an excluded provider.
  4. 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.
  5. 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.
  6. Documentation of patient care need mandating the granting of temporary privileges is obtained.
  7. The Chief of Staff or designee recommends and the Board of Trustees, through the Chief Executive Officer or administrative designee , concurs in the granting of temporary privileges.
- b. Upon receipt of a completed Medical Staff application and a request for temporary privileges, 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 and has received a favorable recommendation from the appropriate Chair of the Department

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and is ready for immediate submission to the Medical Executive Committee for action;

2. no subjection to involuntary termination of medical staff membership or involuntary limitation, reduction, denial, or loss 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 or administrative designee, concurs in the granting of temporary privileges.
  - a. All practitioners requesting temporary privileges pursuant to these Bylaws must demonstrate Active Staff membership at a Joint Commission accredited hospital, although exceptions may be made by the Chief of Staff or designee for good cause.
  - b. 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.
  - c. The omission of any information, response or recommendation specified in this section shall preclude the granting of temporary privileges.

### 5.7-3 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 Hospital.
- b. All temporary privileges are time limited and shall automatically terminate at the end of the designated period. The provisions of these Bylaws shall not apply to such automatic termination. No individual has the right to temporary privileges.
- c. Requirements for FPPE 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.

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

### 5.8 EMERGENCY CARE IN THE ABSENCE OF PRIVILEGES

- a. In the case of an emergency involving a particular patient, any member of the medical staff with clinical privileges, to the degree permitted by the scope of the applicant's license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of the patient or to save the patient from serious harm provided that the care provided is within the scope of the individual's license. The member shall make every reasonable effort to communicate promptly with the department chair concerning the need for emergency care and assistance by members of the medical staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the department chair with respect to further care of the patient at the hospital.
- b. Neither this section nor any other document shall be used to force members to serve on emergency department call panels providing services for which they do not hold delineated clinical privileges.

### 5.9 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 Health System 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.

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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, government-issued photo identification card (ID) (e.g., driver's license, passport) and at least one of the following:
  - a. A current picture hospital ID card clearly identifying professional designation.
  - b. A current license to practice.
  - c. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups.
  - d. Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances.
  - e. Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner'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 themselves 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.

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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.

### **5.10 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT**

On its own, on recommendation of the Credentials Committee, or pursuant to these Bylaws 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.

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. Such dissemination is not a waiver of the confidentiality of peer review information and is limited to only those staff and such information as is deemed necessary for such implementation and monitoring.

### **5.11 TELEMEDICINE PRIVILEGES**

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 to the Medical Staff credentialing and privileging based upon (i) the individual's full compliance with the hospital's credentialing and privileging standards; or (ii) by using the hospital's standards but relying on information provided by the Distant Site hospital or Telemedicine Entity.

#### **5.11-1 SERVICES**

Services provided by telemedicine shall be identified by each specific department and approved by the Medical Executive Committee and Board of Trustees.

#### **5.11-2 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) however in accordance with Article 3, practitioners from a Distant Site who only have Telemedicine clinical privileges may be excused from requirements to attend meetings, pay dues and fees and provide coverage of the emergency department.

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## ARTICLE 6: ADVANCED PRACTICE PROVIDERS

### 6.1 QUALIFICATIONS

Advanced Practice Providers (APPs) are not eligible for Medical Staff membership. APPs who demonstrate evidence of current licensure, relevant training and/or experience, professional competence, and continuously meet the qualifications, standards, and requirements (1) specific to APP's as set forth in these Bylaws, the Rules and policies, and (2) for Medical Staff members as set forth in these Bylaws, the Rules and policies to the extent they may logically apply to APP's, may be granted clinical privileges or practice prerogatives by the Medical Staff.

### 6.2 CATEGORIES OF APP

#### 6.2.1 DELINEATION OF ELIGIBLE APP CATEGORIES

The types of APPs granted clinical privileges or practice prerogatives in the Health System 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

APPs, who practice in categories that have been accepted for admission to this Health System by the Board of Trustees, are eligible for appointment to APP status. The Advanced Practice Provider Policy and Procedure Manual defines the categories of Independent APPs and Dependent APPs.

#### 6.2.3 NON-ELIGIBLE CATEGORIES

An APP who does not have licensure or certification in an APP category identified as eligible to apply for practice prerogatives may not apply for practice prerogatives but may submit a written request to the Medical Executive Committee asking that the Board of Trustees consider identifying the relevant category of APPs 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

APPs 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. APPs may be invited to the Annual Medical Staff meeting as guest with no voting rights.

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## ARTICLE 7: PEER REVIEW

Peer review, fairly conducted, is essential to preserving quality patient care.

All applicants and members are evaluated for membership and privileges using those medical staff peer review criteria adopted consistent with the medical staff's bylaws, rules and policies and applied through the processes established in the medical staff's bylaws, rules, and policies; provided, however that nonprejudicial deviations shall not be grounds for invalidating a review or the action taken. Consideration of members' possible emotional or physical health challenges and the availability of support, referral to the Medical Staff Provider Wellbeing Committee shall inform all peer review activity. Evaluation results are used in privileging, system improvement, and when warranted, corrective action.

### 7.1 ONGOING PEER REVIEW

All members and individuals who hold clinical privileges (referred to herein as "privilege holders") are subject to evaluation based on medical staff peer review criteria, adopted consistent with the medical staff's bylaws, rules and policies. Departments shall develop and routinely update peer review criteria when evaluating those applying for membership and or privileges as well as the performance of members and privilege holders.

### 7.2 INITIAL FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

All initial grants of privileges shall be subject to FPPE/proctoring under the medical staff's bylaws, rules and policies and otherwise reviewed for compliance with the relevant departmental peer review criteria.

### 7.3 FOCUSED PEER REVIEW OF PRACTITIONER

All members and privilege holders are reviewed for compliance with the relevant department peer review criteria on an on-going basis. In addition to information gathered under routine screening determined by the department, such as periodic chart review, proctoring on a rotational basis, monitoring of diagnostic and treatment techniques, and discussions with other professionals, complaints and concerns are analyzed in light of the department peer review criteria.

### 7.4 RESULTS OF REVIEW

Information resulting from peer review of members and privilege holders according to the relevant department criteria and analyzed by the process established in these bylaws must be acted upon. Peer review and any recommendations and determinations pertaining to the member and privilege holders shall be included in the member's and privilege holder's credentials file.

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### **7.5 EXTERNAL PEER REVIEW**

External peer review may be used to inform medical staff peer review. Approval, and retention of an external reviewer to be in accordance with the medical staff policy.

## **ARTICLE 8: CORRECTIVE ACTION**

### **8.1 CORRECTIVE ACTION**

The Medical Staff has the responsibility and accountability for taking reasonable measures to ensure the safe delivery of patient care by those who have been credentialed by the Medical Staff as delegated by the Board of Trustees. All corrective actions recommended or imposed pursuant to this Article, other than routine monitoring and education, are presented to the Board of Trustees for final approval.

#### **8.1-1 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 and respond to questions) in the course of carrying out those functions without initiating formal corrective action. Comments, suggestions, and warnings may be issued orally or via written communication. The practitioner shall be given an opportunity to respond via written communication 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 9.

#### **8.1-2 CRITERIA FOR INITIATION OF CORRECTIVE ACTION**

Any person may provide information to the medical staff about the conduct, performance, or competence of its members and privilege holders. When reliable information indicates a member or privileges holder may have exhibited acts, demeanor, or conduct reasonably likely to be:

1. detrimental to patient safety or to the delivery of quality patient care within the hospital;
2. unethical or unprofessional, including but not limited to violations of patient privacy;

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3. contrary to the Medical Staff Bylaws, Medical Staff rules or regulations Medical Staff policies or the policies of the Health System that have been approved by the Medical Executive Committee; or
4. below applicable professional standards, a request for an inquiry, investigation or action against such member or privileges holder may be initiated by the Chief of Staff, a Department Chair, or the Medical Executive Committee.

A request for corrective action investigation or action against such member or privileges holder may be initiated by the Chief of Staff, a Department Chair, or the Medical Executive Committee.

### **8.1-3 INITIATION OF CORRECTIVE ACTION**

A request for an investigation must be via written communication, submitted to the Medical Executive Committee, and supported by reference to specific activities or conduct alleged; provided however, if the Medical Executive Committee initiates the request, it shall make an appropriate recording of the reasons.

Any patient allegations of sexual misconduct or abuse reported to a professional licensing Board regarding a privilege holder will be provided to the Medical Executive Committee to be addressed as a request for investigation.

### **8.1-4 INVESTIGATION**

If the Medical Executive Committee concludes an investigation is warranted, it shall conduct such investigation as it deems necessary. 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. 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 investigating committee may require the member attend a meeting to be interviewed, with at least five (5) days' notice to the member. The members' failure to attend or refusal to respond to questions

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will result in the automatic suspension until such time as the members appears for such interview and answers questions, unless such absence is excused for documented good cause. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons who may have pertinent knowledge. However, such investigation shall not constitute a "hearing" as that term is used in Article 9, 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.

### **8.1-5 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 retaining the information;
- 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 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.

If the member was not interviewed as part of the investigation, prior to the

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Medical Executive Committee taking any action or making any recommendation described above in subsections 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.

### **8.1-6 SUBSEQUENT ACTION**

If corrective action as set forth these Bylaws 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 9.
- 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. So long as the recommendation or action is supported by substantial evidence, the Medical Executive Committee recommendation or action shall be adopted by the Board of Trustees as the final action.

### **8.1-7 INITIATION OF CORRECTIVE ACTION BY BOARD OF TRUSTEES**

If the Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Board of Trustees may direct the Medical Executive Committee to initiate investigation or disciplinary action, but only after consultation with the Medical Executive Committee. The Board's request for Medical Staff action shall be via written communication and shall set forth the basis for the request. If the Medical Executive Committee fails to take action in response to that Board of Trustees direction, the Board of Trustees may initiate corrective action after written notice to the Medical Executive Committee, but this corrective action must comply with Articles 8 and 9 of these Medical Staff Bylaws.

## **8.2 SUMMARY RESTRICTION OR SUSPENSION**

### **8.2-1 CRITERIA FOR INITIATION**

The Chief of Staff or designee, 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

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that action may result in an imminent danger to the health of any individual, including but not limited to future Health System or clinic patients. Unless otherwise stated, such summary restriction or suspension shall become effective immediately on imposition and the person or body responsible shall promptly give written notice or verbal notice to the member. The summary restriction or suspension may be limited in scope or 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 a corrective action investigation pursuant to this Article.

### **8.2-2 WRITTEN NOTICE**

Within three working days of imposition of a summary restriction suspension, the affected Medical Staff member, Chief Executive Officer and Board of Trustees shall be provided with written notice of such action, including a statement of facts supporting it.

### **8.2-3 MEDICAL EXECUTIVE COMMITTEE ACTION**

As soon as practicable after such summary restriction or suspension has been imposed, a meeting of the medical executive committee or a subcommittee appointed by the chief of staff shall be convened to review and consider the action. The member may be required to attend 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 9, nor shall any procedural rules apply. The medical executive committee may modify, continue, or terminate the summary restriction or suspension, but in any event, it shall furnish the member with notice of its decision.

### **8.2-4 PROCEDURAL RIGHTS**

Unless the Medical Executive Committee promptly terminates the summary restriction or suspension before it constitutes ground for a hearing, the member shall be entitled to the procedural rights to the extent provided under Article 9.

### **8.2-5 INITIATION OF SUMMARY ACTION BY BOARD OF TRUSTEES**

If none of the persons described above in Section 8.2-1 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

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an imminent danger to the health or safety of any person, including but not limited to future Alameda Hospital patients. Prior to taking such action, the Board or designee must make reasonable attempts to contact the Chief of Staff, and Vice Chief of Staff. Such a suspension is subject to ratification by the Medical Executive Committee. As per California Business and Professions Code Section 809.05(b), if the Medical Executive Committee does not ratify the Board's action within two (2) working days, excluding weekends and holidays, the action shall terminate automatically. If the Committee does ratify the Board's action, all other provisions of pursuant to 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.

### **8.3 AUTOMATIC SUSPENSION OR LIMITATION**

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

#### **8.3-1 LICENSURE**

- a. Revocation and Suspension: Whenever a member's license or other legal credential authorizing practice in this State is revoked, or a court has ordered a member not to practice, Medical Staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.
- b. Restriction: Whenever a member's license or other legal credential authorizing practice in this State is limited or restricted, by the applicable licensing or certifying authority, any clinical privileges which the member has been granted at the hospital 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.
- c. Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, their 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.

#### **8.3-2 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,

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as of the date such action becomes effective and throughout its term. If clinical privileges require the member have a DEA certificate or require a DEA with all or certain scheduled substances, and if a member with those clinical privileges has a DEA certificate that limits, restricts, or does not have the required scheduled substances, those clinical privileges automatically shall be revoked as of the day the DEA was so limited, restricted or no longer had the required schedules.

- 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.

### 8.3-3 CONVICTION OF A FELONY INDICTMENT OR CONVICTION

All of the clinical privileges of an individual who is charged with a felony that constitutes a "crime against a person" or attempted "crime against a person," as defined by California law, (e.g. murder, mayhem, robbery, assault or battery) or is charged with a crime of rape, sexual assault, sexual battery, or indecent exposure, shall be automatically suspended pending the individual's presentation for the Chief of Staff's review and approval a plan that would protect hospital patients from risk of such charged conduct pending resolution of the criminal charges. The cost of complying with such plan shall be at the individual's sole cost and expense. If an individual is convicted or pleads no contest or its equivalent in any jurisdiction to a felony that includes any of the foregoing conduct, the individual's medical staff membership and clinical privileges automatically shall terminate, notwithstanding any potential appeals.

### 8.3-4 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

A practitioner's failure to appear and respond at a meeting for which the practitioner was notified pursuant to these Bylaws that attendance was required will result in the automatic suspension of all of the practitioner's clinical privileges until such time as the practitioner satisfies the attendance requirement and responds. Upon demonstration of good cause, the Chief of Staff or designee may excuse the failure to attend the scheduled meeting.

### 8.3-5 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 their designee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this Section, "related privileges", means

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scheduling surgery, assisting in surgery, consulting on hospital cases, and providing professional services within the hospital 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 these Bylaws. Bona fide vacation or illness may constitute an excuse to avoid suspension subject to approval by the Medical Executive Committee.

- b. Whenever a member removes any patient record from the hospital without permission, the member's privileges (except with respect to patients already in the Health System) 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.

### **8.3-6 PROFESSIONAL LIABILITY INSURANCE**

All Medical Staff members and APPs shall maintain professional liability insurance on their own or from Alameda Health System. Members and APPs 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 these Bylaws, shall result in immediate and automatic suspension of a member's privilege to admit and/or provide services. The individual must provide proof of continuous coverage that has "nose" or "tail" if necessary to assure continuous coverage. 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 APP clinical privileges shall automatically terminate. The failure to give notice of cancellation, termination or other change in coverage shall be independent grounds for corrective action pursuant to these Bylaws, Suspension or deemed resignation under this section shall not give rise to hearing rights under Article 9.

### **8.3-7 EXCLUSION FROM FEDERAL HEALTH CARE PROGRAM**

Whenever a practitioner is excluded from any federal health care program, the event shall result in an immediate automatic termination of Medical Staff membership and clinical privileges.

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### **8.3-8 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 if such Bylaws, Rules and/or policies specify an automatic suspension for such conduct.

### **8.3-9 FAILURE TO PROVIDE REQUIRED INFORMATION OR DOCUMENTS**

- a . Members are expected to cooperate with Medical Staff committees and representatives in the discharge of their official functions. This includes but is not limited to responding promptly and appropriately to correspondence and providing requested information and documents, Failure to respond and/or failure to provide required information or documents within thirty (30) days after the date the information or documents were requested may result in an automatic suspension of all clinical privileges until such time as the required information or documents are received by the Medical Staff; provided, however if the required information is not produced within thirty (30) days after automatic suspension, the lack of response will be considered a voluntary resignation. If the member submits a response that fails or refuses to respond to questions asked in the request for information or fails to provide all of the requested documents, the response will be treated as a failure to respond in accordance with these Bylaws. If a practitioner submits documented good cause for needing additional time to respond, the Chief of Staff or Chair of the Committee or Department that requested the documents may grant an extension to respond.
- b . When there is concern for patient safety or the delivery of patient care, members are also required to submit to independent mental and/or physical examinations, as requested by the Chief of Staff or the Medical Executive Committee. Failure to have the required evaluations and provide the results to the Medical Staff within thirty (30) days, unless excused for documented good cause, shall result in an automatic suspension of all clinical privileges until such time as the required information or documents are received by the Medical Staff; provided, however if the required information is not produced within thirty (30) days after the automatic suspension, the lack of response will be considered a voluntary resignation.
- c . For purposes of this section, examples of the information and documents that a Member can be expected to provide includes but is not limited to the following:
  - 1 . Physical and mental examinations and reports.

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2. Information and documents related to credentialing, peer review investigations, corrective action and discipline by other peer review bodies, licensing, managed care providers, accreditation bodies and other healthcare entities, including but not limited to copies of correspondence, external reviews, evidence and transcripts in hearings and administrative proceedings.
3. Information from a member's private office that is necessary to resolve questions that have arisen through the peer review process.
4. Information other than required by Section 8.3-6 related to professional liability coverage, claims and/or actions.

### **8.3-10 FAILURE TO PAY DUES/ASSESSMENTS**

Failure without good cause as determined by the medical executive committee, to pay dues or assessments, as required pursuant to these Bylaws, may result in the automatic suspension of a member's clinical privileges, and if within (three months) after written warnings of the delinquency the member does not pay the required dues or assessments, the member's membership may be automatically terminated.

### **8.3-11 LOSS OF ALTERNATE COVERAGE**

Each practitioner must at all times have at least one covering practitioner. The covering practitioner must have substantially the same clinical privileges as the individual who is being covered and agree to provide coverage for all of the patients of the practitioner for whom coverage is being provided. At any time, the Medical Staff can require that a practitioner with clinical privileges immediately provide the name of their covering practitioner. If a practitioner fails to promptly provide this information or the covering practitioner fails to confirm that s/he has agreed to provide coverage, all of the clinical privileges of the practitioner who cannot document coverage by another practitioner may be automatically suspended pending the Medical Staff's receipt of coverage information and verification of the required coverage subject to the automatic resignation provisions of Section 8.3-9. The Department Chair, Chief of Staff or a designee may recommend, and the Chief Executive Officer may agree that an applicant who is applying for temporary privileges to meet an important patient care be excused from securing coverage for such temporary privileges.

### **8.3-12 EXCLUSIVE CONTRACTS**

To exercise clinical privileges in any department that is subject to an exclusive contract with the hospital, a practitioner must be a member of the Medical Staff (with the exception of Advanced Practice Providers and physicians working in a

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locums capacity for the contracted entity), hold the applicable clinical privileges, and be an employee, partner, contractor, or associate (hereinafter "affiliate") of the group, individual, or entity that holds the exclusive contract (hereinafter "contracted entity"). Upon (1) the departure of the affiliate from the contracted entity, (2) notice from the contracted entity that a practitioner will no longer provide services at the hospital, or (3) the termination of the exclusive contract with the hospital, whichever occurs first, when all of the affiliate's clinical privileges are encompassed by the exclusive contract, the affiliate shall be deemed to have voluntarily resigned from the Medical Staff and to have voluntarily relinquished their clinical privileges. Such a resignation and relinquishment shall not entitle the practitioner to the procedural rights described in Article 9 of the Bylaws. To the extent the practitioner holds clinical privileges beyond those encompassed by the exclusive contract, their departure from the contracted entity or the termination of the exclusive contract will not result in the practitioner's voluntary resignation from the Medical Staff and the practitioner's remaining clinical privileges will remain intact.

### 8.3-13 AUTOMATIC ACTIONS

#### a. Automatic Resignation

Unless duration is otherwise specified in a sub-section of these Bylaws, if privileges are automatically suspended for sixty (60) consecutive days, the practitioner shall be deemed to have resigned from the Medical Staff.

Thereafter, reinstatement to the Medical Staff shall require completion of an application for initial appointment and compliance with the appointment procedures applicable to new applicants.

#### b. There shall be no hearing rights under Article 9 for automatic actions affecting a member's Medical Staff membership, status, or clinical privileges pursuant to these Bylaws. 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 shall be subject to hearing rights to the extent provided by Article 9.

### 8.3-14 MEMBER OBLIGATIONS

Members are responsible for complying with the limitations imposed by the provisions of these Bylaws 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 or criminal court, failure to maintain adequate professional liability insurance, action by the DEA, or action by a federal health care program. The member shall also promptly

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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 require 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 and clinical privileges.

### **8.4 INITIATION OF CORRECTIVE ACTION BY BOARD OF TRUSTEES**

With regard to the MEC taking or failing to take corrective action following a member's perceived significant infraction the Board of Trustees may concur, or if it reasonably determines the Medical Executive Committee's decision to be contrary to the weight of the evidence presented 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 Health System.

## **ARTICLE 9: HEARINGS AND APPELLATE REVIEWS**

### **9.1 GENERAL PROVISION HEARINGS AND APPELLATE REVIEWS**

#### **9.1-1 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 will facilitate peer review by the Medical Staff and Board of Trustees. Accordingly, discretion is granted to the Medical Staff 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.

#### **9.1-2 EXHAUSTION OF REMEDIES**

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

### **9.1-3 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. Any challenge to the merits, substantive validity or legality of a Bylaw, Rule and Regulation or policy must be addressed in accordance with the Bylaws. All actions concerning any Bylaw, Rule or policy must be approved in compliance with the requirements and processes specified in these Bylaws.

### **9.1-4 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.
- c. Medical disciplinary cause or reason (“MDCR”) means and refers to disciplinary action or recommendation based upon an aspect of a practitioner’s competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

### **9.1-5 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.

## **9.2 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, if taken for medical disciplinary cause or reason, shall be deemed grounds for a hearing:

- a. Denial of Medical Staff membership, reappointment and/or Clinical Privileges.

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- b. Revocation or termination of Medical Staff membership,
- c. Revocation or reduction of Clinical Privileges.
- d. Restriction on Medical Staff membership or Clinical Privileges (except for FPPE incidental to, new privileges, insufficient activity, or return from leave of absence) for cumulative total of thirty (30) days or more in a twelve (12) month period.
- e. Summary suspension of Medical Staff membership and or Clinical Privileges that remains in effect for more than fourteen (14) days.
- 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 pursuant to California Business and Professions Code Section 805.

### **9.3 REQUEST FOR HEARING**

#### **9.3-1 NOTICE OF ACTION OR PROPOSED ACTION**

In all cases in which action has been taken or a recommendation made as set forth in these Bylaws, 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,

#### **9.3-2 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 via written communication 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

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accepted the recommendation or action involved. Said action shall thereupon become the final action of the Medical Staff. The Board of Trustees shall approve the final action of the Medical Staff if it is supported by substantial evidence. 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 these Bylaws.

### 9.3-3 TIME AND PLACE FOR HEARING

On receipt of a request for hearing, the Chief of Staff shall schedule a hearing and, within thirty (30) 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 Hearing Officer or the mutual agreement of the Medical Staff and practitioner, the date of the commencement of the hearing shall be not less than thirty (30) days, or more than sixty (60) days from the date of receipt of the request by the Medical Executive Committee for a hearing. The hearing is deemed to commence upon the initial voir dire of the Hearing Officer or the Hearing Committee is conducted, whichever is earlier.

At the discretion of the Medical Executive Committee, all hearing sessions may be conducted by virtual videoconference platform instead of in person. In that circumstance, all hearing participants, including the parties and their legal counsel, if any, the Hearing Officer, the Judicial Review Committee members, the witnesses, and the court reporter, may attend the hearing sessions remotely, so long as all participants can see each other, can hear and be heard during the proceedings, and have access to all evidence admitted at the hearing, either by electronic means or hard copies.

### 9.3-4 NOTICE OF CHARGES

Together with the notice of hearing, the Medical Executive Committee shall state clearly and concisely via written communication 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.

### 9.3-5 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 Medical Staff and an alternate 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

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the recommendation or action. The alternate member of the Judicial Review Committee will not be informed of their role as an alternate. If, at the time of deliberations, all Judicial Review Committee members remain, the alternate member will be entitled to deliberate and vote. However, in the event of a tie, the alternate member's vote will not be counted. 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 Medical Staff, the Medical Executive Committee may appoint practitioners who are not members of the Medical Staff. If feasible, 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. For purposes of this, it shall not be deemed feasible and shall be deemed prohibitive if it would be necessary to pay a practitioner in order to have a Judicial Review Committee member in the same healing arts licensure and/or same specialty.

- b. A majority of the Judicial Review Committee must be present (which includes remote attendance if remote attendance is permitted in accordance with these Bylaws) 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.
- c. As an alternative to the Judicial Review Committee described in these Bylaws, 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.

### 9.3-6 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 Judicial Review Committee or the arbitrator, provided, however, if the failure to proceed is before a hearing panel has been approved, the hearing officer may order an expedited voir dire of the

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proposed judicial review committee and the member's failure to attend the voir dire without documented good cause for such failure to attend shall be deemed the member's waiver of the right to voir dire and acceptance of the proposed judicial review committee.

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.

### **9.3-7 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 their discretion, upon a showing of good cause.

### **9.3-8 ADVERSE ACTION BY THE BOARD OF TRUSTEES**

If the hearing is based upon an adverse action by the Board of Trustees, the Chair of the Board of Trustees 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

## **9.4 MEDICAL STAFF HEARING PROCEDURE**

### **9.4-1 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 via written communication 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.

### **9.4-2 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.

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- 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 or to refer a repeated failure to the Judicial Review Committee to determine if it constitutes a failure to proceed.
- 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

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least ten (10) days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

### 9.4-3 REPRESENTATION

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, or character. 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 not be deemed to deprive any party of its right to be represented by legal counsel for the purpose of preparing for the hearing. Notwithstanding the foregoing, the practitioner and Medical Executive Committee may agree that both parties may be represented at the hearing by an attorney at law.

### 9.4-4 THE HEARING OFFICER

The Medical Executive Committee 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 Health System 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, be a legal advisor to it and assist in drafting the written decision as decided by the Judicial Review Committee, but the Hearing Officer shall not be entitled to vote.

### 9.4-5 RECORD OF THE HEARING

A court 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

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cost of attendance of the court reporter shall be borne by the Health System, 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.

### **9.4-6 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: the Judicial Review Committee, the hearing officer, the court reporter, the member, a representative of the Medical Executive committee, one key consultant for each party Medical Staff Department Representative or designee. An individual who this Section permits to attend the entire hearing 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.

### **9.4-7 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 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.

### **9.4-8 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 request that a party 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.

### **9.4-9 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

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response.

- b. If the practitioner is an initial applicant for Medical Staff membership and/or privileges, the applicant shall bear the burden of persuading the Judicial Review Committee by a preponderance of the evidence of their 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 for membership and/or privileges, 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.

### **9.4-10 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.

### **9.4-11 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 9.5 hereof.

### **9.4-12 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

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written report and shall be delivered to the Medical Executive Committee. For purposes of this section, the hearing shall be finally adjourned upon the Judicial Review Committee's completion of its deliberations regarding its decision and written report. A copy of said decision shall also be forwarded by the Medical Executive Committee to the Chief Executive Officer, the Chief Medical Officer, 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.

### 9.5 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 these 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, or the Medical Executive Committee, (or the Board of Trustees, if applicable based upon the action of the Board of Trustees having recommended or imposed the adverse action), 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 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 an 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, provided that such deadline shall be extended for cause for the Hearing Officer record and/or transcripts to the extent they have not yet been provided by the Hearing Officer or received from the court reporter. 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

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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**

A written request for an appeal shall include an identification of the grounds for the appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing 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 Judicial Review Committee's findings did not support the Judicial Review Committee's decision;
4. 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
5. 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 these Bylaws and 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 these Bylaws and the Board of Trustees Bylaws.

**e. Appellate Review Procedure**

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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 these Bylaws and 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 their/its position on appeal and to personally appear and make oral argument, subject to such reasonable requirements as the Appeal Board may impose. 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.

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 written decision, consistent with the provisions of these Bylaws and 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 Health System. Any recommendation affirmed by the Board shall become effective immediately.

### **9.6      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 adverse action or recommendation.

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### **9.7 EXCEPTIONS TO HEARING RIGHTS**

#### **9.7-1 MEDICAL-ADMINISTRATIVE OFFICERS AND CONTRACT PHYSICIANS**

The hearing rights of Article 9 do not apply to the termination of contracts for practitioners who have contracted with the Health System to provide administrative or clinical services. Termination of contracts and/or termination of any privileges that are exclusively provided pursuant to exclusive contracts shall instead be governed by the terms of their individual contracts with the Health System. Notwithstanding the foregoing, the hearing rights of this Article 9 shall apply if an action is taken which must be reported pursuant to Business and Professions Code Section 805.

#### **9.7-2 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES**

Except as otherwise expressly stated in these Bylaws, any automatic action, including but not limited to an automatic suspension, termination, deemed resignation or limitation that is not reportable pursuant to Business and Professions Code to Section 805 does not invoke hearing rights as described in these Bylaws.

### **9.8 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. The foregoing process must be exhausted prior to filing a ~~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.

### **9.9 JOINT HEARINGS AND APPEALS FOR ALAMEDA HOSPITAL MEDICAL STAFF**

If this Medical Staff and a medical staff(s) of another facility that is affiliated with Alameda Health System each have made recommendations or taken actions that are grounds for a hearing, the Medical Executive Committee may approve conducting a joint hearing, provided that (i) the procedures to be followed are jointly approved by each medical staff's medical executive committee and determined by each medical executive

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committee to substantially comply with the intent of Section 8.3 and 8.4, and (ii) at least one member of the judicial review committee is a member of this Medical Staff. A joint appeals process may be approved by each medical staff's medical executive committee and the Board of Trustees, provided each medical executive committee has determined the procedure will substantially comply with Section 8.5. If within ten (10) days after notice of the proposed joint hearing or joint appeal, the affected member (a) submits to the Medical Executive Committee a written objection that demonstrates to the Medical Executive Committees hardship or unfairness that outweighs the efficiency or economy of having the joint hearing, the Medical Executive Committees may determine in their sole discretion to have separate hearings, or (b) submits to the Board of Trustees the hardship or unfairness that outweighs the efficiency or economy of a joint appeal, the Board of Trustees may determine, in its sole discretion, to have separate appeals. It shall not be deemed a hardship or unfair that the outcome affects privileges and/or membership on more than one medical staff.

### **9.10 ADVANCED PRACTICE PROVIDERS**

Advanced Practice Providers are not entitled to the hearing and appeal rights under these bylaws unless required by applicable State law. APP's who are not entitled to the hearing and appeal rights under these bylaws shall be subject to the review procedures as set forth in the applicable APP rules, policies, and procedures.

## **ARTICLE 10: OFFICERS**

### **10.1 OFFICERS OF THE MEDICAL STAFF**

#### **10.1-1 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. Only individuals meeting the qualifications and who are nominated and elected as expressly provided in these bylaws shall be the officers of the medical staff with all powers and duties vested herein. The right of the medical staff to select and remove medical staff officers is inviolate and shall not be interfered with or restricted in any manner.

#### **10.1-2 QUALIFICATIONS**

Officers must be members of the Active Medical Staff in good standing 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 Medical Staff activities. Officers must remain members of the Active Staff in good standing during their term of office and failure to maintain such status shall result in resignation from their office.

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### **10.1-3 NOMINATIONS**

- a. The Medical Staff election year shall be each even-numbered year for Officers and odd-numbered years for Medical Executive Committee At-Large positions. A Nominating Committee shall be appointed by the incumbent Chief of Staff no later than sixty (60) 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 of the active medical staff 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 that is subject to the forthcoming election. The nominations of the committee shall be reported to the Medical Executive Committee at least forty-five (45) 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 twenty (20) 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 via written communication 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..

### **10.1-4 ELECTIONS**

The Chief of Staff, 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, as determined by the Medical Executive Committee. 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.

### **10.1-5 TERMS OF ELECTED OFFICE**

All officers shall serve two (2) year terms, commencing on the first day of the Medical Staff year following their election. Each officer shall serve in each office until the end of their term, or until a successor is elected, unless he shall

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sooner resign or be recalled from office. At the end of their term, the Chief of Staff shall automatically assume the office of immediate Past-Chief of Staff, and the Vice Chief of Staff shall not automatically assume the office of Chief of Staff. In the event of a vacancy in the Chief of Staff or Vice Chief of Staff, the term of office is filled in accordance with these Bylaws and shall not bar the officer from serving the next full term in the same office.

Medical Executive Committee At-Large positions are a two (2) year term that is elected on odd years. If there is a vacancy in an At-Large position, Medical Executive Committee members may nominate for approval by the Medical Executive Committee an appointee who shall complete the remainder of the term until the next election year.

### **10.1-6 RECALL OF OFFICERS AND MEDICAL EXECUTIVE COMMITTEE AT-LARGE MEMBERS**

A Medical Staff Officers and Medical Executive Committee At-Large Committee members may be recalled from office during their 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 their office. Recall of a Medical Staff Officer or Medical Executive Committee At-Large Committee member may be initiated by either a two-thirds 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. Recall shall be considered at a special Medical staff meeting called for that purpose. Recall shall require a two-thirds (2/3) vote of the Medical Staff members eligible to vote for Medical Staff Officers who actually cast votes by ballot.

### **10.1-7 VACANCIES IN ELECTED OFFICE**

Vacancies in office occur on the death or disability, resignation, or recall of the officer, or such officer's loss of membership or Active Staff status on the Medical Staff. Vacancies for the Chief of Staff shall be filled by the immediate past Chief of Staff until an election can be held. For all other elected positions, Medical Executive Committee will appoint an interim to serve until the next regular election.

If there is a vacancy in the office of Chief of Staff, then the Vice Chief of Staff shall serve out that remaining term. Upon assuming the office of Chief of Staff, the COS shall immediately appoint an ad hoc nominating committee to decide promptly upon nominees for the office of Vice Chief of Staff and report the nominees to the Medical Executive committee at or prior to the next regularly scheduled meeting. The Medical Executive committee shall appoint an interim officer to fill this office until the next regular election. If the Vice Chief of Staff is unable to fill the Chief of Staff role, the Medical Executive Committee shall

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appoint an interim Chief of Staff from the available elected officers.

## 10.2 DUTIES OF OFFICERS

### 10.2-1 CHIEF OF 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 Chair of the Joint Conference Committee;
- e. serving as an ex-officio member of all other staff committees with vote;
- f. interacting with the Chief Executive Officer, Chief Medical Officer, Chief Administrative Officer and Board of Trustees in all matters of mutual concern within Alameda Hospital and the Health System;
- g. appointing, in consultation with or subject to ratification by 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;
- h. Consulting with the Board of Trustees periodically on matters related to the quality of medical care provided to patients of Alameda Hospital and the Health System, and representing the views and policies of the Medical Staff to the Chief Medical Officer, Chief Executive Officer, Chief Administrative Officer and Board of Trustees;
- i. being a spokesperson for the Medical Staff in external professional and public relations;
- j. performing such other functions as may be assigned to them by these Bylaws, the Medical Staff, or by the Medical Executive Committee; and
- k. serving on liaison committees with the Board of Trustees and

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Administration, as well as outside licensing or accreditation agencies;

- l. attend all Governing Body meetings, present medical staff quality data and other information of mutual concern, and offer consultation on the quality of patient care at the hospital at each meeting;
- m. provide continual consultation directly to the Governing Board as he/she determines warranted by the scope and complexity of hospital services and the specific patient populations served by the hospital;
- n. collaborate with Governing Board to discuss and resolve issues of patient safety and quality of care identified by the hospital's quality assessment and performance improvement program or the medical staff including at minimum:
  - (i) hospital-wide systemic deficiencies
  - (ii) system-wide opportunities for quality improvement
  - (iii) achievable goals for improved community health
- o. serve on the Quality Professional Services Committee or standing or ad hoc hospital committee or process not elected or established by the medical staff which purports to inform the Board or Hospital Administration on the quality of patient care and other medical staff issues;
- p. designate an appropriate Medical Staff representative to attend Governing Body meetings, serve on committees or other collaborative bodies, in their absence or as warranted to fulfill the medical staff's responsibility for quality patient care;
- q. report to the Medical Executive Committee all Governing Body consultations and communications;
- r. report to the Medical Staff regarding Governing Body consultations at Medical Staff meetings.

### 10.2-2 VICE CHIEF OF STAFF

The Vice Chief of Staff shall be a member of the Medical Executive Committee and Joint Conference Committee. The Vice Chief of Staff shall attend and represent, at the direction of and in the absence of the Chief of Staff, the views, and policies of the Medical Staff to the Board of Trustees at every Board of Trustees meetings 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. The Vice Chief of Staff shall assume duties of the Chief of staff if the Chief of Staff is not available.

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### **10.2-3 IMMEDIATE PAST CHIEF OF STAFF**

The Immediate Past Chief of Staff shall be a member of the Medical Executive Committee, Joint Conference Committee, Professional Standards Committee and will chair the Bylaws Committee and 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.

### **10.2-4 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.

### **10.3 COMPENSATION OF MEDICAL STAFF OFFICERS**

Medical staff officers should be granted adequate time and compensated for their work spent representing and leading the medical staff. Such compensation shall be equally shared and come from the medical staff's bank account, for which the medical staff has sole control and responsibility and administration, which could be used for clinical FTE back fill by contractual approval. The payment to individual physicians should be in the amount determined by the MEC. If the Health system provides any funds specifically earmarked for such compensation or for other specific purposes, those funds should be requested and accounted for in the Health Systems budget.

In instances where officers of the Medical Staff are on leave for greater than thirty (30) days and another officer assumes the duties as set forth under these Bylaws, the Medical Executive Committee shall determine which individual shall receive

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compensation for performing those duties.

## ARTICLE 11: CLINICAL DEPARTMENTS

### 11.1 ORGANIZATION OF CLINICAL DEPARTMENTS

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 these Bylaws. The Medical Executive Committee will periodically restudy the designation of the departments and what action is desirable in creating, eliminating, or combining departments or divisions for better organizational efficiency and improved patient care.

### 11.2 DEPARTMENTS

There are the following Departments, which are under the supervision of the Department Chair. These are dependent on the scope of services for the department as outlined in the clinical criteria in the policy on Medical Staff Department Structure and Division Leadership.

- a. Anesthesia
- b. Emergency Medicine
- c. Medicine/Critical Care
- d. Gynecology
- e. Orthopaedics
- f. Pathology
- g. Radiology/Imaging
- h. Surgery

### 11.3 ASSIGNMENT TO DEPARTMENTS

Each member shall be assigned primary membership in one department but may also be granted clinical privileges in other departments subject to the rules and regulations of that department under the authority of the Chair of the Department.

### 11.4 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

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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 Health System.
- 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

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staff administrative activities within the department;

1. 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;

### **11.5 CHAIR OF THE DEPARTMENT**

#### **11.5-1 QUALIFICATIONS**

Each department shall have a chair who at all times while holding office must be a member of the Active Medical Staff in good standing 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 shall be board certified by a specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association in at least one of the clinical areas covered by the Department.

#### **11.5-2 SELECTION OF DEPARTMENT CHAIR AND REAPPOINTMENT OF DEPARTMENT CHAIR**

The Medical Executive Committee (MEC), on the recommendation of the Chief of Staff, shall appoint Department Chairs and Vice Chairs.

If a situation should arise in which there is neither a Chair nor a Vice Chair of the Department, the MEC shall have authority to either appoint an Interim Chair or to specify an alternative method for the Department to select its Interim Chair.

#### **11.5-3 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 regarding 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.

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- d. Develop and implement departmental programs, policies and procedures 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 that guide and support the provision of care, treatment, and services.
- e. Be responsible for adequate clinical coverage within the department's scope of services.
- f. Be a member of the Medical Executive Committee, be responsible for clinically related activities of the department, give guidance on the overall medical policies of the Medical Staff and Health System and make specific recommendations and suggestions regarding their department.
- g. 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.
- h. Endeavor to enforce the Medical Staff Bylaws, Rules and Regulations, within the department.
- i. Implement within the department appropriate actions taken by the Medical Executive Committee.
- j. 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 the 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, special regulations, standing orders and techniques;
- k. Provide direct patient care at Alameda Hospital.
- l. Develop and implement department policies and procedures that guide and support the provision of care, treatment, and services in the department.
- m. provide orientation and continuing education of all persons in the department.
- n. Appointment to such committees as are necessary to conduct the functions of the department and designate a Chair for each, such committee may include

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members of another department if approved by such member's department Chair.

- o. Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff and the Medical Executive Committee.
- p. Identify a designee to fulfill these responsibilities when the Chair is unavailable.

### **11.5-4 RECALL OF DEPARTMENT CHAIR**

- a. After election and ratification, removal of department chairs and vice-chairs from office may occur for cause by a two-thirds vote of the medical executive committee and a two-thirds vote of the department members, with both of the forgoing to be by confidential ballot by members eligible to vote on officer who cast votes. Department Chairs shall be ineligible to vote as a result of their conflict of interest in the matter. For cause is defined in Bylaws Section 10.1-6.
- b. Recall of a Chair of a Department may be effectuated at any time by the Chief of Staff in consultation with the Medical Executive Committee. Grounds for recall 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.
- c. The Chair of a Department shall automatically be removed from office if the Chair ceases to be an Active Medical Staff member in good standing.
- d. Neither removal for cause as Chair, discontinue as Chair, nor automatic removal as Chair shall have any effect on the individual's clinical privileges or Medical Staff membership and the foregoing is not subject to hearing procedures described in Article 9 of these Bylaws.
- e. No contract or agreement shall supersede or contradict the provisions of these Bylaws regarding the Department Chair, including but not limited to the Chair's duties, selection, disqualification and/or removal as Chair.

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## ARTICLE 12: COMMITTEES

### 12.1 DESIGNATION

The committees described in this Article and the Rules and Regulations, and the policies of the Medical Staff 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 recalled by the Chief of Staff, subject to consultation with and approval or ratification by the Medical Executive Committee.

Medical Staff committees shall include, but not be limited to, the medical staff meeting as a committee of the whole, meetings of departments, meetings of committees established pursuant to the Bylaws, Rules and policies and meetings of special or ad hoc committees created pursuant to the Bylaws, Rules, and policies. The committees described in this article shall be the standing committees of the medical staff. Special or ad hoc committees may be created by the medical executive committee to perform specified tasks. The quality review activities by medical staff committees and their individual members do not by themselves create a physician-patient relationship.

### 12.2 GENERAL PROVISIONS

#### 12.2-1 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 recalled from the committee. There shall be no set term of appointment for members of the Physician Wellbeing Committee.

#### 12.2-2 CONFLICT OF INTEREST

If an officer or committee member has a professional interest in, or a professional, business, or personal relationship they are required to provide transparency and recuse oneself from participation, discussions, any decisions of any matter prior to action on the matter in which they have a conflict and leave the meeting for that portion of the discussion. However, that individual may be asked, and may answer, any questions concerning the matter before excusing themselves from the meeting. As a matter of procedure, the Committee Chair shall inquire, prior to any discussion of the matter, whether any member has any conflict of interest or bias. The Medical Executive Committee shall determine if a member with a conflict of interest shall be recused.

#### 12.2-3 RECALL

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 recalled by the Chief of Staff, subject to consultation

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with and approval or ratification by the Medical Executive Committee.

### **12.2-3 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 because these Bylaws state a person in a particular position is to chair or be a member of the committee is recalled for cause, a successor may be selected by the Medical Executive Committee.

## **12.3 MEDICAL EXECUTIVE COMMITTEE**

### **12.3-1 VOTING MEMBERS**

All active 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 on the Active Staff. The Medical Executive Committee shall consist of the following voting members:

- a. Officers of the Medical Staff (Chief of Staff, Vice Chief of Staff, Secretary Treasurer, Immediate Past Chief of Staff)
- b. Chairs of the Departments or Vice Chairs of the Departments (Anesthesia, Medicine/Critical Care, Gynecology, Orthopaedics, Pathology, Surgery, Emergency)
- c. Six (6) at-large members of the Active Medical Staff, 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. Board of Trustees Medical Staff Representative
- e. Credentials Committee Chair

### **12.3-2 NON-VOTING MEMBERS**

The Chief Medical Officer, Associate Chief Medical Officer, Chief Administrative Officer, Director of Nursing, and the Alameda-Contra Costa County Medical Association (ACCMA) designee shall be ex-officio members without vote.

Unless the Chief of Staff has invited other individuals to attend some or all of an Executive Session meeting. The Executive Session shall be limited to medical staff members and an individual designated to maintain the minutes only to preserve confidentiality of certain medical staff issues and to encourage full and frank discussion among committee members about sensitive issues, including

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matters directly impacting medical staff self-governance.

### **12.3-3 DUTIES**

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

- a. conveying to the Board of Trustees the views of the medical staff on issues, relating to safety and quality;
- b. 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;
- c. developing, coordinating, and implementing the professional and organizational activities and policies of the Medical Staff;
- d. receiving and acting upon reports and recommendations from Medical Staff departments, divisions, committees, and assigned activity groups;
- e. recommending action to the Board of Trustees on matters of medical- administrative nature;
- f. developing for adoption by the medical staff and adopting appropriate policies to enable clinical privileges holders to maintain the level of practice required under, and to more specifically implement, these Bylaws;
- g. establishing appropriate criteria for cross-specialty privileges in accordance with Section 5.2;
- h. making recommendations directly to the Board of Trustees on medical staff membership, the organized medical staff organization's structure, the process used to review credentials and delineate privileges, the delineation of privileges for each professional privileged through the medical staff process, and the medical executive committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups;
- i. evaluating the medical care rendered to patients in the hospital;
- h. participating in the development of all hospital policy, practice, and planning;
- i. reviewing the qualifications, credentials, performance and professional

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competence and character of applicants and Staff members and making recommendations to the Governing Body 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 maintenance of accreditation, which shall include providing recommendations to the hospital on the selection of the accreditation organization and structure of the survey process. The Board of Trustees shall give great weight to the recommendation of the medical executive committee;
- o. assisting in 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 Health System
- r. reviewing and approving the designation of the hospital's authorized representative for National Practitioner Data Bank purposes;
- s. reviewing the quality and appropriateness of patient care contracted services including clinical services provided by contracted physicians;
- t. fulfilling the Medical Staff organization's accountability to the Board of Trustees for the medical care rendered to patients of the hospital, including the organization of the quality assessment and performance

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improvement activities of the Medical Staff and the mechanism to conduct, evaluate and revise such activities;

- u. assuring that the care, treatment, and services provided to hospital patients meets a uniform standard of quality;
- v. affirmatively implementing, enforcing, and safeguarding the self-governance rights of the Medical Staff including but not limited to the following:
  - 1) Initiating, developing, and adopting Medical Staff Bylaws, Rules and Regulations, and amendments, thereto, subject to the approval of the Board of Trustees.
  - 2) Selecting and recalling Medical Staff Officers.
  - 3) Assessing Medical Staff dues and utilizing the Medical Staff dues as deemed appropriate by the Medical Staff for the purposes of the Medical Staff.
  - 4) The ability to retain and be represented by independent legal counsel at the expense of the Medical Staff.
  - 5) Establishing in Medical Staff Bylaws, Rules or Regulations or policies criteria and standards for Medical Staff membership and privileges, and for enforcing those criteria and standards and for enforcing those criteria and standards.
  - 6) Establishing in Medical Staff Bylaws, Rules or Regulations, clinical criteria, and standards to oversee and manage quality assurance, utilization review and other Medical Staff activities including but not limited to, periodic meetings of the Medical Staff and its committee and departments and review and analysis of the patient medical records.
- w. establishing, in Medical Staff Bylaws, Rules and Regulations or policies, criteria and standards for medical staff membership and privileges, and for enforcing those criteria and standards;
- x. determining the mechanism for establishing and maintaining patient care standards and credentialing and delineation of clinical privileges;
- y. assuring that Medical Staff members participate in organizational performance improvement activities;
- z. assuring accountability of the Medical Staff to the Board of Trustees for the quality of medical care, treatment, and services provided to the

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Health System's patients by credentialed providers;

- aa. 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.
- bb. Interpreting the Medical Staff's Bylaws, Rules and Regulations and policies if the application or implementation in a particular situation is disputed or there are requested for clarification; and.
- cc. Fulfilling such other duties as the Medical Staff has delegated to the Medical Executive Committee in these Bylaws.

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 11.3-3.

### **12.3-4 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 13.3.

### **12.3-5 RECALL 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 recalled 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 recalled from the Medical Executive Committee through the same mechanism as described in Section 9.1.6 related to the recall of officers.

## **12.4 BYLAWS COMMITTEE**

### **12.4-1 COMPOSITION**

The Bylaws Committee shall be composed of three (3) physicians and the Vice President of Physician Services as an ex-officio member without vote. The duties and responsibilities of the Bylaws Committee shall be to:

### **12.4-2 DUTIES**

- a. conduct a review of the Medical Staff Bylaws, and Rules and Regulations; and

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- b. submit recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect current Medical Staff practices.

### **12.4-3 MEETINGS**

The Bylaws Committee shall meet as often as necessary but at least annually and shall report to the Medical Executive Committee.

## **12.5 CREDENTIALS COMMITTEE**

### **12.5-1 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.

### **12.5-2 DUTIES**

The duties of the Credentials Committee shall be:

- a. review and evaluate the qualifications of each practitioner applying for initial appointment, renewal of appointment, or modification of clinical privileges, and, in connection therewith, obtain and consider the recommendations of the appropriate departments;
- b. review and evaluate selected applicants for reappointment as requested by the Chair of the Department or otherwise defined in Medical Staff policy and procedures;
- 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. receive and evaluate recommendations from the Committee on Interdisciplinary Practice (CIDP) on the scope of practice for Advanced Practice Providers;
- f. submit periodic reports to the Medical Executive Committee on its

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activities.

### **12.5-3 MEETINGS**

The Credentials Committee shall meet monthly, at least ten (10) times per year, or when convened by the Committee Chair, and shall maintain a record of its proceedings and actions and shall report to the Medical Executive Committee.

## **12.6 PROFESSIONAL STANDARDS COMMITTEE**

### **12.6-1 COMPOSITION**

Members of the Professional Standards Committee shall include the Immediate past Chief of Staff, and other medical staff members recommended by the Professional Standards Committee Chair and approved by the Medical Executive Committee. Other Medical Staff and APP members may be appointed to the Committee by the Chief of Staff on an "as needed" basis such that the exact membership of the Committee will vary depending on the issues being reviewed. The Chairperson of the Committee shall be appointed by the Chief of Staff.

### **12.6-2 DUTIES**

Duties of the Professional Standards Committee shall include the review of identified concerns related to a provider's behavior and compliance with expected standards of professionalism as defined in the Professional Conduct Standards and Professionalism Review Medical Staff Policies. The Committee shall also review issues related to recurrent non-compliance with Medical Staff Bylaws, policies, and applicable Health System policies. The Professional Standards Committee will oversee the performance of all focused professional practice evaluations (FPPEs) related to disruptive behavior and/or current rule violations. The Professional Standards Committee may from time-to-time appoint ad hoc committees that may include medical staff members who are not members of the Professional Standards Committee to perform initial fact gathering, with findings to be reported to the Professional Standards Committee. The existence of the Professional Standards Committee does not preclude referral of a behavior matter directly to the Medical Executive Committee for corrective action and/or to invoke summary action pursuant to Section 8.2.

### **12.6-3 MEETINGS**

The Professional Standards Committee shall meet when convened by the Committee Chair and shall maintain a record of its proceedings and actions and shall report to the Medical Executive Committee.

## **12.7 JOINT CONFERENCE COMMITTEE**

### **12.7-1 COMPOSITION**

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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, including -the Chief of Staff, Vice Chief of Staff, and Immediate Past Chief of Staff of the Medical Staff. The Chief Executive Officer / Administrator 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. An individual will be excluded from deliberation and voting if the individual has a conflict of interest. If a Medical Staff officer will be excluded from deliberation and voting based on a conflict, the Medical Executive Committee will appoint a substitute voting member for the issue.

### **12.7-2 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.

### **12.7-3 MEETINGS**

The Joint Conference Committee shall meet on the request of the Chief of Staff on behalf of the Medical Executive Committee and shall transmit written reports of its activities to the Medical Executive Committee to Health System Administration and to the Board of Trustees. The Joint Conference Committee will convene within one (1) month of the request to meet. Precautions shall be taken to assure that this Medical Staff (thorough its authorized representative(s) maintains access to and approval authority of all minutes and reports prepared in conjunction with any such meetings.

## **12.8 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 Hospital.

## **12.9 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):

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1. upon written petition signed by either:
  - i. at least 33% of the voting members of the Medical Staff, or
  - ii. upon the MEC's own initiative at any time; or
  - iii. 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 resolve Medical Staff matters or to give the Board the authority to unilaterally amend the Medical Staff Bylaws, Rules and Regulation or policies. This process shall not be used to review a peer review matter.

### **12.10 CREATION OF STANDING COMMITTEES**

The Medical Executive Committee of the Medical Staff may, without amendment of

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these Bylaws, establish a committee to perform one (1) or more staff functions. In the same manner the Medical Executive Committee may, by resolution, dissolve or rearrange committee duties or composition as needed, to better perform the Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to a standing or special committee shall be performed by the Medical Executive Committee.

### **ARTICLE 13: MEETINGS**

#### **13.1 GENERAL MEETINGS OF MEDICAL STAFF**

##### **13.1-1 ANNUAL MEETING OF THE MEDICAL STAFF**

There shall be an annual meeting of the Medical Staff. The Chief of Staff, and/or such other officers, department chairs or division chiefs, 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.

##### **13.1-2 REGULAR AND SPECIAL MEETINGS OF THE MEDICAL STAFF**

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 thirty (30) days prior to a regular meeting.

Special meetings of the Medical Staff may be called at any time by the Chief of Staff, the Medical Executive Committee, or by written request of 20% of the members of the Active Medical Staff. The person calling or requesting the special meeting shall state the purpose of such meeting via written communication. 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.

##### **13.1-3 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:

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- a. reading and acceptance of the minutes of the last special and all special meetings held since the last 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.

### **13.1-4 VOTING**

Unless otherwise specified in these bylaws, only members of the medical staff may vote in medical staff departmental or staff elections, and at department and medical staff meetings and all duly appointed members of medical staff committees are entitled to vote on committee matters, except as may otherwise be specified in these bylaws. Voting may be accomplished by email or other electronic and/or telephone means where permitted by the chair of the meeting on either an individual or group basis, so long as adequate precautions are in place to ensure authentication and security. Proxy voting is not permitted. A vote to abstain is counted toward establishing a quorum but is not considered vote that is cast.

## **13.2 MEDICAL STAFF COMMITTEE / DEPARTMENT MEETINGS**

### **13.2-1 SCHEDULE OF MEETINGS**

Except as otherwise specified in these Bylaws, the chair of committees 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.

### **13.2-2 SPECIAL MEETINGS OF COMMITTEES/DEPARTMENTS**

A special meeting of any Medical Staff committee may be called by the Chair, the Medical Executive Committee, the Chief of Staff, or by request of one-third of the current committee members eligible to vote, but not less than two (2) members.

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Special meetings may be conducted by telephone or other electronic conference. Good faith efforts must be made to give advance notice of special meetings to all members of the committee through an appropriate means.

### **13.3 QUOROM TO TAKE ACTIONS**

A quorum of no less than seven (7) of the voting members shall be required for the Medical Executive Committee meeting. When a quorum has been present at a meeting and voting members have withdrawn from the meeting so that less than a quorum remains, the voting members present may transact business until adjournment. For all other meetings, a quorum shall require the presence of at least three (3) voting members. A recused member shall not be counted in determining the quorum for a vote.

### **13.4 MANNER OF ACTION**

The hospital shall support electronic communication among medical staff leadership and members, who are obligated to supply and update contact information. A member may be present at a meeting by electronic or telephonic means where permitted by the chair of the meeting on either an individual or group basis. Committee action may be conducted by telephone conference or other electronic communication which shall be deemed to constitute a meeting for the matters discussed in that telephone or virtual conference.

### **13.5 MINUTES OF MEETINGS**

Except as otherwise specified herein, minutes of meetings and records of all votes conducted without meetings pursuant to Section 12.4, 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 kept on file with the Medical Staff.

### **13.6 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.

### **13.7 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, or if a member is a witness or participant in care or conduct that is being reviewed, the member may be requested to attend. If a suspected deviation from standard clinical practice or professional behavior is involved, or the member's attendance is required in order for the department, division, or committee to evaluate another member's care or conduct, the notice shall be given at least seven (7) days prior to the meeting and shall include the time

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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 the member 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). Failure to respond to questions at a meeting with respect to which the member was given such notice shall be deemed a failure to appear. Such failure to appear may also be grounds for corrective action.

### **13.8 EXECUTIVE SESSION**

Executive session is a meeting in which only voting Medical Staff members and an individual designated to maintain the minutes may attend, unless others are expressly requested by the member presiding at the meeting to attend. Executive session may be called by the presiding member or upon the request of any medical staff committee member and shall be called by the presiding member pursuant to a duly adopted motion. Executive session may be called to discuss peer review issues, professionalism and conduct, or any other sensitive issues requiring confidentiality. Only those entitled to attend an Executive Session may review minutes of an Executive Session.

## **ARTICLE 14: CONFIDENTIALITY, IMMUNITY AND RELEASES**

### **14.1 AUTHORIZATION AND CONDITIONS**

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

- a. authorizes representatives of the Hospital 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 Hospital 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 and/or clinical privileges, the continuation of such membership and clinical privileges, and to the exercise of clinical privileges at this Hospital.

### **14.2 CONFIDENTIALITY OF INFORMATION**

#### **14.2-1 GENERAL**

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Minutes, files, records and proceedings of all medical staff committee having the responsibility of evaluation and improvement of quality of care rendered in this Health System, including, but not limited to, meetings of the medical staff meeting as a committee of the whole, meetings of departments and divisions, meetings of committees established under the Medical Staff Bylaws, Rules and Regulations, and/or policies, meetings of special or ad hoc committees created in accordance with the foregoing, including but not limited to 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 Section 1157 and other applicable laws and regulations.

Dissemination of such information and records shall only be made where expressly required by law, to other peer review bodies for peer review purposes, 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.

### **14.2-2 BREACH OF CONFIDENTIALITY**

Inasmuch as effective peer review 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 as permitted by these Bylaws is outside appropriate standards of conduct for this Medical Staff, violates these bylaws, and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may take such action as it deems appropriate, including but not limited to recalling such individual from positions that provide access to confidential information, limiting the individual's responsibilities to not include access to confidential information, and/or undertaking such corrective action as it deems appropriate.

### **14.2-3 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.

## **14.3 IMMUNITY FROM LIABILITY**

### **14.3-1 FOR ACTION TAKEN**

The Medical Staff, health System and each representative of the Medical Staff and Hospital 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 their duties as a representative of the Medical Staff or Hospital.

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### **14.3-2 FOR PROVIDING INFORMATION**

The Medical Staff, Health System, and each representative of the Medical Staff and Hospital 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 Hospital, to another health care facility or organization, or to another AHS affiliated entity 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 Hospital.

### **14.4 ACTIVITIES AND INFORMATION COVERED**

The confidentiality 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 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 the Medical Staff Services office, and the Medical Staff's departments, divisions, committee's groups, or individuals as designated and charged in accordance with the Medical Staff Bylaws Rules and Regulations or policies.

### **14.5 RELEASES**

Each applicant or member shall, on request of the Medical Staff or Hospital, 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

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effectiveness of this Article.

### **14.6 INDEMNIFICATION**

- a. Subject to the conditions described below, the Health System shall indemnify, defend and hold harmless, the Medical Staff, members of the Medical Staff and persons acting as representatives or on behalf of the Medical Staff or participating in the processes set forth in the Medical Staff Bylaws, Rules and Regulations or policies (including but not limited to external peer reviewers, witnesses, hearing panel members, hearing officers, or hearing presenters, individuals or organizations that provide information or documents to the Medical Staff or its representatives for review to assist the Medical Staff fulfill its functions) from and against all losses and expenses incurred by reason of any action, suit, proceeding or investigation arising out of actions or activities undertaken to fulfill activities authorized the Medical Staff Bylaws, Rules and Regulations or policies including but not limited to the following:
  1. Attorneys' fees authorized via written communication by the Health System;
  2. Judgments, awards, settlements, and other costs authorized or agreed to by the Health System; and
  3. Reasonable compensation (not to exceed \$200 per hour) for lost income attributable to time spent at or in preparation for depositions or court appearances.
- b. Such defense and indemnification is expressly conditioned upon the following:
  1. the medical staff member shall provide notice to the Health System within fourteen (14) days of receipt of notice of any such suit, action, or proceeding investigation; and
  2. Health System, Medical Staff and individual medical staff members shall have authority to retain legal counsel for, to control litigation in and to settle such disputes.
- c. The medical staff or member may seek indemnification for such losses and expenses under this bylaws provision, statutory and case law, and available liability insurance or otherwise as the medical staff or member sees fit, and concurrently or in such sequence as the medical staff or member is not a condition precedent to the hospital's indemnification obligations hereunder.

## **ARTICLE 15: UNIFICATION / DISUNIFICATION**

### **15.1 UNIFICATION WITH OTHER MEDICAL STAFFS**

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**15.1-1** The Active Medical Staff can be included in a unified medical staff of any health system in which the hospital participates only after:

- a. Six months' prior written notice to all Medical Staff Members describing the proposed unification, setting forth its risks, benefits, and effects to the Medical Staff and its members;
- b. The Medical Executive Committee concurs based on favorable recommendations from two-thirds of all Departments reported to the Medical Executive Committee, following review and study; and
- c. At least two-thirds of Active Medical Staff Members with voting rights who hold clinical privileges to practice on-site at the hospital and have attended at least five (5) Medical Staff meetings of Medicine, Emergency Medicine, Surgery, or MEC at Alameda Hospital over the past rolling 12 months cast votes in favor of unification.

**15.1-2** The Medical Executive Committee shall determine whether the Medical Staff votes:

- i. at a special meeting called for that purpose, or
- ii. via confidential mail or electronic balloting.

### 15.2 DISUNIFICATION FROM OTHER MEDICAL STAFFS

**15.2-2** The Medical Staff shall disunify from any system-unified medical staff by vote to disunify if at least two-thirds of all Active Medical Staff Members with voting rights who hold clinical privileges to practice on-site at the hospital and have attended at least five (5) of Medicine, Emergency Medicine, Surgery or MEC Alameda Hospital Medical Staff meetings over the past rolling 12 months cast votes in favor of disunification. The Medical Staff shall be the unique Medical Staff of the Hospital effective immediately, operating under the Medical Staff Bylaws in effect immediately prior to unification. Special election shall be called to elect officers, department chairs and other medical staff leadership immediately consistent with the Medical Staff Bylaws in effect immediately prior to the unification.

**15.2-3** Notwithstanding provisions of the unified Medical Staff Bylaws, a vote to disunify shall require two-thirds of Active Medical Staff Members with voting rights who hold clinical privileges to practice on-site at the hospital have attended at least six (5) of Medicine, Emergency Medicine, Surgery or MEC Alameda Hospital Medical Staff meetings over the past rolling 12 months cast votes in favor of unification.

### 15.3 UNIFICATION / DISUNIFICATION EFFECT ON BYLAWS

- a. A vote by the Active Medical Staff to accept a unified medical staff shall have no immediate effect on the application of the Medical Staff Bylaws, which shall continue to govern this Medical Staff and be upheld by the Governing Body. Peer

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review and other activities of the Medical Staff and its Members shall continue to be governed by California law by which the Hospital is licensed.

- b. Upon disunification, the Medical Staff Bylaws in effect the date of unification shall return to full force and effect.

## **ARTICLE 16: GENERAL PROVISIONS**

### **16.1 AMENDMENT OF THE MEDICAL STAFF RULES AND REGULATIONS AND MEDICAL STAFF POLICIES AND PROCEDURES**

#### **16.1-1 Rules and Regulations**

- a. The Rules and Regulations of the Medical Staff shall be amended on a periodic basis to facilitate the efficient and effective operation of the Medical Staff and to implement these Bylaws as may be necessary. The Medical Staff delegates to the MEC the authority to adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws.
- b. The Medical Staff Rules and Regulations may be amended by:
  - (1) Majority vote of the MEC at a meeting at which there is a quorum, after having given at least thirty (30) days' notice of the proposed amendment to the Medical Staff; or
  - (2) Any member of the Medical Staff supported by a petition signed by at least twenty (20) percent of the members of the Medical Staff entitled to vote requesting such change(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. If the MEC does not approve the amendment as proposed, the process described in Section 16 for Bylaw changes shall be followed including but not limited to the conflict management process.
- c. **Urgent Amendment**  
The MEC may provisionally adopt and submit to the Governing Board for provisional approval such amendments to the Rules and Regulations as may be necessary to comply with law or regulation. The provisional amendment shall be effective immediately upon provisional approval by the Board. The Medical Staff shall be given immediate notice of such provisional amendment and shall have the opportunity for retrospective review and comment on the provisional amendment. All comments from the Medical Staff shall be submitted to the MEC within thirty (30) days of issuance of the notice. If there is no opposition to the provisional amendment, the MEC shall notify the Governing Board and the provisional approval shall be final. If there is opposition or other conflict

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regarding the provisional amendment, the conflict resolution process shall be invoked, and a revised amendment may be submitted to the Governing Board for approval.

d. **Board Approval of Rules and Regulations**

Following the Medical Staff's approval in accordance with the processes described Sections 15.1-1 a, b and c, the Rules and Regulations shall be effective upon approval of the Board of Trustees. The Board of Trustees' approval shall not be withheld unreasonably. Such approval automatically shall be effective after thirty (30) days if no action is taken by the Board of Trustees. In the latter event, the Board of Trustees shall be deemed to have approved the Rules and Regulations adopted by the Medical Staff. Medical Staff Rules and Regulations shall be reviewed (and may be revised if necessary) every two (2) years. Except for technical amendments as described in Section 16.4, neither the Board of Trustees nor the Medical Staff shall have authority to amend the Medical Staff Rules and Regulations unilaterally.

### **16.1-2 Medical Staff Policies and Procedures**

- a. Medical Staff policies are intended as a resource to assist staff and practitioners in carrying out specific actions/activities. The included procedural steps do not specify all circumstances.
- b. The MEC may approve Medical Staff policies and Health System policies, which must be consistent with the Medical Staff Bylaws and Medical Staff Rules. If the Medical Staff wishes to propose a policy or amendment to a policy, it may submit a petition following the procedures described in Section 15.1-1. b. (2) above and the processes described in Section 15.1-1.b. (2) shall be followed.

c. **Board Approval of Policies**

Following the Medical Staff's approval in accordance with the processes described in this Section 15.1-2; the policy shall be effective upon approval of the Board of Trustees. The Board of Trustees' approval shall not be withheld unreasonably. Such approval automatically shall be effective after thirty (30) days if no action is taken by the Board of Trustees. In the latter event, the Board of Trustees shall be deemed to have approved the policy adopted by the Medical Staff. Except for Technical amendments as described in Section 17.4, neither the Board of Trustees nor the Medical Staff shall have authority to amend the Medical Staff policies unilaterally.

### **16.2 DUES OR ASSESSMENTS**

The Medical Executive Committee shall have the power to determine the amount of dues, assessments, or fines, if any, and to determine the manner of expenditure of such

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funds received.

Medical Staff funds, including but not limited to all dues, fees, and assessments shall be under the sole control of the Medical Staff. The Medical Staff may retain an accountant or other third-party adviser to assist with the management and oversight of the Medical Staff's funds.

### **16.3 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 all genders, regardless of what term may be used.

### **16.4 AUTHORITY TO ACT AND DELEGATION**

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.

The authority and responsibilities vested in any officer, member, or committee of the Medical Staff in these bylaws shall not be delegated to, or otherwise exercised by, any member of the Administrative Staff or any person or entity outside of the Medical Staff, unless the Medical Executive Committee, an officer or chair of the such committee explicitly authorizes such delegation or exercise of authority.

### **16.5 DIVISION OF PROFESSIONAL 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.

### **16.6 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 via written communication properly sealed, and may be sent through United States Postal Service, first class postage prepaid, by private courier service, hand delivery, facsimile, or email. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained. If "mail" is required to be sent by certified mail or registered mail, return receipt requested, it includes U.S. Certified Mail return receipt requested, U.S. Registered mail, return receipt requested, hand delivery with delivery receipt or private courier service with delivery receipt, and includes documented receipt by the addressee's office staff. Documented refusal to accept mail by the addressee or addressee's office staff is considered delivery and receipt.

Notice to the Medical Staff or to officers or committees thereof, shall be addressed as follows:

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

Chief of Staff,  
c/o Medical Staff Services Department  
Alameda Hospital  
2070 Clinton Avenue  
Alameda, CA 94501

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 Hospital.

### **16.7 DISCLOSURE OF INTEREST AND CONFLICT OF INTEREST RESOLUTION**

For the purposes of these Bylaws, conflict of interest means a personal or financial interest or conflicting fiduciary obligation that makes it impossible or not feasible as a practical matter, for the individual to act in the best interests of the medical staff without regard to the individual's private or personal interest. By way of example and not limitation, if a person has a direct personal or financial interest in a motion under consideration not common to other members, the person has a conflict of interest. Such conflict of interest may also be held by an immediate family member of that individual, including that individual's spouse, domestic partner, child, or parent.

The disclosure of an interest, as set forth in these bylaws, does not automatically mean that an actual conflict of interest exists. Whether a disclosed interest constitutes a conflict is determined as set forth below.

#### **16.7-1 CONFLICT RESOLUTION**

1. Not all disclosures of a potential conflict of interest require the member's abstention or recusal; however, a member may abstain from voting on any issue. A member shall recuse if the member reasonably believes that the member's ability to render a fair and independent decision is or may be affected by a conflict of interest. A recused member shall not be counted in determining the quorum for that vote but may answer questions or otherwise provide information about the matter after disclosing the conflict. A recused member must not be present for the remainder of the deliberations or the vote.
2. If a member has not voluntarily recused and a majority of voting members of the committee or in the staff meeting vote that the member should be excused from discussion or voting due to conflict of interest, the chair shall excuse the member.
3. If a member discloses a potential conflict of interest and requests a vote regarding excusing that member, the member shall leave the room while the issue is being deliberated and voted upon.

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4. The minutes of the meeting shall include the names of those who disclosed potential conflicts and those who abstained and/or recused themselves.

### **16.7-2 CORRECTIVE ACTION**

Medical Staff members who fail to comply with all provisions of these Bylaws concerning actual or potential conflicts of interest shall be subject to corrective action under these Bylaws, including but not limited to recall from the Medical Staff position. Recall based upon a failure to comply shall not be grounds for the procedures in Article 9 unless the Medical Executive Committee would determine the action is for medical disciplinary cause or reason.

### **16.8 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 Executive Committee may determine. A nominating committee appointed by the Medical Executive Committee shall make nominations for such positions.

### **16.9 CONFIDENTIALITY OF THE CREDENTIAL FILE**

The following applies to actions relating to requests for insertion of adverse information into the medical staff member's credentials file:

- a. Any person may provide information to the medical staff about the conduct, performance, or competence of its members, APP's or those who have been granted clinical privileges.
- b. When a request is made for insertion of adverse information into the Medical Staff member's credentials file other than in accordance with the routine processes of the Medical Staff, the respective department chair and Chief of Staff shall review such a request.
- c. After such a review, a recommendation will be made by the respective department chair and Chief of Staff to the Medical Executive Committee:
  1. Not insert the information
  2. Notify the member of the adverse information by a written summary and offer the opportunity to rebut this assertion before it is entered into the member's file *or*
  3. Insert the information along with a notation that the information will be reviewed in accordance with the policies and procedures of the Medical Staff,

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which may include but not be limited to a request made to the Medical Executive Committee for an investigation as outlined in Section 7.1-2 of these bylaws

- d. The Medical Executive Committee may either ratify or initiate contrary actions to this recommendation by a majority vote.

### **16.10 RETALIATION PROHIBITED**

- a. Neither the Medical Staff, its members, committees or department chairs, the Board of Trustees, the Chief Executive Officer, or any other employee, director or agent of the Hospital or Health System, may engage in any punitive or retaliatory action against any member of the Medical Staff because that member claims a right or privilege afforded by, or seeks implementation of any provision of, these Medical Staff Bylaws.
- b. The Medical Staff recognizes and embraces that it is the public policy of the State of California that a practitioner be encouraged to advocate for medically appropriate health care for their patients. To advocate for medically appropriate health care includes, but is not limited to, the ability of a physician to protest a decision, policy, or practice that the physician, consistent with that degree of learning and skill ordinarily possessed by reputable physicians practicing according to the applicable legal standard of care, reasonably believes impairs the physician's ability to provide medically appropriate health care to their patients. Subject to Section 15.10 c, no person, including but not limited to the medical staff, the Board of Trustees, the Hospital, its employees, agents, or directors, shall retaliate against or penalize any member for such advocacy or prohibit, restrict or in any way discourage such advocacy, nor shall any person prohibit, restrict, or in any way discourage a member from communicating to a patient information in furtherance of medically appropriate health care.
- c. This Section 15.9 is not to protect individuals who exercise the foregoing rights in an unprofessional, inappropriate, abusive, or disruptive manner, as may be defined or demonstrated by example in a Medical Staff policy or to protect those who violate the Medical Staff Bylaws, Rules, or policies in their method of exercising such rights.

This section does not preclude corrective and/or disciplinary action as authorized by these Medical Staff Bylaws.

### **16.11 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING**

The Medical Executive Committee shall have the 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:

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- 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.

### **16.12 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. Upon the authorization of the medical executive committee or the Chief of Staff or designee acting on its behalf, the medical staff may retain and be represented by independent legal counsel who, to the extent practicable, shall not be employed by a law firm representing the Health System. The medical staff shall enter into a written engagement letter with the firm selected to be independent legal counsel affirming that the medical staff, not the Health System, is the counsel's client, that the counsel represents solely the interests of the medical staff, and that the attorney-client privilege of confidentiality applicable to all communications between the counsel and the medical staff or a third party regardless of who pays the counsel's fees. In the event the counsel is paid for by a third party, the counsel shall also provide a written assurance to the medical staff that there will be no interference by the third party with the counsel's independence of professional judgment or with the attorney-client relationship, as required by State Bar of California Rules of Professional Conduct.

## **ARTICLE 17: ADOPTION AND AMENDMENT OF BYLAWS**

### **17.1 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 twenty (20%) percent of the Active 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.

#### **17.1.1 BYLAWS CHANGES**

Amendment of the Medical Staff Bylaws may take place at a regular meeting, special meeting, or annual meeting of the Medical Staff, or by mail, email, or other electronic means. Bylaws changes require an affirmative vote of majority of the Active Medical Staff to take effect. Proxy voting is not permitted.

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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 of Trustees 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 twenty (20) percent 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 of Trustees 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 via written communication, 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, with

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a copy of the MEC's explanation of why it opposes the amendment. The proposed Bylaws amendment(s) will be submitted to the Board of Trustees 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 of Trustees 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 of Trustees approval, which shall not be withheld unreasonably. Such approval automatically shall be effective after forty-five (45) days if no action is taken by the Board of Trustees. In the latter event, the Board of Trustees shall be deemed to have approved the Bylaws adopted by the Medical Staff. Neither the Board of Trustees nor the Medical Staff shall have authority to amend the Medical Staff Bylaws unilaterally.
- g. If the Board of Trustees does not approve the proposed Bylaws amendment(s), then the matter will be referred to the Joint Conference Committee set forth in Section 11.5-1 of these Bylaws for management of conflicts between the Board and the Medical Staff.

### **17.2 EXCLUSIVITY**

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

### **17.3 REVIEW**

These Bylaws shall be reviewed at least biannually, and revisions made according to the described amendment procedure.

### **17.4 TECHNICAL REVISIONS**

The Medical Executive Committee shall have the authority to adopt non-substantive changes to the Medical Staff 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 to the Board of Trustees. 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

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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).

### **17.5 EFFECT OF THE BYLAWS**

These Bylaws do not constitute a contract, but do establish a system of rights, responsibilities and accountability between the Hospital, the Medical Staff, and its members.

- a. Except as specified in Section 16.4 for technical non substantive changes, these Bylaws may not be unilaterally amended or repealed by the medical staff or board of trustees.
- b. No medical staff governing document and no Health System corporate bylaws or other Health System governing document shall include any provision purporting to allow unilateral amendment of the medical staff bylaws or other medical staff governing document.
- c. Health System bylaws, policy, rules, or other Health System requirements that conflict with Medical Staff Bylaw provisions, Rules, Regulations and/or Policies and Procedures, shall not be given effect and shall not be applied to the Medical Staff or its individual members. In order to be binding on the Medical Staff and Medical Staff members, Health System bylaws, policies, rules, regulations and/or policies and procedures must be approved by the Medical Executive Committee.

### **17.6 NOTICE OF AMENDMENTS TO BYLAWS, RULES AND REGULATIONS AND POLICIES**

Members shall be notified upon the adoption, amendment or other change in the Medical Staff Bylaws, Rules and Regulations or Policies. The Medical Executive Committee shall determine the manner to notify members of such adoption, amendment, or other change.

### **17.7 SUCCESSOR IN INTEREST/AFFILIATIONS**

#### **17.7-1 SUCCESSOR IN INTEREST**

These Bylaws, and privileges of individual members of the Medical Staff accorded under these Bylaws, will be binding upon the Medical Staff, and the Board of Trustees or any successor in interest in this Hospital, except where Hospital Medical Staffs are being combined. In the event that the Medical Staffs are being combined, the Medical Staffs shall work together to develop new Bylaws which will govern the combined Medical Staffs, subject to the approval of the Board of Trustees or its successor in interest. Until such time as the new Bylaws are approved, the existing Bylaws of each institution will remain in effect.

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### **17.7-2 AFFILIATIONS**

Affiliations between the Hospital and the other hospitals, health care systems or other entities shall not, in and of themselves, affect these Bylaws.

ADOPTED by the Medical Staff on

APPROVED by the Board of Trustees on

Date: August 15, 2024

Date: September 18, 2024