



MEDICAL STAFF BYLAWS

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DEFINITIONS

1. **AUTHORIZED REPRESENTATIVE** means the individual designated by the Chief of Staff and approved by the Medical Staff Executive Committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these bylaws.
2. **CHIEF OF STAFF** means the chief officer of the Medical Staff elected by members of the Medical Staff.
3. **CLINICAL PRIVILEGES** or **PRIVILEGES** means the permission granted to a Medical Staff member to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services.
4. **CONTRACTED PRACTITIONER** means a Medical Staff member who is engaged as an independent contractor to perform certain administrative functions (e.g. as a medical director) beyond the professional services otherwise provided by the member.
5. **BOARD OF DIRECTORS** means the Board of Directors responsible for El Camino Hospital.
6. **HOSPITAL** means El Camino Hospital and includes the Mountain View and Los Gatos campuses. The term “Enterprise” refers to both campuses.
7. **MEDICAL STAFF** or **ORGANIZED MEDICAL STAFF (OMS)** means the formal organization of all licensed physicians, dentists, and podiatrists who are privileged to attend patients in the Hospital.
8. **MEDICAL STAFF YEAR** means the period from July 1 to June 30.
9. **EX-OFFICIO** means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.
10. **PHYSICIAN** means an individual with a M.D. or D.O. degree who is licensed to practice medicine.
11. **PRACTITIONER** means, unless otherwise expressly limited, any physician, dentist, or podiatrist who is applying for Medical Staff membership and/or clinical privileges, or who is a Medical Staff member and/or who exercises clinical privileges in this Hospital.
12. **PREROGATIVE** means a participatory right granted, by virtue of staff category or otherwise, to a Medical Staff member, which is exercisable subject to, and in accordance with, the conditions imposed by these Bylaws and by other Hospital and Medical Staff rules and regulations.
13. **ADMINISTRATOR/CHIEF EXECUTIVE OFFICER (CEO)** means the person appointed by the Board of Directors to act on its behalf in the overall management of the Hospital, or his/her designee.
14. **INVESTIGATION** means a process specifically instigated by the Medical Staff Executive Committee to determine the validity, if any, of a concern or complaint regarding a Medical Staff member. It does not include any activity of the Physician Health & Well-Being Committee or of any other Medical Staff committee unless such other committee is directed to conduct the investigation by the Medical Staff Executive Committee.
15. **IN GOOD STANDING** means a member is currently not under suspension or serving with any limitation of voting or other privileges or prerogatives imposed by operation of the bylaws, rules and

regulations or policy of the Medical Staff.

**ARTICLE 1
NAME**

The name of this organization is the Medical Staff of El Camino Hospital.

**ARTICLE 2
PURPOSES**

2.1 ORGANIZATION

The Medical Staff organization is composed of doctors of medicine and osteopathy. The Medical Staff organization also includes dentists and podiatrists and non-physician practitioners who are determined to be eligible for appointment set forth in these Bylaws.

The Medical Staff organization is structured as follows: The members of the Medical Staff are assigned to a Staff category depending upon nature and tenure of practice at the hospital. All new members are assigned to the Provisional Staff. Upon satisfactory completion of the provisional period, the members are assigned to one of the Staff categories described in Bylaws, Article 4, Categories of the Medical Staff.

Members are also assigned to departments, depending upon their specialties, as noted in Article 9. Each department is organized to perform certain functions on behalf of the department, such as credentials review and peer review.

There are medical staff committees which perform staff-wide responsibilities and which oversee related activities being performed by the departments.

Overseeing all of this is the Medical Executive Committee, comprised of the elected officials of the Medical Staff, Hospital-based Division Chiefs, and others as noted in the Medical Staff Executive Committee composition, Article 11.5.

2.2 PURPOSES OF THIS ORGANIZATION

The purpose of this organization shall be to assure excellence in the quality of care delivered to patients at El Camino Hospital, to be an advocate for patients' health care needs and their rights, and to govern the activities of the Medical Staff.

Through its governance structure, the Medical Staff Organization will:

- (a) Assure that physician clinical activities strive for high professional standards, are efficient, effective and ethical.
- (b) Assure that practitioners have and maintain competencies for their clinical activities.
- (c) Assure that opportunities for providing care are fair and accessible to all qualified members.
- (d) Promote clinical quality improvement and the environment of a learning organization through Continuing Medical Education and communication.
- (e) Emphasize caring and compassion towards patients.

2.3 PURPOSES OF THESE BYLAWS

These Bylaws are adopted in order to provide for the organization of the Medical Staff of El Camino Hospital and to provide a framework for self-governance in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. These bylaws provide the professional and legal structure for Medical Staff operations, Organized Medical Staff

relations with the Board of Directors, and relations with applicants to and members of the Medical Staff.

Subject to the authority and approval of the Board of Directors, the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws and associated Rules and Regulations, Policies/Procedures, and under the corporate Bylaws of El Camino Hospital in compliance with law and regulation.

Providing quality medical care in the hospital depends on the mutual accountability, interdependence, and responsibility of the Medical Staff and El Camino Hospital for the proper performance of their respective obligations. The Medical Staff's right of self-governance shall include, but not be limited to, establishment of these bylaws. The El Camino Hospital Board has a duty to act on behalf of the Medical Staff to protect patients in the event the Medical Staff fails in any of its important duties or responsibilities. El Camino Hospital shall not act in the stead of the Medical Staff precipitously, unreasonably or in bad faith.

ARTICLE 3 MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

Membership in the Medical Staff and/or clinical privileges shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to and membership in the Medical Staff shall confer on the member only such clinical privileges and prerogatives as have been granted by the Board of Directors in accordance with these Bylaws. Except as otherwise specified herein, no practitioner shall admit or provide services to patients in the Hospital unless he/she is a member of the Medical Staff or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws.

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2-1 GENERAL QUALIFICATIONS

In order to receive an application for appointment to the medical staff or clinical privileges, applicants must first complete a pre-application questionnaire and meet the following general qualifications:

- (a) Be a graduate from a school of medicine, osteopathy, dentistry or podiatry recognized or approved by the Medical Board of California.
- (b) Hold Education Commission of Foreign Medical Graduate (ECFMG) certification; if applicable.
- (c) Demonstrate completion of residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME), Royal College of Physicians and Surgeons of Canada, or American Osteopathic Association.
 - 1. Podiatrists must have successfully completed a two (2) or three (3) year residency program in podiatric medicine and surgery approved by Council on Podiatric Medical Education of the American Podiatric Medical Association.
 - 2. Dentists must have successfully completed a post graduate program in hospital dentistry approved by American Dental Association and accredited by the Commission on Dental Accreditation.
 - 3. Oral Maxillofacial Surgeons must have successfully completed a post-graduate program in oral and maxillofacial surgery approved by the American Board of Oral and Maxillofacial Surgery.
- (d) Have active board certification in his/her primary specialty (or if recently completed residency/fellowship, will become board certified within five (5) years of completion of residency/fellowship). Boards accepted include the following (or verifiable equivalent*):
 - 1. American Board of Medical Specialties or American Board of Osteopathic Specialties
 - 2. American Board of Foot and Ankle Surgery for DPMs or American Board of Podiatric Medicine
 - 3. American Board of Oral & Maxillofacial Surgery for Oral Maxillofacial Surgeons

4. American Board of General Dentistry or American Board of Pediatric Dentistry

*Verifiable Equivalency: Equivalency shall include, but not be limited to board certification from another certifying body, as evaluated and determined by the Department Chief and presented in writing, for consideration by the Credentials Committee for recommendation to the MEC and Governing Board.

- (e) Have a current and active license to practice medicine in the state of California.
- (f) Have a current DEA certificate or furnishing number to prescribe controlled substances as applicable.
- (g) Provide documented practice of clinical medicine within the past 24 months.
- (h) During the past seven (7) years, the practitioner **may not**:
 - 1. Have had medical staff membership or any clinical privileges denied or terminated by the medical staff of another hospital, ambulatory surgery center (ASC), or healthcare facility;
 - 2. Have had adverse action taken by any state licensing board (for example the Medical Board of California) to include letters of reprimand, probation or any more significant adverse action;
 - 3. Been convicted of a felony or misdemeanor (other than a minor traffic violation); or taken a plea in exchange for not taking a felony conviction;
 - 4. Been sanctioned by Medicare/Medicaid or placed on the Office of Inspector General's (OIG) list of excluded individuals/entities.
- (i) Once the applicant qualifies as noted above and an application has been received, additional qualifications to meet include:
 - 1. Documentation of adequate experience, education, and training, current professional competence, good judgment, and current adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent to fulfill the responsibilities of the Medical Staff membership and/or specific privileges requested and that patients treated by them can reasonably expect to receive quality medical care.
 - 2. Applicant agrees to:
 - 1. adhere to the ethics of their respective profession;
 - 2. work cooperatively with others so as not to adversely affect patient care;
 - 3. keep as confidential, as required by law, all information or records received in the physician-patient relationship;
 - 4. participate in and properly discharge those responsibilities determined by the Medical Staff; and
 - 5. maintain in force professional liability insurance covering the exercise of all requested privileges, in not less than one million per occurrence and three million annual aggregate or such other amount as may be determined and approved by the Board of Directors and

Medical Staff Executive Committee from time to time.

3.2-2 PARTICULAR QUALIFICATIONS

- (a) Physicians. An applicant for physician membership in the Medical Staff must hold a M.D. or D.O. degree issued by a medical or osteopathic school and a valid, unrevoked, and unsuspended certificate to practice medicine issued to him/her by the Medical Board of California or the California Board of Osteopathic Examiners. An applicant for physician membership must be board certified in his/her primary specialty within five (5) years of completion of residency/fellowship. Board certification must be maintained in the physician's primary specialty in order for the physician to be qualified for continued medical staff membership (a two year grace period will be granted if needed, for practitioners to obtain recertification). Physicians who are current medical staff members and held clinical privileges prior to July 14, 2010 (BOD approval date) are exempt but encouraged to obtain and maintain board certification.
- (b) Dentists. An applicant for dental membership in the Medical Staff must hold a D.D.S. or equivalent degree issued by a dental school and a valid, unrevoked, and unsuspended certificate to practice dentistry issued to him/her by the California Board of Dental Examiners.
- (c) Podiatrists. An applicant for podiatric membership on the Medical Staff must hold a D.P.M. degree and a valid, unrevoked, and unsuspended certificate to practice podiatry issued to him/her by the Medical Board of California. An applicant for podiatry membership must be board certified in podiatry within five (5) years of completion of residency/fellowship. Board certification must be maintained in order for the podiatrist to be qualified for continued medical staff membership (a two year grace period will be granted if needed, for practitioners to obtain recertification). Podiatrists who are current medical staff members and held clinical privileges prior to July 14, 2010 (BOD approval date) are exempt but encouraged to obtain and maintain board certification.

3.2-3 EXCEPTIONS FOR BOARD CERTIFICATION OF INITIAL APPLICANTS:

Board certification may become a compounded matter due to the number of multiple boards and specialties, certificates of added qualifications and maintenance of board certification requirements. The Medical Staff Executive Committee recognizes that situations may arise when meeting board deadlines is not easy to fulfill and therefore will consider the following:

- (a) Initial applicants who were previously board certified whose board certification has lapsed may be allowed two (2) years to regain board certification as long as the certifying body allows for board eligibility.
- (b) Exceptions to the requirement for board certification must be substantiated by appropriate medical education and training, extraordinary experience and reputation, and additional evidence of current competency that is endorsed by the Department Chief and presented, in writing, for consideration through the Credentials Committee for recommendation to the MEC and Governing Board.

3.2-4 WAIVER OF MINIMUM QUALIFICATIONS

Insofar as is consistent with applicable laws, the Board of Directors has the discretion to deem an applicant to have satisfied a qualification, upon recommendation of the Medical Staff Executive Committee, if it determines that the applicant has demonstrated he or she has substantially comparable qualifications and that this waiver is necessary to serve the best interests of the patients and of El Camino Hospital. There is no obligation to grant any such

waiver and applicants have no right to have a waiver considered and/or granted. An applicant who is denied waiver or consideration of a waiver shall not be entitled to any procedural hearing and appellate review rights provided for in the Fair Hearing Plan in these Bylaws.

3.3 EFFECT OF OTHER AFFILIATIONS

No practitioner shall be automatically entitled to Medical Staff membership, or to exercise any particular clinical privileges, merely because he/she holds a certain degree, is licensed to practice in California or any other state, is a member of any professional organization, is certified by any clinical board, or had, or presently has, Staff membership or privileges at this Hospital or at another health care facility. Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this hospital.

3.4 NONDISCRIMINATION

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

3.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

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

- (a) providing patients with the quality of care meeting the professional standards of the Medical Staff of this hospital;
- (b) complying with the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Policies, and engaging in performance improvement activities.
- (c) discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments;
- (d) preparing and completing in timely fashion medical records for all the patients to whom the member provides care in the hospital;
- (e) abiding by the lawful ethical principles of the California Medical Association and the member's specialty board, if any; aiding in any Medical Staff, department, or division approved educational programs for medical students, interns, resident physicians, resident dentists, staff physicians and dentists, nurses and other personnel;
- (f) working cooperatively with members, nurses, hospital administration and others so as not to adversely affect patient care;
- (g) making appropriate arrangements for coverage of that member's patients as determined by the Medical Staff;
- (h) refusing to engage in improper inducements for patient referral;
- (i) participating in continuing education programs as determined by the Medical Staff;
- (j) participating in such emergency service coverage or consultation panels as may be determined by the Medical Staff;
- (k) discharging such other staff obligations as may be lawfully established from time to

- time by the Medical Staff or Medical Staff Executive Committee; and
- (l) providing information to the Medical Staff or an accused practitioner regarding any matter under an investigation pursuant to paragraph 7.1-3, and
- (m) those which are the subject of a hearing pursuant to Article 8.

3.6 DURATION OF APPOINTMENT

Except as otherwise provided in these bylaws; initial appointments and reappointments to the Medical Staff shall be for a period up to two (2) years.

3.7. HARASSMENT/DISRUPTIVE/INTIMIDATING BEHAVIOR PROHIBITED

Harassment by a Medical Staff member against any individual (e.g., against another Medical Staff member, hospital employee or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation shall not be tolerated. Refer to Medical Staff Policy 7.1-4 for details.

**ARTICLE 4
CATEGORIES OF MEMBERSHIP**

4.1 CATEGORIES

The categories of the Medical Staff shall include the following: Active, Provisional, Courtesy, Active Community, Affiliate, Emeritus and Dialysis Affiliate.

4.2 ACTIVE STAFF

4.2-1 QUALIFICATIONS

The Active Staff shall consist of practitioners who meet the qualifications set forth in Section 3.2. It is recognized that even though physicians may not admit patients to the hospital, they may wish to remain involved in the hospital and medical staff's functions.

There are two (2) ways to satisfy the activity requirements for Active Staff membership:

- (a) 11+ patient contacts per year (defined below *)
- (b) A practitioner who wishes to serve on the ER call panel or otherwise participate in medical staff functions may request that the Medical Staff Executive Committee appoint him/her to the Active Staff for this purpose. Active Staff membership may be granted by the Medical Staff Executive Committee for as long as the practitioner is involved in medical staff functions.

*Patient contact is defined as an admission, discharge, surgical assist, ED short stay, ED discharge, consultation or procedure.

4.2-2 PREROGATIVES

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

- (a) Provide patient care consistent with his/her privileges unless otherwise provided in the Medical Staff Bylaws or Rules and Regulations.
- (b) Exercise such clinical privileges as are granted to him/her pursuant to Article 6.
- (c) Hold office in the Medical Staff and in the department and committees of which he/she is a member, and serve on committees, unless otherwise provided in the Medical Staff Bylaws.
- (d) Vote for Medical Staff officers, on Bylaws amendments, and on all matters presented at general and special meetings of the Medical Staff and of the Department and committees of which he/she is a member, unless otherwise provided in the Medical Staff Bylaws.

4.2-3 RESPONSIBILITIES

Each Active Medical Staff member shall:

- (a) Meet the basic responsibilities set forth in Section 3.5.
- (b) Actively participate in and regularly assist the Hospital in fulfilling its obligations related to patient care within the areas of his/her professional competence, including, but not limited to, emergency service and back up function **, peer review, utilization management, case management, quality evaluation and related monitoring activities required of the Medical Staff in supervising and proctoring initial appointees and allied health practitioners, and in discharging such other functions as may be required by the Medical Staff Executive Committee from time to time.
- (c) Participate in such emergency service coverage or consultation panels as may be determined by the Medical Staff.

** Emergency Service and backup function – practitioners will be responsible for providing continuous care for his/her patients at the campus they have designated as their “primary” campus (either MV or LG). If the practitioner wishes to provide emergency coverage at the campus where he/she is not designated as “primary”, he/she may contact the emergency room and indicate that he/she is available for such call.

4.3 PROVISIONAL STAFF

4.3-1 QUALIFICATIONS

- (a) The Provisional Staff shall consist of practitioners who meet the qualifications specified for members of the Medical Staff, except that they have not yet satisfactorily completed the focused professional practice evaluation (FPPE) requirements specified in Section 6.3; have been Medical Staff members for less than six (6) months; and/or have not fulfilled such other requirements as may be set forth in these Bylaws, the Medical Staff and department guidelines, or Hospital policies.
- (b) A practitioner may remain a Provisional Staff member for a maximum period of twelve (12) months. At the conclusion of 12 months, an activity profile will be generated and the practitioner will be advanced to the appropriate staff category based on the level of patient contacts (see definition under section 4.2-1). If Focused Professional Practice Evaluation (FPPE) requirements have not yet been satisfied at the end of 12 month period, the privileges that still require proctoring will be relinquished.

4.3-2 PREROGATIVES

The prerogatives of a Provisional Staff member shall be to:

- (a) Provide patient care consistent with his/her privileges, unless otherwise provided in the Medical Staff Bylaws or Rules and Regulations.
- (b) Exercise such clinical privileges as are granted to him/her pursuant to Article 6.
- (c) Serve on committees as a voting member, unless provided otherwise in these Bylaws. A Provisional member may not hold office in the Medical Staff or in the Department of which he/she is a member.

4.3-3 RESPONSIBILITIES

Each Provisional Staff member shall be required to discharge the applicable responsibilities which are specified in Section 4.2-3 for Active Staff members. Failure to fulfill those responsibilities shall be grounds for denial of advancement and termination of Provisional Staff status.

4.4 COURTESY STAFF

4.4-1 QUALIFICATIONS

The Courtesy Staff shall consist of practitioners who:

- (a) Meet the qualifications set forth in Section 3.2
- (b) 1-10 patient contacts per year (as defined in Section 4.2-1). If this number is exceeded for two consecutive 12 month periods, practitioner will be transferred to the Active Staff.

4.4-2 PREROGATIVES

The prerogatives of a Courtesy Staff member shall be to:

- (a) Exercise such clinical privileges as are granted to him/her pursuant to Article 6.
- (b) Attend meetings of the Medical Staff and the Department of which he/she is a member with vote. A Courtesy Staff member may not hold office in the Medical

- Staff or in the department of which he/she is a member.
- (c) Vote for Medical Staff officers, on Bylaws amendments, and on all matters presented at general and special meetings of the Medical Staff and of the Department and committees of which he/she is a member, unless otherwise provided in the Medical Staff Bylaws.

4.4-3 RESPONSIBILITIES

Each Courtesy Staff member shall meet the basic responsibilities set forth in Section 3.5.

4.5 ACTIVE COMMUNITY STAFF

4.5-1 QUALIFICATIONS

The Active Community Staff shall consist of members who:

- (a) Meet qualifications set forth in Section 3.2
- (b) Is active in the medical community and refers patients to El Camino Hospital.

4.5-2 PREROGATIVES

Active Community Staff members hold no clinical privileges. The prerogatives of an Active Community Staff member shall be to:

- (a) Attend meetings of the Medical Staff and the Department of which he/she is a member.
- (b) Hold office in the Medical Staff and in the department and committees of which he/she is a member, and serve on committees, unless otherwise provided in the Medical Staff Bylaws.
- (c) Vote for Medical Staff officers, on Bylaws amendments, and on all matters presented at general and special meetings of the Medical Staff and of the Department and committees of which he/she is a member, unless otherwise provided in the Medical Staff Bylaws.

4.6 AFFILIATE STAFF

4.6-1 QUALIFICATIONS

The Affiliate Staff shall consist of practitioners who do not have a hospital practice but regularly provide professional services for patients in the community served by El Camino Hospital.

4.6-2 PREROGATIVES

Affiliate Staff members are not eligible to admit patients to the Hospital or to exercise clinical privileges in the Hospital. The prerogatives of an Affiliate Staff member shall be to:

- (a) Attend meetings of the Medical Staff and the Department of which he/she is a member in a non-voting capacity, except within committees when the right to vote is specified at the time of appointment. An Affiliate Staff member may not hold office in the Medical Staff or in the department and committees of which he/she is a member.
- (b) An Affiliate Staff member may not vote on any Medical Staff matter, except as specified in 4.6-2(a).

4.6-3 RESPONSIBILITIES

Each Affiliate Staff member shall meet the basic responsibilities specified in Section 3.5 Paragraphs (b), (c), (e), (f), (i), (l), and (m).

4.7 HONORARY AND EMERITUS STAFF

4.7-1 QUALIFICATIONS

The Honorary Staff shall consist of physicians, dentists, and podiatrists who do not actively practice at the hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing and exemplary service to the hospital, and who continue to exemplify high standards of professional and ethical conduct.

The Emeritus Staff shall consist of practitioners, each of whom:

- (a) Wishes to take a less active role on the Medical Staff and refrain from the active care of patients at the Hospital.
- (b) Has passed the age of sixty (60) years.
- (c) Has served more than ten (10) years on the Active Staff.

4.7-2 PREROGATIVES

The prerogatives of an Honorary or Emeritus Staff member shall be to:

- (a) Serve on Medical Staff committees and vote on such committees.
- (b) Attend meetings of the Medical Staff and his/her department/division.

4.7-3 RESPONSIBILITIES

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

Honorary and Emeritus Staff members shall not be eligible to admit or otherwise care for patients, hold office in the Medical Staff or department/divisions, nor shall they be eligible to vote on matters presented at general or special meetings of the Medical Staff.

4.8 CONTRACTED PRACTITIONERS – QA/UR MEDICAL DIRECTOR STATUS AND RECOMMENDATIONS

4.8-1 CONTRACTED PHYSICIANS.

A practitioner who is engaged as an independent contractor to perform certain administrative functions (e.g. medical directors, QA/UR Medical Director) must be a Medical Staff member and obtain any necessary clinical privileges through the procedures provided for in Articles 5 and 6. The clinical practice of such practitioners will be subject to the same quality assurance and peer review processes as applies to all Medical Staff members.

4.8-2 MEDICAL DIRECTOR REVIEW/RECOMMENDATIONS.

Periodically, and no less than every two years, the Medical Staff Executive Committee shall review the quality of care and clinical efficiency of services directed by medical directors. The Medical Staff Executive Committee shall also review the quality of care issues at the time of initial appointment of a medical director. Such reviews shall be based on objective criteria. The Medical Staff Executive Committee shall make recommendations to the Board of Directors regarding retention/appointment of medical directors based on its quality reviews. Such recommendations shall be carefully considered by the Board of Directors. The Board of Directors will not act arbitrarily, and any decision regarding retention/appointment which is contrary to the Medical Staff Executive Committee's recommendation shall be justified in writing. This section shall in no way affect the ongoing quality assurance/peer review process applicable to such physicians in the normal course of their clinical practice.

4.9 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be

subject to limitation by special conditions attached to a particular membership, by other Sections of these Bylaws, or by the Medical Staff Rules and Regulations. The staff shall be limited to those for which they can demonstrate the possession of the requisite licensure, education, training, experience, and current competence.

4.10 EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership in the Medical Staff, limited licensed members:

- (a) shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the chair of the meeting, subject to final decision by the Medical Staff Executive Committee; and
- (b) shall exercise clinical privileges within the scope of their licensure.

4.11 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the Department Chief or pursuant to a request by a member or upon request by the Board of Directors, the Medical Staff Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of the bylaws.

ARTICLE 5
PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

5.1 GENERAL PROCEDURE

The Medical Staff through its designated departments, committees, and officers shall consider each application for appointment or reappointment to the Medical Staff, and for clinical privileges, and each request for modification of staff membership status or clinical privileges, before adopting and transmitting its recommendations to the Board of Directors. 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 Staff Executive Committee or as set forth in Section 5.3-8 (b).

5.2 APPLICATION FOR APPOINTMENT

5.2-1 CONTENT

All applications for appointment to the Medical Staff shall be in writing, signed by the applicant and submitted on a form prescribed by the Medical Staff Executive Committee. The application shall require the applicant to provide:

- (a) Detailed information concerning the applicant's current professional qualifications, continuing education and competency and California licensure.
- (b) The names of at least three (3) persons who hold the same professional license as does the applicant, including, whenever possible Active Staff members who can provide adequate references based on their current knowledge of the applicant's qualifications, professional competency, and ethical character.
- (c) Experience, ability, and current competence in performing the requested privilege(s) is verified by peers knowledgeable about the applicant's professional performance. This process may include an assessment for proficiency in the following six areas of "General Competencies" adapted from the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative.
 - 1. Patient Care
Practitioners are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.
 - 2. Medical/Clinical Knowledge
Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.
 - 3. Practice-based Learning and Improvement
Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
 - 4. Interpersonal and Communication Skills
Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.
 - 5. Professionalism
Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity* and a responsible attitude toward their patients, their profession, and society.
 - 6. Systems-based Practice
Practitioners are expected to demonstrate both an understanding of the

contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

- (d) Information as to whether any action, including any investigation, has ever been undertaken, whether it is still pending or completed, which involves denial, revocation, suspension, reduction, limitation, probation, nonrenewal, or voluntary or involuntary relinquishment by resignation or expiration (including relinquishment that was requested or bargained for) of the applicant's membership status and/or prerogatives, or clinical or admitting privileges at any other Hospital or Institution; membership or fellowship in any local, state regional, national or international professional organization for cause; license to practice any profession in any jurisdiction; Drug Enforcement Administration or other controlled substances registration; specialty board certification; and/or professional school faculty position or membership.
- (e) Information pertaining to the applicant's professional liability insurance coverage, any professional liability claims that have been lodged against him/her, the status or outcome of such matters, and final judgments or settlements.
- (f) Information as to any pending administrative agency or court cases, or administrative agency decisions or court judgments in which the applicant is alleged to have violated, or was found guilty of violating, any criminal law (excluding minor traffic violations), or is alleged to be liable, or was found liable, for any injury caused by the applicant's negligent, or willful omission in rendering services.
- (g) Information as to details of any prior or pending government agency or third party payor proceeding, or litigation challenging or sanctioning applicant's patient admission, treatment, discharge, charging, collection, or utilization practices, including, but not limited to, Medicare and Medi-Cal fraud and abuse proceedings and convictions, not to include usual and customary withhold denials from insurance payors.
- (h) Information pertaining to the condition of the applicant's physical and mental health necessary to determine the applicant's current ability to perform the clinical privileges requested.
- (i) Certification of the applicant's agreement to terms and conditions set forth in Section 5.2-2 regarding the effect of the application.
- (j) An acknowledgment that the applicant has received (or has been given access to) the Medical Staff Bylaws and Rules and Regulations, that he/she has received an explanation of the requirements set forth therein and of the appointment process, and that he/she agrees to be bound by their terms thereof, as they may be amended from time to time, if he/she is granted membership or clinical privileges, and to be bound by the terms thereof, without regard to whether or not he/she is granted membership and/or clinical privileges in all matters relating to consideration of this application.
- (k) The applicant shall also identify the clinical Department, and clinical privileges for which the applicant wishes to be considered. Each applicant for membership shall pay a non-refundable application fee in the amount established by the Medical Staff Executive Committee pursuant to Section 14.3

5.2-2 EFFECT OF APPLICATION

By applying for appointment to the Medical Staff each applicant:

- (a) signifies willingness to appear for interviews in regard to the application;
- (b) authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;

- (c) consents to inspection and copying of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;
- (d) releases from any liability, to the fullest extent provided by law, all persons for their acts performed in connection with investigating and evaluating the applicant;
- (e) releases from any liability, to the fullest extent provided by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;
- (f) consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the hospital or Medical Staff may have, and releases the Medical Staff and hospital from liability for so doing to the fullest extent permitted by law;
- (g) if a requirement then exists for Medical Staff dues, acknowledges responsibility for timely payment;
- (h) agrees to provide for continuous professional care for patients;
- (i) pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing for the continuous care of the applicant's patients, seeking consultation whenever necessary, refraining from failing to disclose to patients when another surgeon will be performing the surgery, and refraining from delegating patient care responsibility to nonqualified or inadequately supervised practitioners; and
- (j) pledges to be bound by the Medical Staff bylaws, rules and regulations, and policies.
- (k) agrees that so long as he/she is an applicant/member, he/she shall promptly advise the Medical Staff Services Office of changes in the information identified in Section 5.2-1.

5.3 PROCESSING THE APPLICATION

5.3-1 APPLICANT'S BURDEN

The applicant shall have the burden of producing accurate and adequate information for a proper evaluation of his/her experience, background, training, demonstrated ability, physical and mental health status, and all other qualifications specified in the Medical Staff Bylaws and Rules and Regulations, and of his/her compliance with standards and criteria set forth in the Medical Staff Bylaws and Rules and Regulations, and for resolving any doubts about these matters. The application will not be considered complete until all information requested of the applicant or other sources has been received and the verifications under Section 5.3-2 have been completed. The provision of information containing misrepresentations or omissions, and/or a failure to sustain the burden of producing adequate information, shall be grounds for ineligibility for Medical Staff membership and denial of his/her application.

5.3-2 VERIFICATION OF INFORMATION

The applicant shall deliver a completed application to the Medical Staff Services Office, which shall, in timely fashion, seek to collect or verify the references, licensure, and other qualification evidence submitted. The Medical Staff Services Office shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information. The Hospital's authorized representative shall query the National Practitioner Data Bank regarding the applicant (or member). The resulting report shall be placed in the applicant's/member's credential file. An applicant whose application is not completed within six (6) months after it was received

by the Medical Staff Services Office shall be automatically removed from consideration for staff membership. Such an applicant's application may, thereafter, be reconsidered only if all information therein which may change over time, including, but not limited to, hospital reports and personal references, has been resubmitted.

When collection and verification is accomplished, the Medical Staff Services Office shall transmit the application and all supporting materials to the chief of each department in which the applicant seeks membership and privileges.

5.3-3 DEPARTMENT ACTION

Upon receipt, the chief of each such department shall review the application, and supporting documentation, and transmit to the Medical Staff Executive Committee his/her written report and recommendations prepared in accordance with Section 5.3-5. A department chief and/or any other appropriate staff committee may ask the applicant to appear for an interview or request further documentation.

Applicants requesting privileges for surgical or other invasive procedures will receive recommendations from the appropriate department/committee monitoring the privileges being requested.

5.3-4 MEDICAL STAFF EXECUTIVE COMMITTEE ACTION

The Medical Staff Executive Committee shall consider the department chief's recommendation, and such other relevant information as may be available. The committee shall then forward to the Administrator/ Chief Executive Officer, for transmittal to the Board of Directors, its written report and recommendations, prepared in accordance with Section 5.3-5. The Committee may also defer action on the application pursuant to Section 5.3-7(a).

5.3-5 APPOINTMENT REPORTS

The department chief and Medical Staff Executive Committee reports and recommendations shall be submitted in the form prescribed by the Medical Staff Executive Committee. Each report and recommendation shall specify whether Medical Staff appointment and privileges are recommended, and, if so, the membership category, department affiliation, and clinical privileges to be granted and any special conditions to be attached to the appointment. The reasons for each recommendation shall be stated, and supported by reference to the completed application and all other documentation which was considered, all of which shall be transmitted with the report.

5.3-6 BASIS FOR APPOINTMENT

Each recommendation concerning an applicant for Medical Staff membership and clinical privileges shall be based upon whether the applicant meets the qualifications specified in Section 3.2, can carry out the responsibilities specified in Section 3.5, and meets all the standard and requirements set forth in all sections of these Bylaws and in the Medical Staff Rules and Regulations. Specifically, recommendations shall also be based upon the practitioner's compliance with legal requirements applicable to the practice of his/her profession and other Hospitals' Medical Staff Bylaws, Rules and Regulations, and policies, rendition of services to his/her patients, any physical or mental impairment which might interfere with the applicant's ability to practice medicine with reasonable skill and safety, and his/her provision of accurate and adequate information to allow the Medical Staff to evaluate his/her competency and qualifications.

5.3-7 EFFECT OF EXECUTIVE ACTION

- (a) Interview, Further Documentation, Deferral. After all outstanding documentation has been received, action by the Medical Staff Executive Committee to interview the applicant, seek further documentation, or defer the application for further consideration must be followed up within seventy (70) days with a subsequent recommendation for appointment with specified clinical privileges, or for denial of the request for Medical Staff membership/privileges.
- (b) Favorable Recommendation. When the Medical Staff Executive Committee's recommendation is favorable to the applicant, the Administrator shall promptly forward it, together with all supporting documentation, to the Board of Directors. For the purposes of this Section 5.3-7(b), "all supporting documentation" includes the application form and its accompanying information and the reports and recommendations of the department chiefs and the Medical Staff Executive Committee.
- (c) Adverse Recommendation. When the Medical Staff Executive Committee's recommendation is adverse to the applicant regarding membership or privileges, the Chief of Staff shall give the applicant written notice of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 8.3-2, and the applicant shall be entitled to the procedural rights as provided in Article 8. For the purpose of this Section 5.3-7(c), and "adverse recommendation" by the Medical Staff Executive Committee is as defined in Section 8.2. The Board of Directors shall be informed of, but not take action on, the pending adverse recommendation until the applicant has exhausted or waived his/her procedural rights.

5.3-8 ACTION BY THE BOARD OF DIRECTORS

- (a) On Favorable Medical Staff Executive Committee Recommendation: The Board of Directors shall, in whole or in part, adopt or reject a Medical Staff Executive Committee recommendation which is favorable to the applicant, or refer the recommendation back to the Medical Staff Executive Committee for further interviews, documentation, or consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. If the recommendation of the Board of Directors is one of those set forth in Section 8.2, the Administrator/ Chief Executive Officer shall give the applicant written notice of the tentative adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 8.3-2; and the applicant shall be entitled to the procedural rights as provided in Article 8 before any final adverse action is taken.
- (b) Without Benefit of Medical Staff Executive Committee Recommendation: If the Board of Directors does not receive a Medical Staff Executive Committee recommendation within the time period specified in Section 5.3-11, it may, after notifying the Medical Staff Executive Committee, take action on its own initiative. If such recommendation is favorable, it shall become effective as the final decision of the Board of Directors. If the recommendation is one of those set forth in Section 8.2, the Administrator/ Chief Executive Officer shall give the applicant written notice of the tentative adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 8.3-2; and the applicant shall be entitled to the procedural rights as provided in Article 8 before any final adverse action is taken.
- (c) After Procedural Rights: In the case of an adverse Medical Staff Executive Committee recommendation pursuant to Section 5.3-7(c) or an adverse Board of Directors recommendation pursuant to Section 5.3-8(a) or (b), the Board of

Directors shall take final action in the matter only after the applicant has exhausted or has waived his/her procedural rights as provided in Article 8. Action thus taken shall be the conclusive decision of the Board of Directors, except that the Board of Directors may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Board of Directors shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and new evidence in the matter, if any, the Board of Directors shall make a final decision.

5.3-9 NOTICE OF FINAL DECISION

- (a) Notice of the Board of Directors' final decision shall be given to the Medical Staff Executive Committee, the chief of each department concerned, and the applicant.
- (b) A decision and notice to appoint shall include: (1) the Staff category to which the applicant is appointed; (2) the department to which he/she is assigned; (3) the clinical privileges he/she may exercise; (4) a description of focused professional practitioner evaluation (FPPE) requirements; and (5) any special conditions attached to the appointment.
- (c) In the case of adverse decision regarding appointment to the Medical Staff and after exhaustion or waiver of the applicant's procedural rights, a report shall be made to the Medical Board of California and to the National Practitioner Data Bank.

5.3-10 REAPPLICATION AFTER WITHDRAWAL/ADVERSE DECISION/OMISSION BY APPLICANT

An applicant who has received a final adverse decision regarding appointment, reappointment or clinical privileges; has withdrawn any application after questions regarding qualifications or competence have been raised; or whose application has been removed from consideration due to omissions/misstatements shall not be eligible to reapply for a period of two (2) years from the date the adverse decision became final or the application was withdrawn.

5.3-11 TIME PERIODS FOR PROCESSING

Applications shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in this Section 5.3-12. The Medical Staff Services Office shall transmit an application to the Department Chief within thirty (30) days after all information collected and verification tasks are completed and all relevant materials have been received. In the event the relevant materials are not received within ninety (90) days after the application is received, the applicant shall be notified and the application shall remain pending until either the materials are received by the Medical Staff Services Office or the expiration of six (6) months after receipt shall automatically be removed from consideration as specified in Section 5.3-2. The applicable department chiefs shall act on an application within thirty (30) days after receiving it from the Medical Staff Office. The Medical Staff Executive Committee shall review the application and make its recommendation to the Board of Directors within forty-five (45) days after receiving the department report. The Board of Directors shall then take final action on the application within forty-five (45) days. The time periods specified herein are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the applicant to have his/her application process within those periods.

5.4 REAPPOINTMENTS

5.4-1 APPLICATION FOR REAPPOINTMENT; SCHEDULE FOR REVIEW

At least one hundred eighty (180) days prior to the expiration of each member's current staff appointment, the Medical Staff Services Office shall mail a reappointment application to the staff member.

At least one hundred twenty (120) days prior to the expiration date of his/her Staff appointment, each Medical Staff member shall submit to the Medical Staff Services Office a completed reappointment application form. The reappointment application shall be in writing, on a form prescribed by the Medical Staff, and it shall require detailed information concerning the changes in the applicant's qualifications since his/her last review. Specifically, the reappointment application form shall request all of the information and certifications requested in the appointment application form, as described in Section 5.2, except for that information which cannot change over time, such as information regarding the member's premedical and medical education, date of birth, and so forth. The form shall also require information as to continuing education activities during the past two (2) years and whether the applicant requests any change in his/her staff status and/or in his/her clinical privileges, including any reduction, deletion, or additional privileges. Requests for additional privileges must be supported by the type and nature of evidence which would be necessary for such privileges to be granted in an initial application for same. The results of peer review at this Hospital and others will be considered as a part of the reappointment review. Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital must also be reported at this time in addition to information as to whether any action, including any investigation, has ever been undertaken, whether it is still pending or completed, which involves denial, revocation, suspension, reduction, limitation, probation, nonrenewal, or voluntary or involuntary relinquishment by resignation or expiration (including relinquishment that was requested or bargained for) of the applicant's membership status and/or prerogatives, or clinical or admitting privileges at any other Hospital or Institution; membership or fellowship in any local, state regional, national or international professional organization for cause; license to practice any profession in any jurisdiction; Drug Enforcement Administration or other controlled substances registration; specialty board certification; and/or professional school faculty position or membership.

5.4-2 VERIFICATION OF INFORMATION

The Medical Staff Services Office shall, in timely fashion, seek to collect and to verify the additional information made available on each reappointment application form including information regarding the practitioner's experience, ability, and current competence with regard to patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice (see 5.2 (c) for details regarding these competencies). The Medical Staff Services Office shall transmit the completed reappointment application form and supporting materials to the chief of each department in which the staff member has or requests privileges.

5.4-3 DEPARTMENT ACTION

- (a) The department chief shall review the application and the staff member's file and shall transmit to the Medical Staff Executive Committee his/her written report and recommendations, which are prepared in accordance with Section 5.4-5. This may include a recommendation for change in staff category, change or no change in clinical privileges, or reappointment for one year, based on departmental guidelines.
- (b) The following applies to the review of information in the Medical Staff member's credentials file at the time of reappraisal or reappointment.

1. Prior to recommendation on reappointment the Department Chief, as part of the reappraisal function, shall review information in the credentials file pertaining to a member.
2. Following this review, the Department Chief, after consultation with the Department Executive Committee, shall determine whether documentation in the file warrants further action.
3. With respect to adverse information, if it does not appear that an investigation and/or adverse recommendation on reappointment is warranted, the Department Chief shall so inform the Medical Staff Executive Committee.
4. However, if an investigation and/or adverse recommendation on reappointment is warranted, the Department Executive Committee shall so inform the Medical Staff Executive Committee and shall proceed appropriately with such investigation as part of the reappointment process.

5.4-4 MEDICAL STAFF EXECUTIVE COMMITTEE ACTION

The Medical Staff Executive Committee shall review the department chief's report, all other relevant information available to it, and shall forward to the Board of Directors, through the Administrator/ Chief Executive Officer, its favorable reports and recommendations, prepared in accordance with Section 5.4-5.

When the Medical Staff Executive Committee recommends adverse action, as defined in Section 8.2, either in respect to reappointment or clinical privileges, the Chief of Staff shall give the applicant written notice of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 8.3-2, and the applicant shall be entitled to the procedural rights as provided in Article 8.

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

Thereafter, the procedures specified in Sections 5.3-8 (Action by the Board of Directors), 5.3-9 (Notice of Final Decision) and 5.3-10 (Reapplication After Adverse Decision Denying Application, Adverse Corrective Action Decision, or Resignation in Lieu of Medical Disciplinary Action) shall be followed. The Committee may also defer action; however, any such deferral must be followed up within seventy (70) days with a subsequent recommendation. In the case of adverse decision regarding appointment to the Medical Staff and after exhaustion or waiver of the applicant's procedural rights, a report shall be made to the Medical Board of California and to the National Practitioner Data Bank.

5.4-5 REAPPOINTMENT REPORTS

The department chiefs and Medical Staff Executive Committee reports and recommendations shall be written and shall be submitted in the form prescribed by the Medical Staff Executive Committee. If reappointment request is accompanied by request for additional privileges, then this request must be reviewed by the specific department/division/committee monitoring such privileges who will specify in writing whether the request for additional privileges should be granted. Each report and recommendation shall specify whether the applicant's appointment should be renewed, renewed with modified membership category, department affiliation, and/or clinical privileges, or terminated. Where non-reappointment, denial of requested privileges, a reduction in status, or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

5.4-6 BASIS FOR REAPPOINTMENT

Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon whether such member has met the qualifications specified in Section 3.2, carried out the responsibilities specified in Section 3.5, and met all of the standards and requirements set forth in all sections of these Bylaws and in the Medical Staff Rules and Regulations. Specifically, recommendations shall also be based upon the practitioner's compliance with legal requirements applicable to the practice of his/her profession, with the Medical Staff Bylaws and Rules and Regulations and Hospital policies, rendition of services to his/her patients, any physical or mental impairment which might interfere with the applicant's ability to practice medicine with reasonable skill and safety, and his/her competency and qualifications.

5.4-7 FAILURE TO FILE REAPPOINTMENT APPLICATION

If the member fails to submit an application for reappointment completed as required, he/she shall be deemed to have resigned his/her membership and privileges in the Medical Staff, effective on the expiration date of his/her appointment.

5.5 LEAVE OF ABSENCE

5.5-1 LEAVE STATUS

A Medical Staff member may obtain a voluntary leave of absence from the Medical Staff by submitting written notice to the Medical Staff Executive Committee and the Administrator/Chief Executive Officer stating the approximate period of time of the leave, which may not exceed one (1) year at a time, renewable up to a total of two (2) years. During the period of the leave, the member shall not exercise clinical privileges at the hospital, and membership rights and responsibilities shall be suspended, except that the member shall still have the responsibility of submitting a reappointment application and dues, if required during the period of requested leave. Alternatively, the Chief of Staff, subject to approval by the Medical Staff Executive Committee, may place a member on a leave of absence if the circumstances warrant such an action.

5.5-2 MEDICAL LEAVE OF ABSENCE

The Medical Staff Executive Committee may also grant a leave of absence specifically for the purpose of obtaining treatment for a medical condition or disability. The Committee shall determine the circumstances under which such a leave is appropriate. Unless accompanied by a specific restriction of privileges, beyond the normal suspension of privileges as described in Section 5.5-1, the leave shall be deemed a "medical leave" which is not related to a medical disciplinary cause or reason."

5.5-3 MILITARY LEAVE OF ABSENCE

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the Medical Staff Executive Committee. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions of Sections 5.5-2 and 5.5-3, but may be granted subject to focused professional practitioner evaluation (FPPE) as determined by the Medical Staff Executive Committee.

5.5-4 TERMINATION OF LEAVE

At least thirty (30) days prior to the termination of the leave (which may be waived by the Medical Staff Executive Committee), or at any earlier time, the Medical Staff member may request reinstatement of his/her privileges and prerogatives by submitting a written notice to

that effect to the Administrator and to the Medical Staff Executive Committee. If so requested by the Medical Staff Executive Committee or the Administrator/ Chief Executive Officer, the staff member shall submit a written summary of his/her relevant activities during the leave. The Medical Staff Executive Committee shall recommend whether to approve the member's request for reinstatement of his/her privileges and prerogatives. Thereafter, the procedure set forth in Sections 5.3-7 through 5.3-11 shall be followed.

Failure, without good cause, to request reinstatement or to provide a requested summary of activities shall be deemed to be a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A practitioner whose membership is so terminated shall be entitled to the procedural rights provided in Article 8, for the sole purpose of determining whether the failure was with or without good cause. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

**ARTICLE 6
CLINICAL PRIVILEGES**

6.1 EXERCISE OF PRIVILEGES

A member providing direct clinical services at this Hospital, in connection with such practice and except as otherwise provided in Section 6.6, shall be entitled to exercise only those clinical privileges specifically granted to him/her by the Board of Directors. Said privileges must be within the scope of any license, certificate, or other legal credential authorizing him/her to practice in this State and consistent with any restrictions thereon. Medical staff privileges may be granted, continued, modified or terminated by the Board of Directors of this hospital only upon recommendation of the Medical Staff, only for reasons directly related to quality of patient care, other provisions of the Medical Staff bylaws, and only following the procedures outlined in these bylaws.

6.2 DELINEATION OF PRIVILEGES IN GENERAL

6.2-1 REQUESTS

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. Requests from an applicant for privileges, or from members for modification of privileges, must be supported by documentation of the requisite training, experience, qualifications and competency to exercise such privileges and continuing medical education. Requests for alteration in privileges may be made at any time and shall not be restricted to the time of renewal.

6.2-2 BASIS FOR PRIVILEGES DETERMINATION

Requests for clinical privileges shall be evaluated on the basis of professional criteria to include the member's education, training, experience, current competence, and demonstrated ability to perform the privileges requested. All privileges requested will be hospital specific. The elements to be considered in determining current clinical competency regarding privileges, whether in connection with periodic reappointment or otherwise, shall include experience, ability, and current competence with regard to patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice (see 5.2 (c) for details regarding these competencies); professional liability claims history, results of queries with the Medical Board of California, National Practitioner Data Bank, and the OIG website; board certification and the documented results of patient care audit and other quality review, evaluation, and monitoring activities required. Privilege determinations shall also take into account pertinent information concerning professional performance obtained from other sources, especially peer recommendations and other institutions and health care settings where a member exercises clinical privileges.

6.2-3 PROCEDURE

All requests for clinical privileges from dentists and podiatrists shall be processed pursuant to the procedures outlined in Article 6.

6.2-4 GENERAL CONDITIONS

Except as otherwise recommended by the Medical Staff Executive Committee and approved by the Board of Directors, all initially granted clinical privileges shall be subject to the focused professional practice evaluation requirements identified in Section 6.3.

6.3 PROFESSIONAL PRACTICE EVALUATION

6.3-1 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE), for additional

information regarding FPPE process, see Medical Staff Policy 13.5.1

(a) FOR INITIAL APPOINTMENTS

Except as otherwise determined by the Medical Staff Executive Committee, all practitioners initially appointed to the Medical Staff shall complete a period of proctoring. Proctoring may include concurrent or retrospective review of a practitioner's competence depending upon the nature of the privileges requested. Each initial appointee shall be assigned to a department where his/her performance shall be proctored by the chief of the department, or his/her designee, during the term of proctoring required by that department, to determine the initial appointee's eligibility for continued Medical Staff membership in the category to which he/she was appointed and to exercise the clinical privileges initially granted in that department. If Hospital utilization is insufficient to permit necessary evaluation of a practitioner's performance, a Department may review the practitioner's clinical care provided in the office or in another hospital or healthcare institution. His/her exercise of clinical privileges in any other department shall also be subject to proctoring by that department's chief, or his/her designee, for the term of proctoring required by that department.

(b) MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

On its own, upon recommendation of the Department Chief, or pursuant to a request from the member, the Medical Staff Executive Committee may recommend a change in the clinical privileges or department assignment(s) of a member. The executive committee may also recommend that the granting of additional privileges to a current Medical Staff member be made subject to performance monitoring.

(c) TERM OF PROCTORING PERIOD

Each department will establish terms for proctoring with a minimum number of cases, and/or a specific number of cases applicable to particular clinical privileges, whenever such requirements are appropriate in view of the clinical privileges which are involved. The period of proctoring may be extended in increments of not more than six (6) months each, for a total proctoring period of not more than (12) twelve months. If an initial appointee fails within that period to complete the applicable minimum number of cases and/or to furnish the certifications required in Section 6.3-1, his/her Medical Staff particular clinical privileges, as applicable, shall be relinquished. If a Medical Staff member requesting modification fails within that period to complete the minimum number of cases and/or furnish the certifications required in Section 6.3-1, the change in Medical Staff category or Department assignment or the additional privileges, as applicable, shall be relinquished. The practitioner will be given written notice at least 30 days in advance that his/her Medical Staff clinical privileges will be relinquished because he/she failed to satisfactorily complete the proctoring requirements. In such circumstances, the affected practitioner has no right to a hearing pursuant to Section 8.3-2.

(d) FOR PHYSICIAN PERFORMANCE ISSUES

FPPE shall be conducted when questions arise regarding a practitioner's professional performance that may affect the provision of safe, high-quality patient care that have been identified through the peer review process, ongoing feedback reports, or pursuant to the corrective action plan.

- 6.3-2 ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE), for additional information regarding OPPE process see Medical Staff Policy 13.5.2
- (a) Purpose: To define the process for ongoing professional practice evaluation (OPPE) of medical staff members at El Camino Hospital. The primary goal is to use OPPE as a tool to assess and ensure current clinical competence of medical staff members as part of El Camino Hospital's commitment to quality.
 - (b) Policy: OPPE is conducted on an ongoing basis and will include review of performance data for all practitioners with clinical privileges at ECH.

6.4 SPECIAL CONDITIONS APPLICABLE TO DENTAL AND PODIATRIC PRIVILEGES AS DIRECTED BY THE MEDICAL STAFF EXECUTIVE COMMITTEE

- (a) Requests for clinical privileges from dentists and podiatrists shall be processed in the same manner as specified in Section 6.2. Surgical procedures performed by dentists and podiatrists shall be under the supervision of the chief of their respective departments. All dental and podiatric patients shall receive the same basic medical appraisal as patients admitted to other surgical services.
- (b) Admission history and physical examination on dental and podiatric patients must be performed and recorded in the hospital record in accordance with Rules and Regulations B – History & Physicals (included at the end of these Bylaws).
- (c) The treating dentist or podiatrist must, when indicated, request consultation and medical management from the admitting staff physician or any physician staff member.

6.5 TEMPORARY PRIVILEGES

6.5-1 CIRCUMSTANCES

The Chief Executive Officer, or his/her designee, upon the recommendation of the Department Chief, when available, or the Chief of Staff in all other circumstances, may grant temporary privileges to a practitioner, subject to the conditions set forth in Section 6.5-2 below, in the following circumstances:

- (a) Pendency of Application: Temporary privileges may be granted upon the recommendation of the department chief for a period not to exceed 120 days when a new applicant with a complete application that raises no significant concerns is awaiting review and approval of the Medical Staff Executive Committee and Board of Directors. The following items must be verified:
 - Current licensure
 - Relevant training or experience
 - Current competence
 - Ability to perform the privileges requested
 - NPDB report
 - Complete application
 - No current or previously successful challenge to licensure or registration
 - No subjection to involuntary termination of medical staff membership at another organization
 - No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges
- (b) Temporary Privileges to Meet an Important Patient Care Need (Care of Specific Patient in physician database): Upon receipt of an application for specific temporary privileges, a practitioner may be granted temporary privileges for the care of up to six (6) specific patients in any one calendar year, for the term of their hospitalization. Practitioners

requesting temporary privileges for more than six (6) times in any one (1) year shall be required to apply for membership in the Medical Staff before being granted the requested privileges. The medical staff verifies, at a minimum, current licensure, current competence, and current malpractice insurance. An AMA and NPDB report will be obtained prior to granting privileges.

6.5-2 CONDITIONS

Temporary privileges may be granted only when the practitioner has submitted a written application for appointment for temporary privileges and the information reasonably supports a favorable determination regarding the requesting practitioner's current licensure, qualifications, ability and judgment to exercise the privileges requested, and only after these items are verified and the practitioner has satisfied the requirement of Section 3.2 (c) regarding professional liability insurance. The chief of the department to which the practitioner is assigned shall be responsible for supervising the performance of the practitioner granted temporary privileges, or for designating a department member who shall assume this responsibility. Special requirements of consultation and reporting may be imposed by that chief.

6.5-3 TERMINATION

- (a) Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended under Articles 6 and/or 7 of these Bylaws. As necessary, the appropriate department chief or, in the chief's absence, the Chief of Staff, shall assign a member of the Medical Staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement Medical Staff member.
- (b) On the discovery of any information, or the occurrence of any event, of a nature which raises a question about a practitioner's professional qualifications, ability to exercise any or all of the temporary privileges granted, or compliance with any Bylaws, rules, regulations, or special requirements, the Chief of Staff or his/her respective designee, may, after consultation with the department chief responsible for supervision, or his/her designee, terminate any or all of such practitioner's temporary privileges, provided that where a patient's life or well-being is determined to be endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose summary suspensions under Article 7. In the event of any such termination, the practitioner's patients then in the Hospital shall be assigned to another practitioner by the department chief responsible for supervision. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

6.5-4 RIGHTS OF THE PRACTITIONER

A practitioner shall be entitled to the procedural rights afforded by Article 8 because his/her request for temporary privileges is refused or because all or any portion of his/her temporary privileges are terminated or suspended.

6.6 EMERGENCY PRIVILEGES

For the purposes of this Section, an "emergency" is defined as a condition in which a patient is in imminent danger of serious or permanent harm or death and any delay in administering treatment would add to that danger. In the case of an emergency, any practitioner, to the degree permitted by his/her license and regardless of department, Medical Staff status, or clinical privileges, shall be permitted to do, and shall be assisted by Hospital personnel in doing, everything possible to save a patient from such danger. When an emergency situation

no longer exists, such practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are either not requested or denied, the patient shall be assigned to an appropriate member of the staff by the chief of staff or his/her designee.

6.7 PRIVILEGING LICENSED INDEPENDENT PRACTITIONERS DURING DISASTER EVENTS

(a) Purpose: To ensure that physicians and allied health practitioners (hereinafter referred to as “practitioner”), who do not possess medical staff or practice privileges, may be accepted to work at El Camino Hospital during a disaster, when Code Triage has been activated (Emergency Management Plan located in Hospital Safety Manual).

These disaster privileges are granted only when the following two conditions are present:

1. The Emergency Management Plan (Code Triage) has been activated
2. El Camino Hospital is unable to meet immediate patient needs

(b) Procedure:

1. A practitioner may present to the hospital to volunteer to provide services during a disaster. The scope of services provided must be within the practitioner's scope of practice as outlined by their state board.
2. All staff will be alerted to direct the practitioner to the hospital triage officer or the medical staff office to process disaster privileges.
3. The practitioner must produce his/her pocket license to practice medicine, a photo ID, the name of his/her malpractice insurance carrier, and the name of a hospital where he/she currently has privileges or has recently practiced. If possible, copies should be made of the license and photo ID.
4. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. The medical staff office will keep the name, title, and license number of the volunteer practitioner on file for future reference if needed.

IN THE EVENT THESE CALLS CANNOT BE COMPLETED, DISASTER PRIVILEGES MAY STILL BE GRANTED UPON RECEIPT OF THE KEY IDENTIFICATION DOCUMENTS NOTED ABOVE.

5. The Chief of Staff (or designee) may grant these disaster privileges. If the Chief of Staff (or designee) is not available, the Administrator/ Chief Executive Officer (or designee) may grant disaster privileges.
6. The practitioner granted disaster privileges must be paired with a credentialed practitioner currently on staff who has a similar specialty. This pairing should be recorded along with the licensing information. Within 72 hours a decision will be made (based on information obtained regarding the professional practice of the volunteer) related to the continuation of the disaster privileges initially granted.
7. The practitioner will wear a temporary El Camino Hospital nametag issued by Security, while working in the facility.
8. A practitioner's privileges, granted under this situation, may be terminated at any time without reason or cause.
9. Termination of these privileges will not give rise to a hearing or review.

6.8 POST-DOCTORAL PRACTITIONER LIMITED PROCEDURAL TRAINING

Privileges may be granted to practitioners to pursue a limited period of clinical training and education in a particular area of their specialty. Upon submission of a written application,

completely verified, and with established documentation of licensure of good standing and adequate malpractice coverage, a practitioner of documented current competence in their specialty field of practice may be granted time-limited privileges for a period not to exceed 1 year, without applying for active Medical Staff appointment or privileges. The burden will rest on the applicant to ensure that all pre-requisite information is accurate and received by the Medical Staff Office in a timely manner to permit processing of this application before the initial date of his/her scheduled procedural training tenure at El Camino Hospital.

Clinical care provided by the applicant practitioner shall always be under the direct supervision of a designated member of the Active Medical Staff of the Hospital, qualified by training, experience and privileging to mentor such care and procedural training. Privileges shall be limited to treatment of his/her patients admitted to El Camino Hospital and/or to the treatment of patients of his/her supervising practitioner as appropriate. He/she shall not be entitled to admit his/her own patients to the Hospital. Applicant practitioners seeking post-doctoral privileges must provide evidence of licensure, malpractice insurance with written verification from his/her malpractice carrier which summarizes information regarding pending or closed malpractice activity, and written verification of good standing at another hospital where he/she maintains Active Staff privileges. The Hospital's authorized representative shall query the National Practitioner Data Bank. The burden rests on the applicant to ensure that pertinent information is received by the Medical Staff Office in a timely manner.

Practitioners engaged in post-doctoral procedural training at El Camino Hospital must be licensed by the Medical Board of California and will be authorized to perform certain pre-approved procedures.

6.9 LOCUM TENENS PRIVILEGES

Locum Tenens privileges may be granted physicians serving locum tenens when an application has been submitted and completely verified in writing.

Upon receipt of a written application, a practitioner of documented current competence who is serving or will serve as a locum tenens for an Active Staff Member of the Hospital may be granted locum tenens privileges for an initial period of sixty (60) days. Such privileges may be renewed for two (2) successive periods of sixty (60) days but not to exceed his/her services as locum tenens, and shall be limited to treatment of the patients of the practitioner for whom he/she is serving as locum tenens. He/she shall not be entitled to admit his/her own patients to the Hospital as a locum tenens.

Physicians seeking locum tenens privileges must provide evidence of licensure, malpractice insurance with written verification from his/her malpractice carrier which summarizes information regarding pending or closed malpractice activity, and written verification of good standing at another hospital where he/she holds Active Staff privileges. If the physician is not on staff at another hospital, evidence of satisfactory completion of a training program within the prior six months must be submitted. The burden rests on the applicant to ensure that pertinent information is received by the Medical Staff Services Office in a timely manner.

6.10 HISTORY & PHYSICAL – PRIVILEGES AND TIMEFRAMES

- (a) H&P must be completed by a practitioner privileged to perform H&Ps – these are defined as:
 1. MD/DO

2. DDS/DMD
 3. DPM
 4. Nurse Practitioner – must be countersigned by supervising practitioner with 14 days of the patient’s discharge.
 5. Certified Nurse Midwife
 6. Physician Assistant – must be countersigned by supervising practitioner with 14 days of the patient’s discharge.
- (b) H&P must be completed and documented for each patient no more than 30 days before or 24 hours after admission, but prior to surgery or procedure requiring anesthesia services.
- (c) **H&P Updates:** When the H&P is conducted within 30 days of admission (inpatient or outpatient), an updated examination, including any changes in the patient’s condition, must be completed and documented by a qualified practitioner (see (a) in this section) within 24 hours of admission (inpatient or outpatient), but prior to surgery or a procedure requiring anesthesia services when the H&P was completed within the previous 30 days.
- (d) The content of complete and focused history and physical examination is delineated in the Rules and Regulations appended to these Bylaws (R&R #B.1).

6.11 TELEMEDICINE PRIVILEGES

- (a) Coverage: Licensed Independent Practitioners (LIPs) who have either total or shared responsibility for patient care, treatment, and services (as evidenced by having the authority to write orders and direct care, treatment, and services) through a telemedicine link. Telemedicine is defined as the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or healthcare provided and for the purpose of improving patient care, treatment, and services.
- (b) Scope:
1. The Medical Staff Executive Committee recommends to the Board of Directors which clinical services are appropriately delivered by LIPs through telemedicine. The clinical services offered are consistent with commonly accepted quality standards.
 2. For contracted services, the contracting entity will ensure that all services provided by contracted individuals who are LIPs will be within the scope of his or her privileges and obtained through a Joint Commission accredited entity. All such LIPs will also be licensed in the State of California, carry professional liability insurance and meet any other qualification standards required by the Medical Staff Bylaws.
- (c) Definitions:
1. Originating Site (El Camino Hospital) – the site where the patient is located at the time the service is provided.
 2. Distant Site – the site where the practitioner providing the professional service is located.
- (d) Procedure: All LIPs who are responsible for the patient’s care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms:
1. El Camino Hospital may fully privilege and credential the practitioner according to Joint Commission standards and its medical staff processes and requirements.
 2. The practitioner may be privileged at El Camino Hospital using credentialing information from the distant site if the distant site is a Joint

- Commission accredited organization. The Board of Directors of grants privileges based on ECH medical staff recommendations.
3. Regardless of the privileging procedure utilized (d. 1-2 above), each LIP must possess those qualifications for LIP utilization of privileges at El Camino Hospital (e.g. California licensure, professional liability insurance, education, training, etc).

**ARTICLE 7
CORRECTIVE ACTION**

7.1 ROUTINE CORRECTIVE ACTION

7.1-1 CRITERIA FOR INITIATION

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the hospital; (2) unethical; (3) contrary to the Medical Staff bylaws and rules or regulations; or (4) below applicable professional standards, a request for an investigation or action against such member may be initiated by the Chief of Staff, a department chief, or the Medical Staff Executive Committee.

7.1-2 INITIATION

An investigation may be initiated by the Medical Staff Executive Committee on its own initiative or by a written request which is submitted to the Medical Staff Executive Committee and identifies the specific activities or conduct which is alleged to constitute the grounds for proposing an investigation or specific corrective action. The Chief of Staff shall promptly notify the practitioner of the formulation of an investigative body. The Chief of Staff shall promptly notify the Administrator/ Chief Executive Officer and Board of Directors of all corrective action investigations and shall continue to keep them fully informed of all action taken in conjunction therewith.

7.1-3 INVESTIGATION

Upon receipt, the Medical Staff Executive Committee may act on the proposal or request or direct that an investigation be undertaken. The Medical Staff Executive Committee may conduct that investigation itself or may assign this task to an appropriately charged officer, or standing or Medical Staff ad hoc committee. If the proposed corrective action could result in an action which is grounds for a hearing under Section 8.2, the Chief of Staff shall promptly notify the practitioner and the practitioner shall be given an opportunity for an interview(s) with the investigating committee or officer and the Medical Staff Executive Committee, as applicable. Any such interview(s) shall be conducted in accordance with Section 7.4. No such investigative process shall be deemed to be a “hearing” as described in Article 8.

If the investigation is delegated to an officer or committee other than the Medical Staff Executive Committee, such officer or committee shall forward a written report of the investigation to the Medical Staff Executive Committee as soon as is practicable after the assignment to investigate has been made. The Medical Staff Executive Committee may, at any time within its discretion, terminate the investigative process and proceed with action as provided in Section 7.1-4 below.

7.1-4 MEDICAL STAFF EXECUTIVE COMMITTEE ACTION

As soon as is practicable after the conclusion of the investigative process, the Medical Staff Executive Committee shall act thereon. Such action may include, without limitation, recommending:

- (a) No corrective action.
- (b) Rejection or modification of the proposed corrective action.
- (c) Letter of admonition, letter of reprimand, or warning.
- (d) Terms of probation or individual requirements of consultation.
- (e) Reduction or revocation of clinical privileges.

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

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

7.1-5 PROCEDURAL RIGHTS

Any recommendation by the Medical Staff Executive Committee, pursuant to Section 7.1-4 which constitutes grounds for a hearing as set forth in Section 8.2, shall entitle the practitioner to the procedural rights as provided in Article 8. In such cases, the Chief of Staff shall give the practitioner written notice of the adverse recommendation and of his/her right to request a hearing in the manner specified in Section 8.3-2.

7.1-6 INITIATION BY BOARD OF DIRECTORS

If the Medical Staff Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Board of Directors may direct the Medical Staff Executive Committee to initiate investigation or disciplinary action, but only after consultation with the Medical Staff Executive Committee. The board's request for Medical Staff action shall be in writing and shall set forth the basis for the request. If the Medical Staff Executive Committee fails to take action in response to that Board of Directors direction, the Board of Directors may initiate corrective action after written notice to the Medical Staff Executive Committee, but this corrective action must comply with Articles 7 and 8 of these Medical Staff bylaws.

7.2 SUMMARY SUSPENSION

7.2-1 CRITERIA FOR INITIATION

Whenever a practitioner's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient, prospective patient or other person, the Chief of Staff, the Medical Staff Executive Committee, or the head of the department or designee in which the member holds privileges may summarily restrict or suspend the Medical Staff membership or clinical privileges of such member.

Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the member, the Board of Directors, the Medical Staff Executive Committee and the Administrator/ Chief Executive Officer and pertinent hospital staff/departments. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the department chief or by the Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute member.

7.2-2 INITIATION BY BOARD OF DIRECTORS

If the Chief of Staff, members of the Medical Staff Executive Committee and the chief of the department (or designee) in which the member holds privileges are not available to summarily restrict or suspend the member's membership or clinical privileges, the Board of Directors or its designee may immediately suspend a member's privileges if a failure to summarily suspend those privileges is likely to result in imminent danger to the health of any patient, prospective patient, or other person, provided that the Board of Directors or its designee made reasonable attempts to contact the Chief of Staff, members of the Medical Staff Executive Committee and the head of the applicable department (or its designee) before the suspension. Such a suspension is subject to ratification by the Medical Staff Executive Committee. If the Medical Staff Executive Committee does not ratify such a summary suspension within two (2) working days, excluding weekends and holidays, the summary suspension shall terminate automatically.

7.2-3 MEDICAL STAFF EXECUTIVE COMMITTEE ACTION

As soon as practicable after such a summary restriction or suspension has been imposed and in any event within ten (10) days, a meeting of the Medical Staff Executive Committee shall be convened to review and consider the action. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Staff Executive Committee may impose, although in no event shall any meeting of the Medical Staff Executive Committee, with or without the member, constitute a hearing within the meaning of Article 8, nor shall any of the procedural rules in Section 8.4 apply. The Medical Staff Executive Committee may modify, ratify, or terminate the summary restriction or suspension, but, in any event it shall notify the member, the Board of Directors, and the Administration of its decision.

7.2-4 PROCEDURAL RIGHTS

Unless the Medical Staff Executive Committee promptly terminates a summary restriction or suspension, the member shall be entitled to the procedural rights afforded by Article 8.

7.3 AUTOMATIC SUSPENSION

7.3-1 LICENSE

- (a) Revocation: Whenever a practitioner's license authorizing him/her to practice in this State is revoked, his/her Medical Staff membership, prerogatives, and clinical privileges shall be immediately and automatically terminated. Such practitioners shall not be entitled to the procedural rights afforded by Article 8.
- (b) Expiration: If a practitioner's license expires, then his/her clinical privileges shall be suspended for up to 60 days, pending notification of reinstated license. If reinstatement is not received in 60 days, practitioner's membership, prerogatives, and clinical privileges shall be terminated. Such practitioners shall not be entitled to the procedural rights afforded by Article 8.
- (c) Restriction: Whenever a practitioner's license authorizing him/her to practice in this state is limited or restricted by the applicable licensing authority, those clinical privileges which he/she has been granted rights to perform that are within the scope of said limitation or restriction shall be immediately and automatically terminated.
- (d) Suspension: Whenever a practitioner's license authorizing him/her to practice in this state is suspended, his/her staff membership and clinical

privileges shall be automatically suspended effective upon, and for at least the term of, the suspension.

- (e) Probation: Whenever a practitioner is placed on probation by the applicable licensing authority, his/her application membership status, prerogatives, privileges and responsibilities, if any, shall automatically become subject to the terms of the probation effective upon, and for at least the term of, the probation.

7.3-2 DRUG ENFORCEMENT ADMINISTRATION

- (a) Revocation or Expiration: Whenever a practitioner's DEA certificate is revoked or has expired, he/she shall immediately and automatically be divested of his/her right to prescribe medications covered by the certificate. See Rules & Regs "O" for information regarding a DEA Certification Waiver.
- (b) Suspension: Whenever a practitioner's DEA certificate is suspended, he/she shall be divested, at a minimum; of his/her right to prescribe medications covered by the certificate effective upon, and for at least the term of, the suspension.
- (c) Probation: Whenever a practitioner's DEA certificate is subject to an order of probation, his/her right to prescribe medications covered by the certificate shall automatically become subject to the terms of the probation effective upon, and for at least the term of, the probation.

7.3-3 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

A practitioner who fails, without good cause, to appear and satisfy the requirements of Section 12.7-1, shall automatically be suspended from exercising all, or such portion of his/her clinical privileges as may be suspended, in accordance with the provisions of said Section 12.7-1.

7.3-4 EXECUTIVE COMMITTEE DELIBERATIONS ON MATTERS INVOLVING LICENSE, DRUG ENFORCEMENT ADMINISTRATION, FAILURE TO SATISFY SPECIAL APPEARANCE, AND RELEASE OF CONFIDENTIAL INFORMATION

As soon as practicable after action is taken as described in Section 7.3-2, Paragraphs (b) or (c), or in Sections 7.3-3, 7.3-4, the Medical Staff Executive Committee shall convene to review and consider the facts upon which such action was predicated. The Medical Staff Executive Committee may then recommend such further corrective action as may be appropriate based upon information disclosed or otherwise made available to it, and/or it may direct that an investigation be undertaken pursuant to Section 7.1-3. The procedure to be followed shall be as provided in Sections 7.1-4 through 7.1-7, as applicable, if the Medical Staff Executive Committee directs a further investigation.

7.3-5 PROCEDURAL RIGHTS – MEDICAL RECORDS

Whenever the Medical Staff Executive Committee has determined that suspensions or deemed resignations for failure to complete medical records were in circumstances where such failure affected or could reasonably affect patient care, a report shall be filed with the Medical Board of California as required under California Business and Professions Code Section 805 and the affected practitioner shall be entitled to the procedural rights set forth in Article 8. In the absence of such a report, a practitioner is not entitled to the procedure rights of Article 8.

7.3-6 MALPRACTICE INSURANCE

For failure to maintain the amount of professional liability insurance, a practitioner's membership and clinical privileges, after written warning of delinquency, shall be automatically suspended and shall remain so suspended until the practitioner provides evidence to the Medical Staff Executive Committee that he/she has secured professional liability coverage. A failure to provide such evidence within sixty (60) days after the date the automatic suspension became effective shall be deemed to be a voluntary resignation of the practitioner's Medical Staff membership.

7.3-7 MEDICARE/MEDICAID EXCLUSION

A practitioner who is the subject of a final administrative decision excluding his/her participation in Medicare, Medicaid, or any similar governmental program is deemed to have resigned from the Medical Staff and is not eligible to apply/reapply until all such sanctions have been lifted.

7.3-8 FAILURE TO PAY DUES

For failure to pay dues, if any, as required under Section 14.3, a practitioner's Medical Staff membership and clinical privileges shall be automatically suspended and shall remain so suspended until the practitioner pays the delinquent dues. A failure to pay such dues within sixty (60) days after the date the automatic suspension became effective shall be deemed to be a voluntary resignation of the practitioner's Medical Staff membership.

7.3-9 PROCEDURAL RIGHTS – MEDICAL RECORDS, MALPRACTICE INSURANCE, AND FAILURE TO PAY DUES

Practitioners whose clinical privileges are automatically suspended and/or who have resigned their Medical Staff membership pursuant to the provisions of 7.3-5 (failure to complete medical records), 7.3-7 (failure to maintain malpractice insurance), or 7.3-7 (failure to pay dues) shall not be entitled to the procedural rights set forth in Article 8.

7.3-10 FAILURE TO COMPLY WITH THE REQUIREMENTS OF A MEDICAL STAFF POLICY

Whenever a practitioner fails to comply with the requirements of a Medical Staff policy (e.g., medical record/HIPPA training, vaccination or required testing/screening, etc.) the practitioner's privileges may be suspended by action of the Medical Staff Executive Committee or its designee. The practitioner shall be given notice of the failure to comply with the applicable policy and be given a period of thirty (30) days to achieve compliance. Absent compliance, the practitioner's privileges will be suspended after the thirty (30) day notice period has run. Compliance must be completed within ninety (90) days of suspension initiation or the practitioner is deemed to have resigned from the Medical Staff.

7.3-11 NOTICE OF AUTOMATIC SUSPENSION; TRANSFER OF PATIENTS

Whenever a practitioner's privileges are automatically suspended in whole or in part, notice of such suspension shall be given to the practitioner, the Medical Staff Executive Committee, the Administrator/ Chief Executive Officer, pertinent hospital staff/departments, and the Board of Directors. Giving of such notice shall not, however, be required in order for the automatic suspension to become effective. In the event of any such suspension, the practitioner is terminated by the automatic suspension, his/her patient(s) shall be assigned to another practitioner by the department chief or Chief of Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

7.4 INTERVIEWS

Interviews shall neither constitute, nor be deemed, a “hearing,” as described in Article 8, shall be preliminary in nature, and shall not be conducted according to the procedural rules applicable with respect to hearings. The Medical Staff Executive Committee shall be required, at the practitioner's request, to grant him/her an interview. In the event an interview is granted, the practitioner shall be informed of the general nature of the circumstance leading to such recommendation and may present information relevant thereto. A record of the matters discussed and findings resulting from such interview shall be made.

**ARTICLE 8
HEARINGS AND APPELLATE REVIEWS**

8.1 PREAMBLE AND DEFINITIONS

8.1-1 INTRAORGANIZATIONAL REMEDIES

The remedies, hearing and appellate review procedures provided for in this Article are strictly quasi-judicial in structure and function. Accordingly, the Article 8 Judicial Review Committee process shall have no power or authority to make determinations as to the substantive validity of bylaws, rules or regulations.

Notwithstanding the foregoing, the Board of Directors may entertain challenges to the substantive validity of bylaws, rules or regulations and in all proper cases shall hear and decide such challenges. Where the substantive validity question is the sole issue, the petitioner shall be permitted a direct appeal in the first instance, before the Medical Staff Executive Committee, under procedures which it shall determine. The Medical Staff Executive Committee shall make a decision regarding the issue and transmit its decision, together with any record it has compiled to the Board of Directors for final decision. Utilization of this process shall be a condition precedent to the petitioner's right to seek judicial review in a court of law.

8.1-2 EXHAUSTION OF REMEDIES

If an adverse ruling is made concerning a practitioner, regardless of whether he/she is an applicant or a Medical Staff member, he/she must exhaust any remedies provided by these Bylaws before resorting to legal action. The exclusive procedure for obtaining judicial review shall be by Petition of Writ of Mandate pursuant to Part 3, Title 1, Chapter 2 of the California Code of Civil Procedure.

8.1-3 DEFINITIONS

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

- (a) "Body" whose decision prompted the hearing" refers to the Medical Staff Executive Committee in all cases where the Medical Staff Executive Committee or authorized officers, members or committees of the Medical Staff took the action or rendered the decision which resulted in a hearing being requested.
- (b) "Notice" refers to a written communication delivered personally to the required addressee or sent by United States Postal Service, first-class postage prepaid, certified or registered mail, return receipt requested, addressed to the required addressee at his/her or its address as it appears in the records of the Hospital and pursuant to Section 8.3-4.
- (c) "Petitioner" refers to the practitioner who has requested a hearing pursuant to Section 8.3 of these Bylaws.
- (d) "Date of Receipt" of any notice or other communication shall be deemed to be the date such notice or communication was delivered personally to the required addressee or, if delivered by mail, such notice or communication shall be deemed received 48 hours after being deposited, postage prepaid, in the United States mail in compliance with paragraph (b) of this Section 8.1-3.

8.2 GROUNDS FOR HEARING

8.2-1 GROUNDS

Any one or more of the following actions or recommended actions shall constitute grounds for a hearing if such action requires a report under California Business & Professions Code

Section 805:

- (a) Denial of Medical Staff membership;
- (b) Denial of requested advancement in staff membership status (except that a refusal to advance a Provisional Staff member before the conclusion of the permissive twelve (12) month proctoring period shall not constitute grounds for a hearing);
- (c) Denial of staff reappointment;
- (d) Demotion to lower staff category or membership status;
- (e) Suspension of staff membership for a certain time period or until completion of specific conditions or requirements;
- (f) Summary suspension of staff membership during the pendency of corrective action hearing and appeals procedures;
- (g) Expulsion from staff membership;
- (h) Denial of requested privileges (not including temporary privileges);
- (i) Reduction in privileges;
- (j) Suspension of privileges until completion of specific conditions or requirements;
- (k) Summary suspension of privileges (including temporary privileges);
- (l) Termination of privileges;
- (m) Requirement of consultation;
- (n) Monitoring requirements for other than investigational purposes (excluding monitoring incidental to Provisional Staff status);
- (o) Any other actions which require a report be made to the Medical Board of California under the provisions of Section 805 of the California Business and Professions Code and the National Practitioner Data Bank.

Recommendation of any one of these actions shall constitute an "adverse recommendation" for the purposes of these Bylaws.

8.2-2 FINAL ACTION

Adverse recommendations shall become final only after the hearing and appellate rights set forth in these bylaws have either been exhausted or waived, and only upon being adopted as final actions by the Hospital Board of Directors.

8.3 REQUEST FOR A HEARING

8.3-1 NOTICE OF ACTION

In all cases in which actions have been taken or recommendation made which give rise to rights of appeal under Section 8.2 of the Bylaws, the person or body responsible for such action or recommendation shall give the affected practitioner: (i) written notice of the recommendation or final proposed action, (ii) notice that the action, if adopted, shall be taken and reported pursuant to California Business and Professions Code Section 805 and the National Practitioner Data Bank, (iii) notice of his or her right to request a hearing pursuant to section 8.3-2 (iv) notice that such hearing must be requested within thirty (30) days, and (v) a summary of the hearing and appeal rights under these Bylaws.

8.3-2 REQUEST FOR HEARING

The affected practitioner shall have thirty (30) days following the date of receipt of notice of such action to request a hearing. Said request shall be effected by notice to the Chief of Staff with a copy to the Administrator/ Chief Executive Officer. In the event the affected practitioner does not request a hearing within the time and in the manner herein above set forth, he or she shall be deemed to have accepted the recommendation, decision, or action involved and it shall there upon become the final recommendation of the Medical Staff.

Such final recommendation shall be considered by the Board of Directors within forty-five (45) days.

8.3-3 TIME AND PLACE OF HEARING

Upon receiving a request for a hearing, the Chief of Staff shall schedule and arrange for a hearing which will commence within sixty (60) days after receipt of the request for the hearing unless such time period is otherwise extended as permitted under these Bylaws.

The Chief of Staff shall give notice to the affected practitioner of the time, place and date of the hearing not less than thirty (30) days before the commencement of the hearing.

8.3-4 NOTICE OF CHARGES

Together with the notice stating the place, time and date of the hearing, the chief of staff, on behalf of the Medical Staff Executive Committee, shall state the reasons for the final proposed action, including the acts or omissions with which the affected practitioner is charged and a list of the charts in question, where applicable.

8.3-5 JUDICIAL HEARING BODY

When a hearing is requested, it shall be held before a Judicial Hearing Committee appointed by the Medical Staff Executive Committee, consisting of at least three (3) individuals, and alternates as appropriate.

The Judicial Hearing Committee shall be composed of individuals who gain no direct financial benefit from the outcome of the hearing, who have not acted as accusers, investigators, fact finders or initial decision makers in the matter at any previous level and shall include, where feasible, and an individual practicing in the same specialty as the affected practitioner. Preferably, the members of the Judicial Hearing Committee shall be members of the Medical Staff.

When a Judicial Hearing Committee is appointed, the Chief of Staff shall designate a chair who shall preside in the manner described in section 8.4-3 and who shall handle all pre-hearing matters and preside until a Hearing Officer, as described in Section 8.4-4 below is appointed.

8.3-6 FAILURE TO APPEAR OR PROCEED

Failure without good cause of the affected practitioner to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved. Such final recommendations shall be considered by the Board of Directors within forty-five (45) days.

8.3-7 CONTINUANCES

Continuances shall be granted upon agreement of the parties or by the hearing officer on a showing of good cause.

8.3-8 DISCOVERY

(a) The affected practitioner shall have the right to inspect and copy at his or her expense any documentary information relevant to the charges which the Medical Staff has in its possession or under its control as soon as practicable after receipt of the request for a hearing. The Medical Staff Executive Committee shall have the right to inspect and copy at its expense any documentary information relevant to the charges which the affected practitioner has in his or her possession or control as

soon as practicable after receipt of the request for a hearing. Any request for inspection of documentary information relevant to the charges must be submitted in writing. The failure by either party to provide access to such information at least thirty (30) days before the hearing shall constitute good cause for continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable practitioners, other than the affected practitioner under review. The hearing officer appointed pursuant to Section 8.4-4 shall consider and rule upon any request for access to information and may impose any safeguard as the protection of the peer review process and justice requires. When ruling upon requests for access to information and determining the relevance thereof, the Hearing Officer shall, among other factors, consider the following: (i) whether the information sought may be introduced to support or defend the charges; (ii) the exculpatory or inculpatory nature of the information sought, if any; (iii) the burden imposed on the party in the possession of the information sought, if access is granted, and (iv) any previous requests for access to any information submitted or resisted by the parties to this same proceeding.

- (b) If either side to the hearing requests in writing a list of witnesses, each party shall furnish to the other within fifteen (15) days of such request a written list of the names and addresses of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. Failure to disclose the identity of a witness at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance. Requests for a list of witnesses shall be submitted in writing to the other party.
- (c) At the request of either side, the parties shall exchange copies of all documents expected to be introduced at the hearing. Failure to produce copies of all such documents at least ten (10) days before commencement of the hearing shall constitute good cause of continuance. A request for all documents expected to be introduced at the hearing shall be submitted in writing to the other party.

8.4 HEARING PROCEDURE

8.4-1 PREHEARING PROCEDURE

It shall be the duty of the petitioner and the body whose decision prompted the hearing to raise objections regarding procedural issues and the composition of the hearing committee as soon as such objections are or should have been known. For these purposes, all such objections should be submitted in writing to the presiding officer identified in Section 8.4-3 at least seven (7) days before the scheduled hearing. Objections to any prehearing decisions concerning procedural issues and committee composition shall be raised at the judicial hearing and when so raised shall be preserved for consideration at any appellate review hearing which, thereafter, might be requested.

8.4-2 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. The member shall be entitled to representation by legal counsel at his or her expense in any phase of the hearing, should he/she so choose. In the absence of legal counsel, 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, and the Medical Staff Executive Committee shall not be represented by an attorney-at-law if the affected practitioner elects not to be so represented.

8.4-3 THE PRESIDING OFFICER

The presiding officer at the hearing shall be a hearing officer as described in Section 8.4-4, or if no such hearing officer has been appointed, the chair of the Judicial Hearing Committee shall preside over the hearing. The presiding officer shall act to assure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence, and that proper decorum is maintained. He/she shall be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing. He/she shall have the authority and discretion, in accordance with these Bylaws, to make all rulings on questions which, with reasonable diligence, could not have been raised prior to the hearing and which pertain to matters of law, procedure, or the admissibility of evidence. He/she shall also have discretion to make all rulings necessary to assure a timely, efficient and orderly hearing process.

8.4-4 HEARING OFFICER

The Medical Staff Executive Committee shall appoint a hearing officer to preside with respect to pre-hearing issues and at the hearing. The hearing officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, however, an attorney regularly utilized by the hospital, the Medical Staff or the individual Medical Staff member or applicant for membership, for legal advice regarding its affairs and activities shall not be eligible to serve as a hearing officer. The hearing officer shall gain no direct financial benefit from the outcome 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 an 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 arguments 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 including those which arise prior to the hearing. 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. If requested by the Judicial Hearing Committee, the hearing officer may participate in the deliberations of such a committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

8.4-5 RECORD OF THE HEARING

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

8.4-6 RIGHTS OF THE PARTIES

At a hearing both sides shall have the following rights to ask Judicial Hearing Committee members and the hearing officer questions which are directly related to determine whether they are impermissibly biased and challenge the impartiality of any member or hearing officer, to call and examine witnesses, to introduce exhibits or other documents, to cross-examine or otherwise attempt to impeach any witness who shall have testified orally on any matter relevant to the issued, and otherwise to rebut evidence, and to be provided with all information made available to the Judicial Hearing Committee. The affected practitioner may be called by the body whose decision prompted the hearing and examined as if under cross-examination. Any challenge directed at one or more members of the committee or hearing officer shall be ruled on by the hearing officer.

8.4-7 BURDENS OF PRESENTING EVIDENCE AND PERSUASION

(a) The Medical Staff Executive Committee shall have the initial duty to present evidence which supports the charge(s) or recommended action.

(b) When the hearing involves an applicant, and his or her Medical Staff membership, the applicant shall bear the burden of persuading by a preponderance of the evidence of his or her qualifications by producing information which allows for adequate information and resolution of reasonable doubts concerning his or her current qualifications for staff privileges, membership or employment. Initial applicants shall not be permitted to introduce information not produced upon request of the Medical Staff Executive Committee during the application process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(c) Except as provided for initial applicants in paragraph (b) above, the Medical Staff Executive Committee shall bear the burden of persuading by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.

8.4-8 MISCELLANEOUS RULES

The rules of law relating to the examination of witnesses and presentation of evidence shall not apply in any hearing conducted hereunder. Any relevant evidence, including hearsay, shall be admitted by the presiding officer if it is the sort of evidence which responsible persons are accustomed to rely on in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a written statement to be filed following the conclusion of the presentation of oral testimony. The Judicial Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

8.4-9 BASIS OF DECISION

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

(a) Oral testimony of witnesses.

(b) Briefs or written statements presented in connection with the hearing.

(c) Any material contained in the Hospital or Medical Staff personnel files regarding the petitioner, which shall have been made a part of the hearing record.

(d) Any and all applications, references, medical records, exhibits and other documents and records which shall have been made a part of the hearing record.

(e) Any other evidence admissible hereunder.

8.4-10 ADJOURNMENT AND CONCLUSION

The hearing officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Both parties shall have the right to submit written statements at the close of the hearing. Upon conclusion of the presentation of oral and written evidence and argument and written statements, if any, the hearing shall be closed. The Judicial Hearing Committee shall there upon, outside the presence of any persons, except the hearing officer, conduct its deliberations, and render a decision and accompanying report.

8.4-11 DECISION OF THE JUDICIAL HEARING COMMITTEE

Within thirty (30) days after final adjournment of the hearing, the Judicial Hearing Committee shall render a decision which shall be accompanied by a report in writing and which shall be delivered to the Medical Staff Executive Committee. If the affected practitioner is currently under suspension, however, the time for the decision and report shall be fifteen (15) days. A copy of said decision also shall be forwarded to the affected practitioner, the Administrator/ Chief Executive Officer, and the Board of Directors. The report shall contain a precise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached.

Both the affected practitioner and the Medical Staff Executive Committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the Judicial Hearing Committee shall be subject to the right of appeal to the Board of Directors as provided in 8.5-4.

8.5 APPEALS TO THE BOARD OF DIRECTORS

8.5-1 TIME FOR APPEAL

Within thirty (30) days after the date of receipt of the Judicial Hearing Committee decision, either the petitioner, or the body whose decision prompted the hearing may request an appellate review by the Board of Directors. Said request shall be delivered to the Administrator/ Chief Executive Officer in writing either in person, or by certified or registered mail, return receipt requested, and it shall include a brief statement of the reasons for the appeal. If such appellate review is not requested within such period, both sides shall be deemed to have accepted the action involved and it shall thereupon become the final action of the Medical Staff. Such final recommendation shall be considered by the Board of Directors within forty-five (45) days, but shall not be binding on the Board of Directors.

8.5-2 REASONS FOR APPEAL

The reasons for appeal from the hearing shall be: (a) substantial failure of any person to comply with the procedures required by these Bylaws or applicable law in the conduct of the hearing and the rendering of the decision so as to deny petitioner of fair hearing; (b) the lack of substantive rationality of a Medical Staff bylaw, rule or regulation relied upon by the Judicial Hearing Committee in reaching its decision; and/or (c) action taken arbitrarily, unreasonably or capriciously.

8.5-3 TIME, PLACE AND NOTICE

When appellate review is requested pursuant to the preceding subsection, the Board of Directors shall, within thirty-five (35) days after the date of receipt of such an appeal notice, schedule and arrange for an appellate review. The Board of Directors shall give the petitioner notice of the time, place, and date of the appellate review. The date of appellate review shall not be less than fifteen (15) nor more than ninety (90) days from the date of receipt of the request for appellate review, provided, however, that when a request for appellate review is from a petitioner who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed forty-five (45) days from the date of receipt of the request for appellate review. The time for appellate review may be extended for good cause by the Board of Directors, or appeal board (if any).

8.5-4 APPEAL BOARD

When an appellate review is requested, the Board of Directors may sit as the appeal board or in its sole discretion it may appoint a hearing officer who shall conduct the appellate hearing and make recommended findings, conclusions and a decision which may be adopted, modified or rejected by the Board of Directors. If a hearing officer is appointed, he/she shall be an attorney at law, admitted to practice in California for at least ten (10) years, shall not be legal counsel to the Hospital and shall not act as a prosecuting officer, an advocate for the Hospital, the practitioner, the Board of Directors or any other body whose action prompted the proceeding. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board or hearing officer, so long as that person did not take part in a prior hearing on the same matter. For the purposes of this Section, participating in an initial decision to recommend adverse action shall not be deemed to constitute participation in a prior hearing on the same matter.

8.5-5 BOARD OF DIRECTORS APPEALS PROCEDURE

The proceedings by the Board of Directors shall be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Hearing Committee, provided that the Board of Directors may accept additional oral or written evidence, subject to the foundational showing that such additional evidence could not have been made available to the Judicial Hearing Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the Judicial Hearing Committee hearing; or may remand the matter to the Judicial Hearing Committee for the taking of further evidence and for decision. Each party shall have the right to present a written statement in support of his or her position on appeal, the right to present a written statement in support of his or her position on appeal, the right to appear and respond, and the right to be represented by an attorney or any other representative designated by the party. At the conclusion of oral argument, the Board of Directors may there upon conduct, at the time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The Board of Directors shall have the option of having legal counsel present during the appeal and their deliberations to advise them in questions relating to the conduct of the appellate review. The legal counsel's role shall be limited to that of an advisor.

8.5-6 ACTION BY A HEARING OFFICER

If the Board of Directors has appointed a hearing officer, he/she shall prepare findings of fact and a proposed decision in such form that it may be adopted as the decision of the Board of Directors. The findings of fact and proposed decision shall be filed by the hearing officer with the Board of Directors within fifteen (15) days after conclusion of the hearing, and a copy thereof shall be served at the same time on all parties to the action. Within ten (10) days after the filing of such findings and proposed decision with the Board of Directors by the hearing officer, the practitioner or the chairman of the committee whose decision prompted the hearing may file a request to present oral or written argument directly to the Board of Directors. No later than the next regular meeting of Board of Directors, a time shall be fixed for hearing of such arguments by the Board of Directors, which shall not be more than thirty (30) days after the filing of the hearing officer's findings and proposed decision. At the time so fixed, such arguments shall be presented and heard by the Board of Directors. In such event, no member of the Board of Directors shall vote on the final decision who is not present at oral argument, or who did not read written argument.

8.5-7 FURTHER REVIEW OF FINDINGS AND RECOMMENDED DECISION

After the hearing officer's findings and recommended decision have been filed with the Board of Directors, if the findings and recommended decision are at material variance with

the recommendations of the Medical Staff, or if Board of Directors deems that there are matters raised by the hearing officer's findings and recommended decision which the Board of Directors believes were not considered in the Medical Staff proceedings, or if Board of Directors proposes to render a decision at variance with the recommendations of the Medical Staff or the hearing officer, Board of Directors may refer the findings and proposed decision to the Judicial Hearing Committee or any other body or person for further review and recommendation. If the matter is so referred for further review and recommendation, that committee or person shall, within thirty (30) days after such referral, conduct its review and make its further recommendations to the Board of Directors in accordance with the instructions given by the Board of Directors.

8.5-8 DECISION

Within ten (10) days after the conclusion of the appellate review proceedings, the Board of Directors shall render a final decision in writing. The Board of Directors may affirm, modify or reverse the Judicial Hearing Committee decision or, at its discretion, remand the matter for further review and recommendation by the Judicial Hearing Committee or any other body or person. The decision shall be in writing and shall specify the reasons for the action taken, and shall be forwarded to the affected practitioner, the Medical Staff Executive Committee, and the Administrator/ Chief Executive Officer.

8.5-9 RIGHT TO ONE HEARING

Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one judicial, evidentiary hearing and one appellate review on any matter which shall have been the subject of action by either the Medical Staff Executive Committee or the Board of Directors (whether or not in conjunction with a hearing officer) or by both.

8.6 EXCEPTIONS TO HEARING RIGHTS

- (a) The Medical Staff Executive Committee shall review and make written recommendations to the Board of Directors regarding quality of care issues related to exclusive arrangements for physician services, prior to any final Board decision being made to execute an exclusive contract in a previously open department or service. In such cases, the Medical Staff Executive Committee's recommendation shall be made within a reasonable time in light of the Hospital's need to execute such an exclusive contract, as determined by the Board of Directors in its sole discretion. Regarding Board decisions (i) to renew or modify an exclusive contract in a particular department or service, or (ii) to terminate an exclusive contract in a particular department or service, the Board shall consult with the Medical Staff Executive Committee regarding quality of care issues related to such decisions prior to taking final action on the contracts, unless the Board decides, in its sole discretion, that such prior consultation would subject the Hospital's business interests or its patients to a risk of imminent harm. In cases in which the Board decides it must proceed without such prior consultation, the Board shall, within thirty (30) days of taking action, inform the Medical Staff Executive Committee of the reasons for its decision, excluding confidential financial information.
- (b) The hearing and appellate review rights of any physician whose Medical Staff membership or privileges are adversely affected by decision by the Board of Directors falling within the provisions of 7.6-1 shall be governed by Article 7 of these Bylaws. The hearing rights of Article 7, however, shall apply only to the extent that an action is taken or a recommendation is made which, when final, must be reported to the Medical Board of California under Business and Professions Code section 805 and to the extent that Medical Staff membership status or clinical

privileges which are independent of the practitioner's contract are also removed or suspended.

8.7 REPORTS

The Chief of Staff or Authorized Representative shall provide the affected Practitioner with a copy of any Section 805 and/or National Practitioner Data Bank report filed with respect to him/her.

**ARTICLE 9
CLINICAL DEPARTMENTS AND DIVISIONS**

9.1 ORGANIZATION OF DEPARTMENTS AND DIVISIONS

The unified El Camino Medical Staff will be comprised of a combination of campus-specific departments and enterprise departments. Enterprise departments are those departments that serve constituency at all campuses (including MV & LG). All departments ultimately report to a unified Medical Staff Executive Committee. Each Department shall be organized as a separate part of the Medical Staff and shall have a Chief and a Vice-Chief who are elected and have the authority, duties, and responsibilities specified in Article 10. Each Division of a Department shall be organized as a specialty subdivision within a Department, shall be directly responsible to the Department within which it functions, and shall have a Division Chairman who has the authority, duties, and responsibilities specified in Article 10.

9.2 DESIGNATION

The current departments and divisions are:

Campus Departments:

MV Medicine, Obstetrics/Gynecology, Surgery

LG Medicine, Obstetrics/Gynecology, Surgery

Enterprise Departments

Family Medicine, Orthopedics, Pediatrics, Psychiatry

Divisions: Divisions reporting to Medical Department – Emergency Medicine,
Radiology, Hospitalists

Divisions reporting to Surgical Department – Pathology, Anesthesia

9.3 ASSIGNMENT TO DEPARTMENTS AND DIVISIONS

Each practitioner will declare his/her primary campus and shall be assigned membership in one Department and/or Division within such Department within that campus. The exercise of privileges within each Department and Division shall be subject to the Rules and Regulations thereof and to the authority of the Department Chief and Division Chairman.

9.4 FUNCTIONS OF DEPARTMENTS

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

To carry out this responsibility, each Department shall:

- (a) Conduct patient care reviews for the purpose of analyzing and evaluating the quality of care and appropriateness of treatment provided to patients by the members of the Department. Such reviews shall be conducted in accordance with such procedures as may be adopted by Medical Staff Executive Committee in consultation with other appropriate committees. Each Department shall review all clinical work performed under its jurisdiction, whether or not the particular person whose work is subject to such review is a member of that Department. The criteria to be used in such review shall be objective and reflect current knowledge and clinical experience. Each

Department shall also identify actions that should be taken in order to resolve identified problems in patient care and clinical performance and evaluate the effectiveness of actions which have been taken in resolving such problems.

- (b) Prepare written reports for submission to the Medical Staff Executive Committee concerning:
 - 1. findings of the Department's review, evaluation, and monitoring activities, conclusions, actions taken thereon, and the results of such action; and
 - 2. recommendations and actions taken for maintaining and improving the quality of care provided in the Department and the Hospital.
- (c) Meet as necessary for the purpose of receiving, reviewing, and considering patient care review findings and for the performance or reception of reports on other Department and Staff functions.
- (d) Establish criteria for the granting of clinical privileges within the Department for approval by the Medical Staff Executive Committee.
- (e) Submit to the Medical Staff Executive Committee the recommendations required under Articles 5 and 6 regarding the clinical privileges each member or applicant should be authorized to exercise.
- (f) Conduct or participate in, and make recommendations regarding the need for, continuing education programs pertinent to changes in the state-of-the-art and regarding findings of review, evaluation, and monitoring activities.
- (g) Take appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified.
- (h) Coordinate the patient care provided by the Department's members with nursing and ancillary patient care services and with administrative support services.
- (i) Establish such committees or other mechanisms as are necessary and desirable to properly perform the functions assigned to it.

9.5 FUNCTIONS OF DIVISIONS

Each Division, upon the approval of the Medical Staff Executive Committee, shall perform the functions assigned to it by the Department Chief. Such functions may include, without limitation, the continuous monitoring of patient care practices, credentials review and privileges delineation, and continuing education programs. The Division shall transmit regular reports to the Department Chief on the conduct of its assigned functions.

9.6 MODIFICATIONS IN CLINICAL ORGANIZATION UNIT

When deemed appropriate, the Medical Staff Executive Committee and the Board of Directors, by their joint action, may create, eliminate, subdivide, further subdivide, or combine departments, divisions, and/or clinical services.

- (a) Creation of Subdivision: If (i) a sufficient number of practitioners are available for appointment to and will be appointed to and/or actively participate in the new organizational component to enable accomplishment of the functions generally assigned to such components in these Bylaws and relevant Rules and Regulations adopted pursuant hereto; and, (ii) the patient or service activity to be associated with the new component is substantial enough to warrant imposition on the members thereof the responsibility to accomplish such functions, a subdivision may be created.
- (b) Eliminations: If the number of members available is no longer adequate and will not be so in the foreseeable future to accomplish assigned functions, or the patient or service activity associated with the component to be dissolved is no longer substantial enough to warrant imposition of the responsibility to accomplish those assigned functions on the members of such subdivision, a subdivision may be

eliminated.

- (c) **Combination:** If the union of the two or more organizational components will result in more effective and efficient accomplishment of assigned functions, and the patient or service activity to be associated with the combination is substantial enough, without being unwieldy, to warrant imposition of the responsibility to accomplish those assigned functions on the members of such combined components, subdivisions may be combined. In all instances of modification, the Hospital's written plan of development, as currently being implemented, and any constraints or mandates imposed by external planning authorities, shall also be considered.

9.7 FUNCTIONS OF HOSPITAL BASED DIVISIONS

Each Hospital Based Division shall be organized as part of the Medical Staff and have a Medical Director who is appointed by Hospital Administration. Members of the individual Hospital Based Divisions (Emergency Services, Radiology, Pathology, Anesthesia, and Hospitalists), shall have the following authority and duties: They shall meet independently as necessary; review on-going care of patients; review morbidity and mortality of these patients; attend the Medical Staff Executive Committee and Quality Council; and report on their activity to Medical Staff Executive Committee. Radiation Therapy physicians shall act as a subdivision of Radiology. One representative from Radiology, Emergency Medicine, and Hospitalists shall be a member of the Medicine Department Executive Committee. One representative from Anesthesia and one representative from Pathology shall be a member of the Surgery Department Executive Committee.

**ARTICLE 10
OFFICERS**

10.1 GENERAL OFFICERS OF THE MEDICAL STAFF

10.1-1 IDENTIFICATION

The general officers of the Medical Staff shall be the MV Chief of Staff, the Vice-Chief of Staff, Immediate Past Chief of Staff, and the LG Chief of Staff, Vice-Chief of Staff, and Immediate Past Chief of Staff. The MV Chief of Staff will serve as Chair of the Medical Executive Committee and will act as Enterprise Chief of Staff.

10.1-2 QUALIFICATIONS

General officers must be members of the Active or Active Community Staff and must be board certified or qualified in his/her primary specialty at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

10.1-3 NOMINATIONS

The Medical Staff election shall be held bi-annually. The Nominating Committee shall consist of the past Chiefs of each Department. The Immediate Past Chief of Staff shall Chair the Committee. The Nominating Committee shall nominate one or more nominees for Chief and Vice-Chiefs for each campus. The Nominating Committee's nominees shall be presented to the Medical Staff.

Further nominations may be made for any Medical Staff or Department office by any voting member of the Medical Staff, provided that the name of the candidate is submitted in writing to the chair of the nominating committee, is endorsed by the signature of at least 10% of the Medical Staff/Department 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 five (5) days prior to mailing of the written ballots under Section 10.1-4. Candidates nominated by this procedure shall have their names included on the written ballot mailed to eligible voting members of the Medical Staff/Department.

10.1-4 ELECTION

Voting shall be by: (1) Secret written mail ballot, as defined in Article 14, Section 14.9, which shall be mailed to eligible voting members of the Medical Staff during the first week of March of an election year and must be returned to the Medical Staff Office within two weeks of receipt of the ballot or (2) Electronic vote, with the voting method to be determined by the Medical Staff Executive Committee. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote, a runoff election shall be arranged promptly between the two candidates receiving the highest number of votes. Elected officers shall be announced to the entire Medical Staff, method of communication to be determined by the Medical Executive Committee.

10.1-5 IMMEDIATE PAST CHIEF OF STAFF PROVISIONS

Sections 10.1-4 and 10.1-5 shall not apply to the office of Immediate Past Chief of Staff. The Chief of Staff shall, upon completion of his/her term of office in that position, immediately succeed to the office of Immediate Past Chief of Staff.

10.1-6 TERM OF ELECTED OFFICERS

Each officer shall serve a two year term, commencing on the first day of the Medical Staff year following election. Each officer shall serve until the end of this term and until a successor is elected, unless he/she shall sooner resign or be removed from office.

10.1-7 REMOVAL OF ELECTED OFFICERS

Except as otherwise provided in these Bylaws, grounds for dismissal of an elected officer may be initiated by the Medical Staff Executive Committee or upon the written request of twenty percent (20%) of the members eligible to vote for officers. Such removal may be effected by a two-thirds (2/3) vote of the members eligible to vote for officers. Voting on removal of an elected officer shall be by secret written mail ballot, as defined in Article 14, Section 14.9.

The written mail ballots shall be sent to each voting member at least two weeks before the voting date and the ballots shall be counted by the Immediate Past Chief of the Medical Staff (except when he/she is the subject of the balloting, in which case the Chief of Staff shall count the ballots) and the Vice Chief of Staff and, in the case of a petition by members, a representative of the petitioners and the officer subject to recall or his/her designee.

Grounds for removal of an officer are as follows:

- (a) Failure to remain a member in good standing of the Active or Active Community Staff.
- (b) Failure to perform his/her duties in a timely or appropriate manner.
- (c) Subjection to corrective action (as defined in Article 7).
- (d) Subjection to a summary suspension, imposed pursuant to Article 7, which remains in effect for fourteen days (14) or longer.
- (e) Declaration that the officer is of unsound mind by order of court or convicted of a felony.
- (f) Evidence that the officer has acted in a fraudulent or dishonest way or has grossly abused authority or discretion with reference to the Medical Staff or Hospital.

10.1-8 VACANCIES IN ELECTED OFFICES

Vacancies in office, other than that of Chief of Staff, shall be filled by the Medical Staff Executive Committee. If there is a vacancy in the office of Chief of Staff, the Vice-Chief of Staff shall serve out the remaining term and shall then serve as Chief of Staff for the following term. A vacancy in the office of Immediate Past Chief of Staff need not be filled, except that the Medical Staff Executive Committee may appoint qualified successors to serve as the Chief of, or as a member of, any committee that the Immediate Past Chief of Staff is automatically appointed to pursuant to these Bylaws.

10.1-9 COMPENSATION

The amount and source of compensation of Medical Staff Officers shall be determined annually by the Medical Staff Executive Committee in consultation with the Board of Directors.

10.2 DUTIES OF GENERAL OFFICERS

10.2-1 CHIEF OF STAFF

The MV and LG Chiefs of Staff shall serve as the Chief Executive Officer of the Medical Staff members of his/her primary campus. He/she shall:

- (a) Act in coordination and cooperation with the Administrator in all matters of mutual concern within the Hospital where consistent with these Bylaws.
- (b) Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.
- (c) The MV Chief of Staff will serve as Chairman of the Enterprise Medical Staff Executive Committee.
- (d) Serve as an ex officio member of all other Staff committees without vote, unless his/her membership in a particular committee is required by these Bylaws.
- (e) Be responsible for the enforcement of the Medical Staff Bylaws and Rules and Regulations, for the implementation of sanctions where indicated, and for the Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.
- (f) Appoint, with Medical Staff Executive Committee approval, committee members to all standing and special Medical Staff committees, except where otherwise provided by these Bylaws or by Medical Staff Rules and Regulations.
- (g) Serve as a member of the Board of Directors in such capacity as may be permitted or required by the Hospital's corporate Bylaws.
- (h) Represent the views, policies, needs, and grievances of the Medical Staff to the Board of Directors and to the Administrator/Chief Executive Officer.
- (i) Interpret the policies of the Board of Directors to the Medical Staff.
- (j) Serve as a spokesperson for the Medical Staff in external professional and public relations.
- (k) Perform such other functions as may be assigned to him/her by these Bylaws, by the membership, by the Medical Staff Executive Committee or by the Board of Directors and where consistent with these Bylaws.

10.2-2 VICE CHIEF OF STAFF

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

10.2-3 IMMEDIATE PAST CHIEF OF STAFF

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

10.3 DEPARTMENT OFFICERS

10.3-1 QUALIFICATIONS

Each Department Chief and Vice-Chief shall be a member of the Active or Active Community Staff, shall be certified by the appropriate specialty board or have affirmatively demonstrated comparable ability, through the credentialing process, in at least one of the clinical areas covered by the Department, and be willing and able to faithfully discharge the functions of the office.

10.3-2 SELECTION

The Department Chief and Vice-Chief shall be elected by the eligible voting staff members of the Department. Each Department shall appoint a Department Nominating Committee consisting of three (3) Active or Active Community Staff members who are members of the Department. The Committee shall be appointed not later than January of each election year. The Nominating Committee recommendations for one or more nominees for Department Chief and Vice-Chief shall be reported to the members of each Department prior to the election. Nominations will be accepted from the floor in the manner described in 10.1-3. The Department officers may be elected at the Department meeting. Eligible voting members of the Department may vote. If more than one candidate is proposed, voting shall be conducted by written ballot or by electronic methods, as determined by the current Department Chief.

10.3-3 TERM OF OFFICE

Each Department Chief and Vice-Chief shall serve a two year term commencing on their appointment. They shall serve until the end of the Medical Staff year and until their successors are chosen, unless either shall sooner resign or be removed from office.

10.3-4 REMOVAL

Removal of a Department Chief and Vice-Chief from office may be initiated by the Medical Staff Executive Committee or by written request from twenty percent (20%) of the members of the Chief's or Vice-Chief's Department who are eligible to vote. Grounds for removal shall be consistent with those listed in 10.1-7 in this section. Such removal may be effected by a majority vote of the Medical Staff Executive Committee members or by a majority vote of the Department members eligible to vote on departmental matters. All voting shall be conducted by written secret mail ballot, as defined in Article 14, Section 14.9, which shall be sent to those eligible to vote within forty-five (45) days after the initiation of removal, pursuant to this Section. The ballots must be received no later than two weeks days after they are mailed and shall be counted by the Chief of Staff, Vice Chief of Staff, and Medical Staff Coordinator and the officer subject to recall or his/her designee. No removal shall be effective unless and until it is ratified by the Medical Staff Executive Committee.

10.3-5 DUTIES

Each Department Chief shall have the following authority, duties, and responsibilities, and the Vice-Chief, in the absence of the Chief, shall assume all of them and shall otherwise perform such duties as may be assigned to him/her:

- (a) Be accountable to the Medical Staff Executive Committee and to the Chief of Staff for all clinical and administrative activities within his/her department, and particularly for the quality of patient care rendered by members of his/her department and for the continuous assessment and improvement of the quality of care, treatment, and services provided by his/her department and the maintenance of quality control programs as appropriate.
- (b) Develop, implement and evaluate departmental programs in cooperation with the Chief of Staff, and/or Quality Assessment/Utilization Management Director for monitoring and evaluation of patient care, credentials review, privileges delineation, medical education and utilization management.
- (c) Be a member of the Medical Staff Executive Committee, give guidance on the overall medical policies of the Hospital, and make specific recommendations and suggestions to the Medical Staff Executive Committee and the Medical Staff, as

appropriate regarding his/her own Department including, but not limited to, criteria for clinical privileges in the department.

- (d) Maintain continuing review of the professional performance of all practitioners with clinical privileges in his/her department and report thereon to the Medical Staff Executive Committee.
- (e) Provide to the Medical Staff Executive Committee his or her recommendations concerning appointment and classification, completion of FPPE requirements, reappointment, delineation of clinical privileges, and corrective action with respect to practitioners in his/her department. Provide input to the Hospital and/or the Interdisciplinary Practice Committee, as appropriate, regarding the determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.
- (f) Enforce the Hospital and Medical Staff Bylaws, rules, regulations, and policies within his/her department, including initiation of corrective action and investigation of clinical performance and ordering of consultations to be provided or sought when necessary.
- (g) Participate in the integration of the department into the primary functions of the hospital in cooperation with the nursing service and the Hospital administration in matters affecting patient care, including personnel, space and other resources, supplies, special regulations, standing orders and techniques, and assessing and recommending sources for needed patient care services not provided by the department or organization.
- (h) Be involved in orientation and continuing education of all persons in the department.
- (i) Assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her Department as may be required by the Medical Staff Executive Committee or the Board of Directors.
- (j) Perform such other duties commensurate with his/her office as may from time to time be reasonably requested of him/her by the Chief of Staff, the Medical Staff Executive Committee, or the Board of Directors and where consistent with these Bylaws.
- (k) Vice Chief shall be a member of the Quality Council; and perform other duties as ordinarily pertain to that office or as may be assigned from time to time by the Department Chief.
- (l) The Immediate Past Chief shall be a member of the Capital Expenditure Committee.

10.4 DIVISION CHIEFS

10.4-1 QUALIFICATIONS

Each Division Chief shall be a member of the Active or Active Community Medical Staff and a member of the Division which he/she is to head, shall be qualified by training, experience, interest, and demonstrated current ability in the clinical area covered by the Division, and shall be willing and able to discharge the administrative responsibilities of his/her office.

10.4-2 SELECTION

Each Division Chief shall be elected by the Division.

10.4-3 TERM OF OFFICE

Each Division Chief shall serve a one-year term, commencing on his/her appointment. He/she shall serve until the end of the succeeding Medical Staff year and until his/her successor is chosen, unless he/she shall sooner resign or be removed from office. A Division

Chief may be removed by majority of the Board of Directors, the Medical Staff Executive Committee, the Department Executive Committee or the members of the Division. Grounds for removal shall be consistent with those listed in 10.1-7.

10.4-4 DUTIES

Each Division Chief shall:

- (a) Account to his/her Department Chief and to the Medical Staff Executive Committee for the effective operation of his/her Division.
- (b) Develop and implement, in cooperation with his/her Department Chief, and/or the Quality Assessment/Utilization Management Director, programs to carry out the quality review, evaluation, and monitoring functions assigned to his/her Division.
- (c) Exercise general supervision over all clinical work performed within his/her Division.
- (d) Conduct investigations and submit reports and recommendations to his/her Department Chief regarding the clinical privileges to be exercised within his/her division by members of, or applicants to, the Medical Staff.
- (e) Act as presiding officer at all Division meetings.
- (f) Perform such other duties commensurate with his/her office as may from time to time be reasonably requested of him/her by his/her Department Chief, the Chief of Staff, the Medical Staff Executive Committee or the Board of Directors.

No person shall occupy two of the following offices, General Officer, Department Officer, or elected Division Chief at the same time. He/she shall resign one or the other position.

ARTICLE 11 COMMITTEES

11.1 GENERAL

There will be enterprise committees (those serving all campuses, including MV and LG campuses) and campus-specific committees. The enterprise committees are designated as such – all others are campus-specific. Enterprise committees will have appropriate representation from members of both campuses.

11.1-1 DESIGNATION AND SUBSTITUTION

The committees described in this Article shall be the standing committees of the Medical Staff. Unless otherwise specified, the members of such committees and the chairman of such committees shall be appointed by the MV or LG Chief of Staff if the committee is a campus-specific committee; by the Enterprise Chief of Staff if an enterprise committee and is subject to Medical Staff Executive Committee approval. Unless specified, non-Medical Staff committee members shall be appointed by the Chief Executive Officer or his/her designee, subject to approval by the Medical Staff Executive Committee. Medical staff committees shall be responsible to the Medical Staff Executive Committee.

In addition, special committees may be created by the Medical Staff Executive Committee on an ad hoc basis to perform specified tasks. The members of special committees shall also be appointed by the Enterprise, MV, or LG Chief of Staff as appropriate, and is subject to the Medical Staff Executive Committee's approval.

11.1-2 TERMS AND REMOVAL OF COMMITTEE MEMBERS

Unless otherwise specified, a committee member shall be appointed for a term of one (1) year and shall serve until the end of this period and until his/her successor is appointed, unless he/she shall sooner resign or be removed from the committee. Any committee member who is appointed by the Enterprise, MV, or LG Chief of Staff as appropriate may be removed by a majority vote of the Medical Staff Executive Committee. Any committee member who is appointed by the Department Chief may be removed by a majority vote of the Department Executive Committee or the Medical Staff Executive Committee. The removal of any committee member who is automatically assigned to a committee because he/she is a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official pursuant to Article 10, Section 10.1-7.

11.1-3 VACANCIES

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

11.1-4 CONDUCT AND RECORDS OF MEETINGS

Committee meetings shall be conducted and documented in the manner specified for such meetings in Article 12.

11.1-5 VOTING

Practitioners in all categories may vote on committees to which they have been appointed.

11.2 CARE REVIEW COMMITTEE – *Enterprise Committee*

11.2-1 COMPOSITION OF COMMITTEE

The committee shall be multidisciplinary and shall include voting and non-voting members.

Voting Members shall consist of the following:

- (a) The Chairperson. The Chairperson must have been a past chief of staff or past department chief and will be appointed to an initial three (3) – year term by the current Enterprise Chief of Staff and subject to Medical Staff Executive Committee approval. The chair may serve subsequent three (3) year terms with approval of the Chief of Staff and MEC.
- (b) Members. The Immediate Past Chiefs of Staff from the MV and LG campuses and Immediate Chiefs of all Medical Staff Department and Divisions will serve on the committee. If appropriate, a physician from the department or division may be appointed to the committee by majority vote of the Department/Division Chief, Enterprise Chief of Staff and Chair of the Care Review Committee.
- (c) Members-At-Large. At-large members will be rotating to provide consistency, with representation from MV and LG campuses.

The At-large members shall be appointed by the CRC chair, with Enterprise Chief of Staff approval, to a three (3)-year term. The At-large member may serve subsequent three (3)-year terms with approval of the CRC chair and Enterprise Chief of Staff. There will be a maximum of three (3) at-large members.

Non-voting Members may include:

- (d) Medical Director of Quality and Patient Safety
- (e) Director Risk Management
- (f) Chief Medical Officer
- (g) Chief Nursing Officer
- (h) Associate Chief Medical Officer

11.2-2 MEETINGS

- (a) Committee shall meet monthly, or as needed, at the discretion of the chairperson.
- (b) The chair shall report to the Medical Staff Executive Committee monthly as a standing report.

11.2-3 DUTIES

The Care Review Committee shall perform the following duties:

- (a) Perform peer review. Cases will be referred to the committee from:
 - 1. Department Chiefs
 - 2. QA/UR Medical Directors
 - 3. Leadership Council
 - 4. Credentials Committee
- (b) Provide oversight and review of Medical Staff departmental peer review processes for consistency.
- (c) Identify hospital systems problems in the course of peer review.
- (d) Identify cases with educational value, in liaison with the Medical Director of continuing education, for presentation to continuing medical education program.
- (e) Act as ad hoc committee in the event that indications for surgical or other invasive procedures are questioned and intervention needs to be considered. The Medical Staff Executive Committee will act as the body to which an

- appeal may be presented.
- (f) Decide which data elements/indicators do not require physician review (informational letter only).
- (g) Review determinations from prior levels of review
 1. Quality Department
 2. Leadership Council
 3. Department Chiefs

If the Care Review Committee disagrees with the prior level of review, it may:

1. Send the matter back to Leadership Council or Department Chief with questions or concerns and/or ask that matter be reconsidered.
 2. Refer the matter to an individual Medical Staff member, another Medical Staff Committee or hospital department for review.
 3. Review the matter itself.
- (h) Determine who presents cases before the Care Review Committee
 1. Presenter of the case may be:
 - i. Department Chief
 - ii. Assigned Reviewer
 - iii. Appropriate Care Review Committee member
 2. Obtain additional clinical expertise if necessary
 - i. Internal
 - ii. External
 - (i) Develop Performance Improvement Plans (PIP) when warranted. A PIP may consist of (but is not limited to):
 1. Additional education/CME
 2. Prospective monitoring/review of a specific number of cases
 3. Second opinions/consults
 4. Concurrent proctoring
 5. Participation in formal evaluation/assessment program
 6. Additional training
 7. Educational LOA
 8. Other

11.3 CREDENTIALS COMMITTEE – *Enterprise Wide*

11.3-1 COMPOSITION

- (a) The chairperson of the Credentials Committee will be appointed to an initial three (3) year term by the current Enterprise Chief of Staff, subject to Medical Staff Executive Committee approval. The chair may serve subsequent three (3) year terms with approval of the Chief of Staff and subject to MEC approval.
- (b) The credentials committee shall consist of the Vice-Chiefs of Staff from LG and MV, Vice-Chiefs of each medical staff department/division and the chair of the Interdisciplinary Practice Committee and up to three (3) members- at-large, with at least one(1) member-at-large from each campus, Los Gatos and Mountain View.
- (c) The At-large members shall be appointed by the Credentials Committee chairperson, with Enterprise Chief of Staff approval, to a three (3) year term. The At-large members may serve subsequent three (3) year terms with approval of the chairperson and Enterprise Chief of Staff.

11.3-2 DUTIES

The credentials committee shall:

- (a) Review all recommendations from departments and divisions and provide recommendations to the Medical Staff Executive Committee regarding all applications for medical staff and allied health professional appointments, reappointments and privilege requests.
- (b) Review any question of appointment or privilege where there is a dispute between departments or divisions, or when a credentials committee review has been specifically requested.
- (c) Assist in development of privileging standards to ensure that credentialing and privileging are based on a consistent standard of care within the medical staff.
- (d) Recommend delineation of privilege forms and criteria, review and revision of privileging forms and processes, and review and approve credentialing policies and procedures.
- (e) Ensure focused professional practice evaluation (FPPE) of each practitioner applying for initial membership, privileges or modification of privileges is consistently implemented in accordance with the criteria defined by the Medical Staff's Policy.
- (f) Review the recommendation of the Department Chief to determine when each FPPE has been adequately completed and report to the MEC and Governing Board. The Credentials Committee and the Department Chief have the right to extend or shorten FPPE as needed.
- (g) Approve Ongoing Professional Practice Evaluation (OPPE) data elements and Focused Professional Practice Evaluation (FPPE) indicators recommended by departments.
- (h) Review recommendations from the Interdisciplinary Practice Committee on Advanced Practice Providers.
- (i) Review and report on matters referred by the Chief of Staff or Medical Staff Executive Committee regarding the qualifications, competence, conduct or professional character of any applicant or medical staff member during reappointment.
- (j) Submit monthly reports and recommendations to the Medical Staff Executive Committee.

11.3-3 MEETINGS

The committee will meet monthly, but may convene more frequently or be canceled as determined by the Chairperson. The committee may also meet electronically, as needed.

11.4 DEPARTMENT EXECUTIVE COMMITTEES – *Campus-Specific*

11.4-1 COMPOSITION

Each department designated in Article 9 shall have a Department Executive Committee including but not limited to the Department's Chief and Vice-Chief. The Department Chief will select members that are representative of the specialties and sub-specialties within the department whenever possible. The Department Chief may designate the department as a whole to act as the Department Executive Committee. The Department Chief shall act as Chairman of the Department

Executive Committee. The peer review portion of the Department Executive Committees will be attended by physicians, dentists, and/or podiatrists of the committee.

11.4-2 DUTIES

Each Department Executive Committee shall assist the Chief of the Department to carry out the functions described in Article 9.

11.4-3. MEETINGS

As often as necessary but at least quarterly.

11.5 LEADERSHIP COUNCIL – Enterprise Committee

11.5-1 COMPOSITION

The Leadership Council shall be comprised of the Chiefs of Staff from MV and LG campuses, Vice Chiefs of Staff from MV and LG campuses, and Immediate Past Chiefs of Staff from MV and LG campuses, Chief Medical Officer, Associate Chief Medical Officer (ex officio, no vote), Medical Director of Quality and Patient Safety (ex officio, no vote), other members for clinical expertise as needed (ex-officio, no vote). Support personnel will include the Director, Medical Staff Services (ex-officio, no vote), and the Supervisor, Medical Staff Services (ex-officio, no vote).

11.5-2 CHAIR

The committee will be chaired by the Enterprise Chief of Staff (Chief of Staff MV).

11.5-3 DUTIES

- (a) Performs prompt, initial review of complex* cases and handles matter if possible. Cases will be brought to the Leadership Council through the QRR process, or individuals with concerns may refer cases to the Leadership Council for review and disposition.
 - No further review or action
 - Address through alternate policy
 - Educational letter
 - Collegial interventionThe above will be reported to CRC.
- (b) Determines appropriate avenue for full review if needed
 - Further review is required, refer as appropriate, to:
 - Department Executive Committee
 - Expert reviewer of case, expert chosen in consultation with department chief
 - Care Review Committee – refer cases that are defined as complex
 - Medical Staff Executive Committee – requires immediate disciplinary action
 - Leadership Council will provide oversight of the cases that are referred until they are concluded.
- (c) Review new technology/procedures – refer to Care Review Committee if additional expertise is necessary.
- (d) Serve as the Nominating Committee for the Medical Staff Officer Elections. Submit nominations for MV and LG Chiefs of Staff and MV and LG Vice Chiefs of Staff as required by these Bylaws.

- (e) Review the Bylaws and the rules, regulations, procedures, and forms promulgated in connection therewith as necessary.
- (f) Submit recommendations to the Medical Staff Executive Committee and to the Board of Directors for changes in these documents as necessary to reflect current medical staff practices.
- (g) Receive and consider all matters specified in subparagraph (a) as may be referred by the Board of Directors, the Medical Staff Executive Committee, the Departments, the Chiefs of Staff and the Administrator/Chief Executive Officer.

***Definition of a complex issue:**

- Requires immediate or expedited review
- Involves practitioners from two or more departments or specialties
- Involves department chief
- Involves possible conflicts of interest
- Involves professional conduct, disruptive practitioner behavior
- Involves possible health issue
- Pattern has developed despite prior interventions
- Prior PIP; recurrence of issues
- EMTALA violations
- Serious Safety Event – if referred to Leadership Council due to need for peer review or medical staff input.

11.5-4 MEETINGS

Leadership Council will meet monthly or as needed (determined by the chair).

11.5-5 REPORTING REQUIREMENTS

Leadership Council reports directly to the Medical Staff Executive Committee with regard to activity/reviews performed, recommendations made, actions taken.

11.6 MEDICAL STAFF EXECUTIVE COMMITTEE (MEC) – *Enterprise Committee*

11.6-1 COMPOSITION

The Medical Staff Executive Committee members shall consist of:

- (a) The general officers of the Medical Staff as listed in Section 10.1-1; The Chair of Medical Staff Executive Committee will be the MV Chief of Staff. The Chair of Medical Staff Executive Committee will act as the Enterprise Chief of Staff.
- (b) The department chief(s) of all Medical Staff Departments. If the department chief is unable to attend a Medical Staff Executive Committee meeting, the immediate past chief or vice-chief may attend and vote in both General and Executive Sessions.
- (c) The Chief of each Hospital Division (Emergency, Radiology, Pathology, Hospitalist, and Anesthesia) or designee approved by the Enterprise Chief of Staff.

In addition, the following may attend General and Executive Sessions without vote:

- (a) The Chief Executive Officer;
- (b) The Chief Medical Officer;
- (c) Associate Chief Medical Officer;
- (d) The Medical Director of Psychiatric Services;
- (e) Medical Director of Quality and Patient Safety;
- (f) The Chair of the Care Review Committee;

- (g) The Medical Director of Neonatology Intensive Care Unit;
- (h) The Chief Nursing Officer;
- (i) Sr. Quality Director/Chief Quality Officer.

The following may attend the General Session (without vote). Executive Session attendance will be by invitation in order to discuss specific pertinent issues:

- (a) The Hospital Administrator of El Camino Hospital Los Gatos Campus;
- (b) The Santa Clara County Medical Association Councilor.

All members of the organized medical staff, of any discipline or specialty, are eligible for membership on the Medical Staff Executive Committee.

11.6-2 DUTIES

The duties of the Medical Staff Executive Committee (MEC) shall be to:

- (a) Represent and to act on behalf of the organized medical staff in the absence of a general staff meeting, subject to such limitations as may be imposed by these Bylaws.
- (b) The Medical Staff Executive Committee shall recommend Bylaws amendments to the organized medical staff for approval in accordance with Article 15 of these Bylaws.
- (c) The Medical Staff Executive Committee shall formulate, review, and propose to the Board of Directors any medical staff rule, regulations, policies/procedures, and amendments as needed and in accordance with Article 15 of these Bylaws.
- (d) Coordinate the activities and general policies of the Medical Staff not otherwise established as the responsibility of the Departments.
- (e) Receive and act upon Department, Division, and committee reports and requests evaluations of practitioners privileged through the medical staff process in instances where there is doubt about an applicant's ability to perform the privileges requested.
- (f) Implement policies of the Medical Staff not otherwise the responsibility of the Departments.
- (g) Provide liaison between the Medical Staff and the Administrator/ Chief Executive Officer and the Board of Directors.
- (h) Recommend action to the Administrator/ Chief Executive Officer/ Board of Directors on matters of a medico-administrative nature.
- (i) Make recommendations on Hospital management matters, such as long-range planning, to the Board of Directors through the Administrator/ Chief Executive Officer.
- (j) Fulfill the Medical Staff's responsibility of accountability to the Board of Directors for the medical care rendered to patients in the Hospital.
- (k) Assure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital.
- (l) Review the credentials of applicants through Department Chief reports and make recommendations to the Board of Directors for staff membership, assignments to departments, delineation of clinical privileges, disciplinary actions, and terminations.
- (m) Review periodically all information available regarding the performance and clinical competence of staff members, other practitioners, and allied health practitioners with practice privileges, and as a result of such review, make recommendations for reappointments and renewals or changes in clinical or practice privileges.

- (n) Take all reasonable steps to assure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff and allied health practitioners including the initiation of and/or participation in Medical Staff corrective or review measures when warranted.
- (o) Review and appoint Hospital's authorized representative for reporting purposes to the National Practitioner Data Bank.
- (p) Perform such other functions as may be assigned to it consistent with these Bylaws, by the Medical Staff, or by the Board of Directors.
- (q) Establish a mechanism for dispute resolution between Medical Staff members (including limited license practitioners) involving the care of a patient.
- (r) Makes recommendations directly to the Board of Directors with regard to the organized medical staff's structure.
- (s) Provide oversight in the process of analyzing and improving patient, physician, and employee satisfaction.
- (t) Monitors the quality of medical histories and physical examinations.

11.6-3 MEETINGS

Monthly or at the discretion of the chair.

11.7 PHYSICIAN HEALTH & WELL-BEING COMMITTEE – *Enterprise Committee*

11.7-1 COMPOSITION

The committee will at least be composed of licensed independent practitioners (LIPs) from the clinical specialties of Anesthesia, Surgery, Addiction Medicine and Emergency Medicine and representatives from Behavioral Health. Except for initial appointments, each member shall serve a term of at least three years and the term shall be staggered as deemed appropriate by the Medical Staff Executive Committee to achieve continuity. Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assessment committees while serving on the committee.

11.7-2 DUTIES

- (a) Receipt of Reports, Evaluation and Referrals: Receive reports related to the physical or mental health, well-being or impairment of LIPs, including reports of self-referrals or referrals by other organizational staff, and as it deems appropriate, evaluate such reports. For matters involving individual LIPs, the committee shall evaluate the credibility of a complaint, allegation, or concern and provide such advice, counseling, or referral to an appropriate internal or external professional resource for evaluation, diagnosis, and treatment of the condition or concern.
- (b) Confidentiality: The activities of this committee shall be confidential except as limited by law, ethical obligation, or when the health and safety of a patient is threatened. The Committee shall have no investigatory or disciplinary responsibility or any role in the corrective action process under these Bylaws.
- (c) Reporting: If information received by the Committee demonstrates that the LIP is providing unsafe treatment, that information shall be referred to the organized medical staff leadership for consideration of initiating an investigation under Section 8.1-2 of these Bylaws.
- (d) Monitoring: Review and monitor a LIP's progress in and adherence to any treatment program and the safety of patients until rehabilitation is complete and periodically thereafter, if required. Provide recommendations to other appropriate committees or officers regarding reasonable safeguards concerning a LIP's

continued practice in the Hospital while undergoing treatment, rehabilitation or during any disciplinary process. Appropriate actions will be initiated if a LIP fails to complete the required rehabilitation program.

- (e) Education: Consider general matters related to the health and well-being of the LIP, including educational programs about illness- and impairment-recognition issues specific to —LIPs or related patient safety in coordination with other appropriate committees.
- (f) Policy Setting: Establish guidelines for the management of licensed individual practitioners thought to be acting under the influence of chemical agents (reference Medical Staff Policy 7.1-2, Impaired Physicians, and Physician Health & Well-Being Committee Guidelines).

11.7-3 RECORDS/REPORTING

The committee shall maintain such records of its proceedings as it deems advisable, and shall report on its activities on a quarterly basis to the Medical Staff Executive Committee and the Board of Directors. Any records regarding individual licensed individual practitioners shall be kept strictly confidential and maintained independently from the general records of the committee and the affected licensed individual practitioner's credentials file, subject to any need for disclosure to protect patients.

11.7-4 MEETINGS

At least quarterly, or more often if necessary.

11.8 QUALITY COUNCIL – *Enterprise Committee*

11.8-1 COMPOSITION

The committee shall be composed of vice chiefs of Medical Staff Departments, Medical Director of Quality and Patient Safety, Senior Director of Quality and Patient Safety, , and other members as appointed by the Chief of Staff.

11.8-2 DUTIES

- (a) Review information on clinical path variances.
- (b) Assure uniform standards of care and heightened awareness of resource allocation in all Medical Staff and hospital departments. Optimal outcomes management will be emphasized.
- (c) Identify certain projects that require multidisciplinary action, hear results and follow-up on these actions.

11.8-3 MEETINGS

At least quarterly, or more often if necessary.

**ARTICLE 12
MEETINGS**

12.1 MEETINGS

12.1-1 GENERAL MEDICAL STAFF ANNUAL MEETING

There shall be an annual meeting of the Medical Staff members in June. The meeting shall be chaired by the Enterprise Chief of Staff – see Article 10, Officers of the Medical Staff. The Enterprise Chief of Staff, or such other officers as the Enterprise Chief of Staff or Medical Staff Executive Committee may designate, shall present a summary report on events of the preceding year and matters believed to be of interest and value to the membership. Notice of this meeting shall be given to the membership at least thirty (30) days prior to the meeting.

12.1-2 REGULAR MEETINGS

Regular meetings of the medical staff shall be held as determined by the Medical Staff Executive Committee and will be chaired by the Enterprise Chief of Staff. The date, place and time of the regular meetings shall be determined by the Medical Staff Executive Committee, and adequate notice shall be given to the members. The annual meeting shall count as a regular meeting of the Medical Staff.

12.1-3 AGENDA

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

- (a) Reading and acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting.
- (b) Administrative reports from the Administrator/ Chief Executive Officer, the Chief of Staff, the departments and committees.
- (c) Reports by responsible officers, committees, and departments on the overall results of patient care audit and other quality review, evaluation, and monitoring activities of the staff and on the fulfillment of the other required staff functions.
- (d) Recommendations for improving patient care within the Hospital.
- (e) Old business.
- (f) New business.

12.1-4 SPECIAL MEETINGS

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

12.2 COMMITTEE AND DEPARTMENT MEETINGS

12.2-1 REGULAR MEETINGS

Committees and departments, by resolution, may provide the time for holding regular meetings and no notice other than such resolution shall then be required. The Chairs shall make every effort to ensure that the meeting dates are disseminated to the members.

12.2-2 SPECIAL MEETINGS

A special meeting of any committee or department may be called by, or at the request of, the Chairman thereof, the Medical Staff Executive Committee, the Chief of Staff or by one-third of the group's current members eligible to vote, but not less than three (3) members.

12.3 NOTICE OF MEETINGS

Written notice stating the place, day, and hour of any regular or special committee or Department meeting not held pursuant to resolution shall be delivered either personally or by mail to each person entitled to be present thereat not less than seven (7) days before the date of such meeting, in the manner specified in Section 14.8, hereof. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

12.4 QUORUM

12.4-1 STAFF/COMMITTEE MEETINGS

A quorum for any regular or special meeting of the general medical staff shall consist of the presence of ten (10) percent of those eligible to vote. A quorum of fifty (50) percent of the voting members shall be required for Medical Staff Executive Committee meetings. For other Committees, a quorum shall consist of the majority of those present and voting.

12.4-2 IRB MEETINGS

At IRB meetings, a majority of the total membership must be present to transact business, one member to be a lay person.

12.5 MANNER OF ACTION

Except as otherwise specified; the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. Committee action may be conducted by telephone/electronic conference which shall be deemed to constitute a meeting for the matters discussed in that conference. Valid action may be taken without a meeting by a committee if it is acknowledged by a writing setting forth the action so taken which is signed by at least two-thirds of the members entitled to vote.

12.6 MINUTES

Minutes of all meetings shall be prepared and shall include a record of the attendance of members and the resultant conclusions, recommendations and actions taken on each matter. The minutes shall be signed by the presiding officer. Each Committee and Department shall maintain a permanent file of the minutes of each meeting in the Medical Staff Office.

12.7 ATTENDANCE REQUIREMENTS

Members of the Medical Staff are encouraged to attend meetings of the Medical Staff. Meeting attendance may be used by the Executive Committee in evaluating Medical Staff members at the time of reappointment.

12.8 SPECIAL APPEARANCE

Whenever an apparent or suspected deviation from standard clinical practice is involved, notice shall be given at least fourteen days (14) days prior to the meeting and shall include the time and place of the meeting, a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to

which he/she was given such notice, unless excused by the Medical Staff Executive Committee upon a showing of good cause, shall result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the Medical Staff Executive Committee may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Medical Staff Executive Committee, as provided in Section 7.3-4.

12.9 CONDUCT OF MEETINGS

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

ARTICLE 13
CONFIDENTIALITY, IMMUNITY, AND RELEASES

13.1 AUTHORIZATIONS AND CONDITIONS

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

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

13.2 CONFIDENTIALITY OF INFORMATION

13.2-1 GENERAL

Records and proceedings of all Medical Staff committees having the responsibility of evaluation and improvement of quality of care rendered in this hospital, 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 Article 14, and meetings of special or ad hoc committees created by the Medical Staff Executive Committee or by departments and including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential.

13.2-2 BREACH OF CONFIDENTIALITY

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

13.3 IMMUNITY FROM LIABILITY

13.3-1 FOR ACTION TAKEN

Each representative of the Medical Staff and hospital shall be immune, to the fullest extent provided 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 duties exercised as a representative of the Medical Staff, hospital or El Camino Hospital District.

13.3-2 FOR PROVIDING INFORMATION

Each representative of the Medical Staff and hospital and all third parties shall be immune, to the fullest extent provided 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 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.

13.4 ACTIVITIES AND INFORMATION COVERED

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

- (a) application for appointment, reappointment, or clinical privileges;
- (b) corrective action;
- (c) hearings and appellate reviews;
- (d) department, or division, committee, or Medical Staff activities conducted in executive sessions; and
- (e) queries and reports concerning the National Practitioner Data Bank, peer review organization, the Medical Board of California, and similar queries and reports.

13.5 RELEASES

Each applicant or member shall, upon 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 effectiveness of this Article.

13.6 INDEMNIFICATION

The hospital shall indemnify, defend and hold harmless the Medical Staff and its individual members from and against losses and expenses (including attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities, as long as such activities are subject to a privilege afforded by State or Federal law. These activities include, but are not limited to, (1) as a member of or witness for a Medical Staff department, service, committee or hearing panel, (2) as a member of or witness for the hospital board or any hospital task force, group, or committee, and (3) as a person providing information to any Medical Staff or hospital group, officer, board member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a Medical Staff member or applicant. The Medical Staff or member may seek indemnification for such losses and expenses under this bylaws provision, statutory and case law, any 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 may choose. Payment of any losses or expenses by the Medical Staff or member is not a condition precedent to the hospital's indemnification obligations hereunder.

**ARTICLE 14
GENERAL PROVISIONS**

14.1 RULES AND REGULATIONS

14.1-1 MEDICAL STAFF RULES AND REGULATIONS

The Medical Staff Rules and Regulations may be adopted, amended or repealed by the Medical Staff Executive Committee subject to approval of the Board of Directors, which approval shall not be withheld unreasonably. Neither body may unilaterally amend the Rules and Regulations.

14.1-2 DEPARTMENT GUIDELINES

Subject to approval of the Medical Staff Executive Committee, each Department shall formulate and approve its own guidelines, each Clinical Service shall formulate and approve its own protocols, and each committee its own standing orders.

Such guidelines, protocols and standing orders shall not conflict with these Bylaws, the rules and regulations of the Medical Staff, or other policies of the Staff and Hospital. When adopted and approved by the Medical Staff Executive Committee, the guidelines, protocols and standing orders shall have the same force and effect as these Bylaws.

14.2 DUES

Active, Provisional, Courtesy, Active Community, and Affiliate Staff members are required to pay annual dues. A failure to pay such dues shall result in those actions specified in Section 7.3-8. The Medical Staff Executive Committee shall have the authority to set the amount of annual dues, if any, for each category of Medical Staff membership and the amount of the processing fee for initial applications, and to determine the manner of expenditure of funds received.

14.3 CONSTRUCTION OF TERMS AND HEADINGS

Words used in these Bylaws shall be read as the masculine or feminine gender and as the singular or plural as the context and circumstances require. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

14.4 AUTHORITY TO ACT

Action of the Medical Staff in relation to any person other than the members thereof shall be expressed only through the Chief of Staff or the Medical Staff Executive Committee, or his/her or its designee, and they shall first confer with the Administrator. Any member or members who act in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Staff Executive Committee or Board of Directors may deem necessary.

14.5 ACCEPTANCE OF PRINCIPLES

All members of whatever class or category, by application for membership in this Medical Staff, do thereby agree to be bound by the provisions of these Bylaws, a copy of which shall be delivered to each member on his/her initial appointment, and a copy of each amendment thereto, promptly after adoption. Any violation of these Bylaws shall subject the applicant or member to such disciplinary action as the Medical Staff Executive Committee or Board of Directors shall direct.

14.6 DIVISION OF FEES

The practice of the division of professional fees under any guise whatsoever is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff.

14.7 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests, and other communications required or permitted to be served on or given to a party or parties by another, pursuant to these Bylaws, shall be in writing and shall be delivered personally or by United States Postal Service, first-class postage prepaid, certified or registered, return receipt requested.

In the case of notice to hospital, Board of Directors, Medical Staff or officers or committee thereof, the notice shall be addressed as follows:

El Camino Hospital
2500 Grant Road
Mountain View, CA. 94039-7025

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

14.8 SECRET WRITTEN BALLOT

Whenever these Bylaws require voting by secret, written mail ballot, the mail ballots shall be returned in an unmarked envelope, which shall be placed inside a properly identified return envelope on which the staff member has printed and signed his/her name, and their participation shall be confidential. The staff member's name shall be verified against the Medical Staff records. Whenever electronic voting is utilized, appropriate safeguards for confidentiality shall be implemented as determined by the Medical Staff Executive Committee.

14.9 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff offices, department chief, or the Medical Staff Executive Committee shall, at least 5 days prior to the date of election or appointment, disclose in writing to the Medical Staff Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. Such disclosures shall also be made during physician's term as they occur.

ARTICLE 15
ADOPTION AND AMENDMENT OF MEDICAL STAFF DOCUMENTS

15.1 MEDICAL STAFF RESPONSIBILITY

The Medical Staff shall have the responsibility to formulate, review, adopt and propose to the Board of Directors the Medical Staff documents and amendments thereto which shall be effective when approved by the Board of Directors, which approval shall not be withheld unreasonably. The medical staff exercises this responsibility regarding Bylaws through direct vote of its medical staff members who are eligible to vote. The medical staff exercises this responsibility regarding Rules and Regulations and Policies/Procedures through its elected and appointed leaders via the Medical Staff Executive Committee. Such responsibility shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized professional level of quality and efficiency and of maintaining a harmony of purpose and effort with the Board of Directors and with the Community.

15.1-1 MEDICAL STAFF DOCUMENTS

Medical Staff documents consist of the following:

- (a) Medical Staff Bylaws
- (b) Medical Staff Rules & Regulations – attached to these Bylaws
- (c) Medical Staff Policies/Procedures – located in Medical Staff Policy Binder
- (d) Allied Health Professionals Policy Manual – located in Medical Staff Policy Binder

15.2 PROCEDURE FOR AMENDMENTS/ADOPTION MEDICAL STAFF DOCUMENTS

- (a) Medical Staff Bylaws: Amendments to the Bylaws occur through direct vote of the medical staff members. Proposed amendments occur in one of the following ways:
 - 1. Upon the request of (i) the Medical Staff Executive Committee (MEC), (ii) the Chief of Staff or Bylaws Committee after approval by the Medical Staff Executive Committee.
 - 2. The organized medical staff (OMS) has the ability to adopt medical staff bylaws, rules, regulations, and policies, and amendments thereto, and to propose them directly to the Board of Directors. Proposed amendments to the Bylaws or Rules and Regulations may be originated by the Medical Staff Executive Committee or by a petition signed by twenty-five percent (25%) of the voting members of the medical staff. Any amendments proposed by this procedure must be in writing and accompanied by a written description of the reasons for the amendment. Proposals received in this manner will then follow the usual and customary method of voting for an amendment prior to the proposal being forwarded to the Board of Directors for approval.
 - When proposed by the Medical Staff Executive Committee, there will be communication of the proposed amendment to the OMS before a vote is taken by the OMS.
 - When proposed by the OMS, there will be communication of the proposed amendment to the Medical Staff Executive Committee before a vote is taken by the OMS.
- (b) Medical Staff Rules and Regulations: The OMS delegates authority for amendments to the Rules and Regulations to the Medical Staff Executive Committee. Proposed amendments to these Rules and Regulations may be originated by the Medical Staff Executive Committee or by a petition signed by twenty-five percent (25%) of the voting members of the OMS.

1. When proposed by the Medical Staff Executive Committee, there will be communication of the proposed amendment to the OMS before a vote is taken by the Medical Staff Executive Committee.
 2. When proposed by the OMS, there will be communication of the proposed amendment to the Medical Staff Executive Committee. If the Medical Staff Executive Committee does not pass the proposed amendment to the Rules and Regulations, the OMS can ask for a medical staff vote using the mechanisms noted in the conflict resolution process (Article 15.2-1).
- (c) The Medical Staff Executive Committee and Board of Directors may adopt such provisional amendments to these Rules and Regulations that are in the Medical Staff Executive Committee's and Board's judgments necessary for legal or regulatory compliance without first communication to the OMS. After adoption, these provisional amendments to the Rules and Regulations will be communicated to the OMS for their review. If the OMS does not approve of the provisional amendment, this will be resolved using the conflict resolution mechanism noted in Article 15.2-1. If a substitute amendment is then proposed, it will follow the usual approval process.
- (d) Medical Staff Policies/Procedures – Allied Health Procedures: The OMS delegates authority for amendments to the Policies/Procedures to the Medical Staff Executive Committee. When the Medical Staff Executive Committee adopts a policy or amendment thereto, there will be communication of the policy or amendment to the OMS.

15.2-1 CONFLICT RESOLUTION (Between OMS and the MEC)

Any conflict between the OMS and the Medical Staff Executive Committee will be resolved using the mechanisms noted below:

- (a) Each medical staff member eligible to vote may challenge any rule or policy established by the Medical Staff Executive Committee through the following process:
1. Submission of written notification to the Enterprise Chief of Staff of the challenge and the basis for the challenge, including any recommended changes to the rule or policy.
 2. At the meeting of the Medical Staff Executive Committee that follows such notification, the Medical Staff Executive Committee shall discuss the challenge and determine if any changes will be made to the rule or policy.
 3. If changes are adopted, they will be communicated to the OMS, at such time each medical staff member eligible to vote may submit written notification of any further challenges(s) to the rule or policy to the Enterprise Chief of Staff.
 4. In response to a written challenge to a rule or policy, the Medical Staff Executive Committee may, but is not required to, appoint a task force to review the challenge and recommend potential changes to address concerns raised by the challenge.
 5. If a task force is appointed, following the recommendations of such task force, the Medical Staff Executive Committee will take final action on the rule or policy.
 6. Once the Medical Staff Executive Committee has taken final action in response to the challenge, with or without recommendations from a task force, any medical staff member may submit a petition signed by twenty-five percent (25%) of the medical staff members eligible to vote requesting review and possible change of a rule, regulation, policy, or procedure. Upon

presentation of such a petition, the adoption procedure outlined in Article 15.2 will be followed.

- (b) If the OMS votes to recommend directly to the Board an amendment to the Bylaws, Rules and Regulations, or Policy/Procedure that is different from what has been recommended by the Medical Staff Executive Committee, the following conflict resolution process shall be followed:
 - 1. The Medical Staff Executive Committee shall have the option of appointing a task force to review the differing recommendations of the Medical Staff Executive Committee and the medical staff, and recommend language to the Bylaws, Rules and Regulations or Policy/Procedure that is agreeable to both the OMS and the Medical Staff Executive Committee.
 - 2. Whether or not the Medical Staff Executive Committee adopts modified language, the medical staff shall still have the opportunity to propose directly to the Board of Directors the alternative language. If the Board receives differing proposals for amendments for Bylaws, Rules and Regulations, or a policy from the Medical Staff Executive Committee and the OMS, the Board shall also have the option of appointing a task force of the Board to study the basis of the differing recommendations and to recommend appropriate Board action. Whether or not the Board appoints such a task force, the Board shall have final authority to resolve the difference between the OMS and the Medical Staff Executive Committee.
- (c) At any point in the process of addressing a disagreement between the OMS and the Medical Staff Executive Committee regarding the Bylaws, Rules, Regulations, or Policy/Procedures, the OMS, the Medical Staff Executive Committee, or the Board of Directors shall each have the right to recommend utilization of an outside resource to assist in addressing the disagreement. The final decision regarding whether or not to utilize an outside resource, and the process that will be followed in so doing, is the responsibility of the Board of Directors.

15.3 METHODOLOGY

Neither the Board of Directors nor the Medical Staff may unilaterally amend the Medical Staff Bylaws. Medical Staff Bylaws may be adopted, amended or repealed by the following combined action:

15.3-1 STAFF MEMBERS

- (a) The affirmative vote of a majority of the medical staff members eligible to vote Staff Members voting on this matter by secret written ballot, or
- (b) By the affirmative vote of a majority of those eligible staff members voting by electronic voting, method to be determined by the Medical Staff Executive Committee.
- (c) The method of voting will be determined by the Medical Staff Executive Committee and at least fourteen (14) days prior written notice, accompanied by the proposed Bylaws and/or amendments, will be provided to Staff Members eligible to vote.

15.3-2 BOARD OF DIRECTORS

Amendments will be approved by the affirmative vote of a majority of the Board of Directors. If approval is withheld, the reason for doing so shall be so specified by the Board of Directors in writing and shall be forwarded to the Medical Staff Executive Committee and Bylaws Committee.

**ADOPTED by the Medical Staff
on: December 28, 2018**

**APPROVED by the Board of Directors
on: January 16, 2019**

Previous approvals: 8/2015; 1/2016; 4/2017; 10/2018

**EL CAMINO HOSPITAL
MEDICAL STAFF
RULES AND REGULATIONS**

Appendix I

A. ADMISSIONS/DISCHARGES

1. Patients shall be admitted only under the care of a qualified member of the Medical Staff. The attending physician must be available to the admitted patient at all times or must arrange such coverage.

Allied health practitioners may initiate arrangements for admission and complete charts and forms pertinent to the admission and the medical record if privileged to do so within their scope of practice and under the supervision of the attending physician (if applicable).

2. Except in an emergency, patients shall not be admitted to the Hospital until a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon as possible after admission.
3. Medical Staff members admitting patients shall be held responsible for giving such information as may be necessary or appropriate to assure the protection of other patients from those who are a source of danger from any cause whatsoever.
4. According to policy of Medical Staff (see Operating Room Committee policy), pre-operative lab work shall be ordered at the discretion of the admitting surgeon. If pre-op lab work is ordered, the attending surgeon will be responsible for either including a copy of the lab work in the chart or in the dictated H&P or the admission note in the progress notes.
5. Potassium levels shall be obtained within 72 hours of surgery for all patients on potassium depleting diuretics.
6. All laboratory procedures, for patients being investigated or treated within the Hospital, shall be done in the Hospital except in those circumstances where the Hospital refers laboratory work outside the Hospital.
7. Decisions concerning the use of reference laboratories for studies not performed in the Hospital shall be delegated to the director of the medical laboratory services.
8. Each patient on admission shall be provided with a wristband unless the patient's condition will not permit such identification. Minimum information shall include the name of the patient and the Hospital admission number.
9. Patients shall not be routinely admitted to a distinct part of the Hospital unless it is appropriate for the level of care required by those patients.
10. Patients with critical burns shall be treated in a Burn Center unless transfer of the patient to the center is contraindicated in the judgment of the attending physician.
11. Any outpatient psychotherapist arranging for inpatient psychiatric care of his/her patient at El Camino Hospital will share with the ECH treatment team all

information relevant to the patient's treatment. When the outpatient therapist is not the admitting psychiatrist, a special effort should be made to inform the admitting psychiatrist of all relevant treatment issues. This communication is for purposes of ensuring optimal short-term patient care. Information must be held in strict confidence within the treatment setting, but the availability of relevant information to the treatment team is essential to provide adequate and appropriate therapy.

12. A mentally competent adult shall not be detained in the Hospital against his will. An unemancipated minor shall not be detained against the will of his parent or legal guardian. In those cases where the law permits an unemancipated minor to contract for medical care without the consent of his/her parent or guardian, he/she shall not be detained in the Hospital against his/her will. This provision shall not be construed to preclude or prohibit attempts to persuade a patient to remain in the Hospital in his own interest nor the detention of a mentally disordered patient for the protection of himself or others under the applicable provisions of the Welfare and Institutions Code, Section 5000, et seq., until transfer to an appropriate facility can be arranged.
13. Patients shall not be transferred or discharged for purposes of effecting a transfer from the Hospital to another health facility unless arrangements have been made in advance for admission to such health facility and the person legally responsible for the patient has been notified or after reasonable attempts have been made to notify the responsible person. A transfer or discharge shall not be carried out if, in the opinion of the patient's physician, such transfer or discharge would create a medical hazard.
14. A minor shall be discharged only to the custody of his or her parent or to his legal guardian or custodian, unless such parent or guardian shall otherwise direct. This provision shall not be construed to preclude a minor legally contracting for medical care from assuming responsibility for himself upon discharge.
15. Patients may only be discharged upon the order of a Medical Staff member.
16. In the event that a hospitalized patient refuses treatment by a physician, the affected physician will:
 - a. Communicate with the patient with regard to what he/she needs (tests, follow-up care, etc).
 - b. Ask a physician in his/her call group or specialty to take over care of the patient or,
 - c. Ask the chief of department or chief of staff for assistance in assigning another physician to care for the patient.

If the affected physician is acting as a consultant, the primary physician will find another consultant, absent an emergency situation. The primary physician is always responsible for the patient's care in the immediate emergency situation absent the patient's direct wishes to not be cared for in the interim.

- 17a. Prior to initiation of definitive therapy at El Camino Hospital which is based on interpretation of a biopsy or cytology done at an outside lab, it is strongly recommended that review and report of the findings must be documented by an ECH pathologist.

- 17b. Prior to initiation of definitive therapy for breast cancer at El Camino Hospital which is based on interpretation of a biopsy or cytology done at an outside lab, review and report of the findings must be documented by an ECH pathologist.

B. RECORDS

The responsible staff member shall be accountable for the preparation of a complete medical record for each patient. Unless otherwise provided in standing orders, protocols, or guidelines, a record shall include (a) identification data; (b) chief complaint; (c) details of present illness; (d) relevant past, social, and family histories; (e) inventory of body systems; (f) complete physical examination; (g) provisional diagnosis; (h) consultation reports; (i) reports from laboratory, i.e., pathology, radiology, etc.; (j) progress notes detailing medical surgical treatment that reflect any change in condition and results of treatment; (k) reports of procedures (also see below), e.g., nuclear medicine, radiology, anesthesia; (l) principal & secondary diagnosis(es); (m) discharge summary, discharge instructions; (n) follow-up plans; and (o) appropriate consents; and (p) autopsy results, if applicable. All entries shall be dated, timed, and authenticated by the appropriate practitioner. Any entries made for the practitioner (fellow, resident, physician assistant, etc.) must be dated, timed, and counter-signed by the practitioner, except emergency department (ED) reports. ED assessments may be dictated and signed by the responsible nurse practitioner or physician's assistant, and must include the name of the supervising ED physician. The ED physician must document in the ED record that he/she has reviewed the assessment and care provided.

Medical Records may be authenticated by a computer key code, in lieu of a physician's signature, only when that physician has placed a signed statement in the hospital administrative offices to the effect that he/she is the only person who has possession of the key code and the only person who will use the key code. Signature/authentication by a practitioner other than the author is permitted only when the author is unavailable, but not for convenience or as common practice.

History & Physical (H&P)

1. H&P must be completed by a practitioner privileged to perform H&Ps – these are defined as:
 - a. MD/DO
 - b. DDS/DMD
 - c. DPM
 - d. Nurse Practitioner – must be countersigned by supervising practitioner within 14 days of the patient's discharge.
 - e. Certified Nurse Midwife
 - f. Physician Assistant – must be countersigned by supervising practitioner within 14 days of the patient's discharge.

2. H&P must be completed and documented for each patient no more than 30 days before or *within* 24 hours *of* admission *or registration*, but prior to surgery or procedure requiring anesthesia services.

At a minimum, the following systems must be included in the H&P:

- a. Heart and lungs
- b. Abdomen
- c. General appearance and orientation
- d. Vital signs (including blood pressure, heart rate, respiratory rate, and temperature – afebrile is acceptable) or reference to vital signs obtained

- e. elsewhere in the admission process
- f. Major integumentary
- g. Musculoskeletal or sensory systems when problems such as blindness, deafness, missing limbs, or open sores and wounds exist
- h. Rectal/pelvic examinations are recommended when pertinent to the admission diagnosis
- i. Salient features of the case
- j. Drug tolerances
- k. Pertinent positive and negative findings that relate to the reason for admission.

Outpatients receiving local anesthesia or conscious sedation require, as a minimum, a current statement of present illness, a statement of absence of infection or intercurrent disease, a description of cardiorespiratory status, known allergies, current medications, and a preoperative diagnosis.

Obstetrical records should include all pertinent and significant prenatal information. A durable, legible original or reproduction of the office or clinical prenatal record is acceptable. The report of the physical examination shall reflect a comprehensive current physical assessment

ECT Patients - For patients receiving a series of ECT treatments, the history and physical must be within thirty (30) days prior to the initial treatment. For subsequent treatments within the same series, an update to the H&P will be required (the update must include auscultation of the lungs and heart and any significant change in condition or absence of any significant change). This may be documented on the anesthesiologist pre-anesthesia assessment form.

3. **Updates:** When the H&P is conducted within 30 days of admission (inpatient or outpatient), an updated examination, including any changes in the patient's condition, must be completed and documented by a qualified practitioner (see #1 in this section) within 24 hours of admission (inpatient or outpatient) or registration, but prior to surgery or a procedure requiring anesthesia services when the H&P was completed within the previous 30 days.
 - a. The update must include review of the H&P, updated examination including auscultation of the lungs and heart, and any significant change in condition or absence of any significant change from the previous report. If the patient is an inpatient, the update may be documented in the progress note or on the 'Procedure Notes' form.
4. If the reviewing practitioner finds the H&P incomplete, inaccurate, or otherwise unacceptable, he/she may disregard the H&P and perform a new H&P within 24 hours or prior to surgery/procedure as noted above.

Other Medical Record Documentation:

1. **Pre-Anesthetic and Post-Anesthetic Notes**
There shall be pre-anesthetic and post-anesthetic notes documented in the medical record which include the anesthesiologist's pre-anesthetic evaluation, the patient's condition upon admission to the Post Anesthesia Care Unit, a description of the post-operative course, a description of any anesthesia complications, and a description of the patient's condition upon discharge from the Post Anesthesia Care

Unit.

2. Operative Reports

The immediate post-operative note must be entered in the medical record before the patient is transferred to the next level of care. This documentation includes the name(s) of the primary surgeon and assistants, procedures performed and a description of each procedure finding, estimated blood loss, specimens removed, and complications, if any; condition at the end of the case, and postoperative diagnosis. This documentation must be documented in the electronic medical record on the 'post procedure note'. Downtime paper forms may be used when the EMR is not functional.

The comprehensive operative report describing techniques, findings, and tissues removed or altered must be written or dictated within 24 hours of surgery and signed by the surgeon.

- Date and times of the surgery;
- Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision);
- Pre-operative and post-operative diagnosis;
- Name of the specific surgical procedure(s) performed;
- Type of anesthesia administered;
- Complications, if any;
- A description of techniques, findings, and tissues removed or altered;
- Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues); and
- Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.

3. Progress notes shall be written/dated/timed/signed on each day of the hospital stay and within 24 hours of discharge by the attending physician, his/her associate, or his/her designated PA or NP with El Camino Hospital privileges.

4. Orders for treatment and tests must be entered into the computer system by the Medical Staff member or authorized person at the direction of the staff member. When ordering diagnostic CT, MRI, PET, or nuclear medicine imaging exams, the practitioner should consider the patient's age and recent imaging exams. Drug and treatment orders must be appropriately signed within forty-eight (48) hours. All other orders must be signed within seventy-two (72) hours or prior to the discharge or transfer of the patient. Telephone orders shall immediately be recorded and then read back to the staff member for confirmation, shall be signed by the person to whom dictated with the name of the Medical Staff member per his own name, and shall be signed by the Medical Staff member within the prescribed time limits.

Persons authorized to accept orders defined: Persons to accept and transcribe orders at the direction of Staff Member shall include the nursing staff, pharmacists, and those persons designated by department guidelines or service protocols in conformity with applicable statutory provisions.

Orders and patient referrals for outpatient services shall be accepted from any member of the El Camino Hospital Medical Staff or Allied Health Professional Staff who holds a current, unrestricted California license and is privileged to do so.

Practitioners (physicians, podiatrists, dentists, and other allied health professionals) who are not members of the El Camino Hospital Medical Staff or Allied Health Professional Staff may order outpatient services and refer patients for outpatient services in accordance with the provisions and condition set forth below.

- a. If the ordering practitioner is not a member of the El Camino Hospital Medical Staff or Allied Health Professional Staff, verification that the practitioner is licensed and acting within his/her scope of practice in the State in which he/she sees the patient shall be obtained by the outpatient department(s) prior to performing or providing the test, study, or outpatient service. The license shall be verified via the appropriate website or by obtaining verbal verification from the appropriate licensing board by the department providing the service. In addition, a telephone number for the ordering practitioner will be verified by the outpatient department(s) prior to performing or providing the test, study, or outpatient service.
- b. Orders for outpatient services must include the name of the patient, the date of the order, the test or treatment to be performed, and the reason for the test or treatment to be performed (symptoms or diagnosis). Orders for outpatient diagnostic tests (i.e., laboratory, radiology exams, EKG, etc.) may be submitted on a requisition form, a prescription/order form from the practitioner's office, or may be telephoned to the appropriate department by the practitioner's office staff with follow-up written orders.
- c. Results shall be directly sent to the ordering practitioner unless otherwise requested by the ordering practitioner.
- d. Practitioners who are not members of the El Camino Hospital Medical Staff or Allied Health Professional Staff may order or refer patients for all outpatient services provided by El Camino Hospital except for chemotherapy orders.

Verbal or telephone orders must be signed/authenticated, dated and timed by the author within 48 hours. Faxed or electronic signatures may be used to authenticate a verbal or telephone order. Signature/authentication by a practitioner other than the author is permitted only when the author is unavailable, but not for convenience or as common practice. Verbal or telephone orders should be limited to those situations in which it is impossible for the prescriber to enter it into a computer.

In the case of an incorrect order, the practitioner must document in the medical information system or on the Unsigned Orders Summary, that the order was entered incorrectly.

5. A Record of Newborn must be completed for each normal newborn. The Admission Examination must be completed within twenty-four (24) hours of birth by the attending physician.
6. Medical Screening Exams (as defined under the Emergency Medical Treatment and Labor Act) shall be performed and documented in the Emergency Department and Labor and Delivery. Medical Screening Exams shall be performed by a credentialed MD, DO, certified nurse midwife, Emergency Department physician assistants under appropriate supervision and within scope of practice, or, in the case of a patient

presenting with pregnancy and/or signs and symptoms of labor, RNs who have demonstrated current competence (per hospital policy) in assessing the laboring patient.

7. A discharge summary is required on all stays over forty-eight (48) hours, except for uncomplicated obstetrical cases and normal newborns. Discharge summaries are also required for patients who are transferred to another acute care facility or who die within forty eight (48) hours, and shall be written or dictated at the time of discharge, transfer or death.

A discharge summary should briefly recapitulate the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient on discharge, medications, and any specific instructions given to the patient and/or family regarding follow-up care.

For stays less than forty-eight (48) hours, a final progress note may be completed in lieu of a discharge summary unless the patient is transferred or dies. If a discharge summary is not required, the following information must be included in the final progress note: diagnosis, condition of the patient, diet, activity, medications, and follow-up instructions (if not covered with a preprinted form).

8. Discharge instructions are required on all hospital stays, including short-stay and cancelled surgeries. Discharge instructions must include the following elements: 1) Discharge medication reconciliation; 2) discharge diet; 3) follow-up appointments; 4) activity level; 5) signs/symptoms to watch for.
9. In the event of a death, a discharge summary should be added to the record which the physician must authenticate. The final summary should indicate the reason for admission, the findings, course in the hospital including significant conditions (present on admission and comfort care), and immediate cause of death.
10. When a necropsy is performed, the provisional anatomic diagnosis should be recorded on the medical record within seventy-two (72) hours and a final completed report shall become a part of the record.
11. The records of discharged patients will be completed within 14 days following discharge.
12. All forms designed to become a part of the medical record must be approved by the Medical Records Committee and by the Medical Staff Executive Committee.
13. Procedures for making changes or amendments to record entries:
 - a. Any individual who discovers an error or omission of his or her own shall immediately upon discovery correct it and do so in accordance with the procedures in this section.
 - b. Simple corrections may be made during the actual writing of a record entry and shall be lined through (not obliterated), initialed and dated/timed.
 - c. Errors or omissions discovered at a later time shall be corrected by a separate entry to the appropriate portion of the record. The original entry shall be lined out (not obliterated).

14. **Physician Review of Medical Records**
A physician may request to review a chart only when he/she is actively involved in that patient's care or if reviewing the case for official peer review or quality assessment purposes. Any abuse of this privilege may result in disciplinary action.

15. **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**
This Act, as implemented by the HIPAA Privacy Regulation (42 CFR Parts 160 and 164) requires that El Camino Hospital implement policies and procedures to protect the privacy and security of "protected health information" and to afford patients certain rights with regard to their information. "Protected health information" includes any health-related information that identifies or could be used to identify an individual, including patient medical and billing records. HIPAA applies both to the Hospital and to the members of the Medical Staff
 - a. El Camino Hospital has adopted privacy practices for the use and disclosure of patient information within the Hospital. These privacy practices are summarized in the Hospital's Notice of Privacy Practices, which is furnished to patients and posted at the Hospital's facilities.
 - b. The Notice of Privacy Practices applies to all patient health information created or received in the course of providing health care or conducting business operations at any hospital operated location. The Notice is given jointly on behalf of the Hospital and the members of the Medical Staff. It does not, however, apply to patient health information at other locations, such as a Medical Staff member's private office.
 - c. Each member of the Medical Staff shall abide by the terms of the Notice of Privacy Practices and with the Hospital's policies and procedures for health information privacy and security, as amended from time to time. Medical Staff members must adopt their own notice of privacy practices at their private offices as necessary to comply with the Privacy Regulations.

C. REMOVAL OF ORIGINAL RECORDS FROM THE HOSPITAL

Original records may be removed from the Hospital's custody only pursuant to court order, subpoena or statute, with exception of x-rays and other images, tracings, recordings and clinical and anatomical pathological materials which are sought for purposes of continuing care of the patient.

D. AUTOPSIES

Every member of the Medical Staff shall try to secure permission for autopsy when appropriate. No autopsy shall be performed without the written consent of the appropriate party. All autopsies shall be performed by the hospital pathologist(s) or by a physician to whom he may delegate the duty. In all cases where any doubt exists regarding the legal status of death, the coroner shall be notified and request for an autopsy made. (Indications for autopsy are found in the Pathology Department Policy "Autopsies for QA – Indications for Autopsy".)

E. CONSULTATIONS

Consultation(s) shall be obtained by all Medical Staff members whenever the patient appears to be developing unexpected complications or untoward results which threaten life or serious harm, either from the failure of the patient to appropriately respond to the therapy being given and/or substantial medical uncertainty in diagnosis and management.

The Consultant shall document the fact that all available, pertinent past medical records were examined.

F. MANDATORY CONSULTATIONS

Mandatory consultation(s); in specific, urgent or critical clinical conditions; may be imposed at the discretion of a Medical Staff officer, department or division chief or their designees with concurrence of a Medical Staff officer. Mandatory consultations may be imposed on any staff member in a specific urgent clinical management problem and/or as an overall continuing requirement in all similar types of clinical management cases.

Mandatory consultations may be imposed by departments or division guidelines for all staff members or classes of members in specific clinical conditions, subject to approval of the Medical Staff Executive Committee.

The consultant in a specific urgent or critical situation may or may not be a staff member, but must be a practitioner with acknowledged expertise. Temporary privileges, if necessary, may be granted at the discretion of an appropriate Department Chief, Chief of Staff, and Hospital Administration and are subject to Sections 6.5-1 and 14.2 of the Bylaws.

The imposition of mandatory consultation requirements on a member in a specific, urgent or critical clinical condition, or such imposition on all members or a class of members, does not constitute a reduction in privileges. Mandatory consultation requirements constitute a reduction in privileges of a member when the requirement is imposed on the individual member and as a continuing requirement in all similar cases.

Patients who have attempted suicide prior to or during their hospitalization, or who have suicidal ideation identified following hospitalization, must be evaluated for suicidal risk prior to discharge. Such evaluation is to be done by a psychiatrist or by a member of the Behavioral Health Services staff who must then review the case with a psychiatrist prior to discharge.

If an inpatient is on an involuntary psychiatric hold (i.e. 5150 or 5152); then a psychiatrist must evaluate the patient directly prior to such a hold being released.

G. PATIENT COVERAGE

Each staff member is responsible to respond to an emergency involving a member's patient or have a substitute staff member respond. In case of failure to respond, the Medical Staff officers or department executive officers of the appropriate department or service shall have the authority to request emergency services from any staff member. When a staff member finds a substitute for coverage of his practice that substitute physician must be a member in good standing of the El Camino Hospital Medical Staff with similar scope of privileges and will assume all duties of the primary physician.

H. HOSPITAL SERVICES

Outpatient diagnostic or therapeutic services may be performed only on request of a Medical Staff member with clinical privileges or practitioners who by training, practice, and California licensure would otherwise qualify for Medical Staff membership or if approved by the Medical Staff Executive Committee.

I. PROCEDURE FOR CREATION OF NEW MEDICAL STAFF DEPARTMENTS

Existing services or divisions of the Medical Staff may be considered for provisional department status if:

1. This is mandated by Joint Commission or Hospital Board of Directors, and
2. A majority of the members of the considered service or division approve, and

3. The considered service or division has at least 15 Medical Staff members.

Procedure for obtaining provisional department status:

Following approval by a majority of its members, a written request shall be forwarded to the Medical Staff Executive Committee. If the Medical Staff Executive Committee grants provisional departmental status, it shall be bound to review the performance of this provisional department after one year. At this review, the Executive Committee may grant full department status or mandate an additional six month provisional period. If an additional six month provisional period is mandated, the Medical Staff Executive Committee will again review the performance of this provisional department at the end of this time and will either grant full department status or will return it to its prior division or service level.

Responsibilities of a provisional Medical Staff department shall include:

1. The establishment of regular meetings at the frequency of not less than quarterly, which must be attended by not less than 50% of its members.
2. The maintenance of minutes that reflect concurrent review of appropriateness of care provided by its members consistent with the Quality Assessment program of the Medical Staff.
3. The review and recertification of its members' privileges in accord with established guidelines.
4. The development of departmental guidelines which are to be submitted to the Medical Staff Executive Committee within three months.
5. The development of member privileging criteria which are also to be submitted for approval to the Medical Staff Executive Committee within three months.

The Chief and Vice-Chief may sit on the Medical Staff Executive Committee during the provisional period, but may not vote until the department has been granted full status.

J. FEES

An applicant to the Medical Staff shall be required to pay \$300 as a processing fee.

K. RESIDENTS

1. Nature of Affiliation: Residents engaged in patient care at El Camino Hospital must be post-doctoral trainees (residents or fellows) in training programs of approved teaching institutions which have a contract with El Camino Hospital. Residents must be licensed by the Medical Board of California. They may be authorized to perform clinical duties consistent with their training program, and as outlined in the contract between El Camino Hospital and the residency program and the Medical Staff Guidelines for Supervision of Residents (Medical Staff Policy/Procedure, Section 9). The contracting teaching institution must provide professional liability insurance for residents to cover the performance of all clinical duties at El Camino Hospital. The Medical Staff Executive Committee and Board of Directors shall approve the residency contract. Authorization to perform clinical duties will cease at the completion of an individual physician's rotation or under the terms of the contract. Residents are required to comply in all respects with the Medical Staff Bylaws and Rules and Regulations, departmental or service rules and regulations as well as applicable policies and procedures.

Residents do not enjoy the due process rights afforded Medical Staff members. Moreover, the Medical Staff retains the right to require the immediate suspension or withdrawal of any resident if such action is deemed warranted in order to protect

patients or other individuals.

2. Supervision: All clinical care provided by residents shall be under the supervision of a member of the Medical Staff. Guidelines for supervision can be found in the ECH Medical Staff Policies and Procedures, Section 9. All policies related to supervision of residents shall be approved by the Medical Staff Executive Committee.

2. Authorized Activities: A resident may make entries in the patient's medical record as delineated in the Medical Staff Guidelines (Medical Staff Policy/Procedure, Section 9). The extent to which the resident may otherwise participate in patient care services and make entries in the medical record shall be determined by the Supervising Physician and Training Program and shall be consistent with the applicable Guidelines.

L. ALLIED HEALTH PROFESSIONALS

Allied Health Professionals ("AHPs") are covered in the Medical Staff policy regarding these practitioners.

M. DEA Certification Waiver

Exemption may be granted upon written attestation of the physician that the physician will not prescribe controlled substances in the hospital. The Department Chief and Medical Staff Executive Committee need to concur that a DEA is not required based on the physician's attestation.

**EL CAMINO HOSPITAL
MEDICAL STAFF
RULES AND REGULATIONS**

Appendix II

A. CANCER CARE COMMITTEE – *Enterprise Committee*

1. COMPOSITION

The Committee shall consist of at least one Board certified physician representative, from Surgery, Gyn Oncology, Medical Oncology, Radiation Oncology, Radiology and Pathology, and all other representatives as required by the current American College of Surgeons/Commission on Cancer Standards.

2. DUTIES

The Committee shall:

- (a) develop and evaluate annual goals and objectives for clinical, educational and programmatic activities related to cancer;
- (b) promote a coordinated, multi-disciplinary approach to patient management;
- (c) coordinate educational and consultative cancer conferences to cover all major sites and related issues;
- (d) monitor quality management and improvement through completion of quality management studies that focus on quality, access to care and outcomes;
- (e) promote clinical research;
- (f) supervise the Cancer Registry and ensure accurate and timely abstracting, staging and follow-up reporting;
- (g) perform quality control of registry data;
- (h) encourage data usage and regular reporting;
- (i) uphold medical ethical standards; and
- (j) annually provide a summary quality management report to the Medical Staff Executive Committee.

3. MEETINGS

The committee shall meet at least quarterly and will submit an annual report to the Medical Staff Executive Committee.

B. CAPITAL EXPENDITURE COMMITTEE – *Enterprise Committee*

1. COMPOSITION

The committee will be interdisciplinary and at least composed of physicians from Surgery, Medicine, Radiology, Pathology, Obstetrics/Gynecology, Family Practice and Orthopedics. Additionally, there will be a representative from Finance, OR, Nursing Administration, Ancillary Services and Administration. The committee will be co-chaired by the MV and LG Vice Chiefs of Staff.

2. DUTIES

- (a) Participate in the selection of patient care equipment/instrumentation.
- (b) Review and approve recommendations from clinical departments or divisions.
- (c) Participate in the review of equipment evaluation.
- (d) Submit recommendations to the Medical Staff Executive Committee.

3. MEETINGS

As necessary.

C. CARDIOVASCULAR/PERIPHERAL VASCULAR SERVICES (CPVS) COMMITTEE – *MV Campus*

1. COMPOSITION

Committee members may include healthcare professionals involved in the diagnosis and treatment of cardiovascular and peripheral vascular disease including interventional cardiologists, vascular surgeons, vascular medicine surgeons, interventional radiologists, interventional neuroradiologists, interventional nephrologists. Nonvoting members may include support staff from the Cardiac Catheterization Laboratory, Angiography and Interventional Radiology Services, Non-invasive Imaging and Surgery. The peer review portion of the Cardiovascular/Peripheral Vascular Services Committee will be attended by physicians of the committee.

2. DUTIES

- (a) Conduct multidisciplinary review of coronary and peripheral vascular intervention procedures performed at El Camino Hospital.
- (b) Develop recommendations and/or criteria for clinical privileges for percutaneous endovascular procedures.
- (c) Develop protocols for a registry of cases performed at El Camino to include indications and outcomes statistics to ensure consistent quality of care
- (d) Promote teaching and education amongst the healthcare professionals involved in the evaluation, combined percutaneous-surgical diagnostic and therapeutic endovascular procedures.
- (e) Review selected cases identified via medical staff approved criteria and refer cases for secondary peer review to the appropriate department executive committee.

3. MEETINGS

The committee shall meet as often as necessary, but at least quarterly.

D. CONTINUING MEDICAL EDUCATION/LIBRARY COMMITTEE – *Enterprise Committee*

1. COMPOSITION

The continuing medical education/library committee shall be composed of physician members and other health professionals of the Medical Staff whose number shall be appropriate to the size of the hospital and amount of program activities produced annually. The chairperson shall be the MV Director of Medical Education, who shall serve for at least two years, the Medical Librarian, and committee members selected by the MV Director of Medical Education who shall serve staggered terms in order to assure continuity. The LG Director of Medical Education will serve as assistant chair.

2. DUTIES

The continuing medical education/library committee shall perform the following duties:

- (a) plan, implement, coordinate and promote educational activities that relate, at least in part, to the type and nature of care, treatment, and services offered by the hospital for the Medical Staff. This includes:
 - 1. identifying the educational needs of the Medical Staff;

2. formulating clear statements of objectives for each program;
 3. assessing the effectiveness of each program;
 4. choosing appropriate teaching methods and knowledgeable faculty for each program; and
 5. documenting staff attendance at each program.
- (b) assist in developing processes to assure optimal patient care and contribute to the continuing education of each practitioner.
 - (c) establish liaison with the quality assessment and improvement program of the hospital in order to be apprised of problem areas in patient care, which may be addressed by a specific continuing medical education activity.
 - (d) maintain close liaison with other hospital Medical Staff and department committees concerned with patient care.
 - (e) make recommendations to the Medical Staff Executive committee regarding library needs of the Medical Staff.
 - (f) advise administration of the financial needs of the continuing medical education program.

3. MEETINGS

At least quarterly. It shall maintain minutes of the program planning discussions and report to the Medical Staff Executive committee.

E. INFECTION CONTROL COMMITTEE – *Campus-Specific*

1. COMPOSITION

The Infection Control Committee shall be a multi-disciplinary committee consisting of the Infection Control Officer and representatives from the Medical Staff departments as needed: the departments of medicine, surgery, obstetrics/gynecology, pediatrics, pathology, nursing, Administration, and the Nurse Epidemiologist, nursing, Administration and the Nurse Epidemiologist. The Chairman shall be a physician with knowledge of and special interest in Infection Control. Representatives from key hospital departments such as but not limited to Facilities Services, Environmental Services, Pharmacy, Central Services, Operating Room and Employee Health.

2. DUTIES

The Infection Control Committee shall:

- (a) Develop a hospital-wide infection program and maintain surveillance over the program.
- (b) Develop a system for reporting, identifying and analyzing the incidence and cause of all nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, as well as for required follow-up action.
- (c) Develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing, and evaluating aseptic, isolation, and sanitation techniques. Such techniques shall be defined in written policies and procedures.
- (d) Develop written policies defining special indications for isolation requirements in relation to the medical condition involved and for monitoring the implementation of the policies and quality of care administered.
- (e) Act upon recommendations related to infection control received from the Chief of Staff, the Medical Staff Executive Committee, the departments, and

other Medical Staff and Hospital committees.

3. MEETINGS

The Committee and subcommittees (if any) shall meet at least quarterly. It shall maintain a record of its proceedings and shall submit quarterly reports to the Medical Staff Executive Committee.

F. INTERDISCIPLINARY PRACTICE COMMITTEE – *Enterprise Committee*

1. COMPOSITION

The Committee shall be a multi-disciplinary committee consisting of at least eight (8) members, including, as the minimum, the Chief Nursing Officer, the Administrator/ Chief Executive Officer or his/her designee, and an equal number of physicians appointed by the Medical Staff Executive Committee and of registered nurses appointed by the Chief Nursing Officer.

- (a) The committee shall be responsible for appointment and reappointment of all allied health practitioners in approved categories.
- (b) The committee shall review quality assessment issues pertaining to allied health practitioners at the time of reappointment as needed.

2. DUTIES

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

- 1. Provision for securing recommendations from Medical Staff members in the medical specialty or clinical field of practice under review, and from persons in the appropriate non-medical category who practice in the clinical field or specialty under review.
- 2. Methodology for the approval of standardized procedures in accordance with Section 2725 of the Business and Professions Code, which requires affirmative approval of the procedures by the Administrator/ Chief Executive Officer or his/her designee, a majority of the physician members, and a majority of the registered nurse members after consultation has been obtained from medical and nursing staff members practicing in the medical and nursing specialties under review.
- 3. Provision for maintaining clear lines of responsibility of the nursing service for nursing care of patients and of the Medical Staff for medical services in the Hospital.
- 4. Provision for securing approval for each recommendation of the Committee from the Medical Staff Executive Committee and, if so approved, the Board of Directors.

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

(c) Standardized Procedures for Registered Nurses: The Committee shall be responsible for:

1. Identifying the functions and/or procedures which required the formulation and adoption of standardized procedures under Section 2725 of the Business and Professions Code in order for them to be performed by registered nurses in the Hospital, and initiating the preparations of such standardized procedures in accordance with this Section.
 2. The review and approval of such standardized procedures covering practice by registered nurses in the Hospital.
 3. Recommending policies and procedures for the authorization of employed staff registered nurses to perform the identified functions and/or procedures. These policies and procedures may be administered by the Committee or by delegation to the Director of Patient Care Services.
- (d) Each standardized procedure approved by the Committee shall:
1. Be in writing and set forth the date it was approved by the Committee.
 2. Specify the standardized procedures which registered nurses are authorized to perform and under what circumstances.
 3. State any specific requirements which are to be followed by registered nurses in performing all or part of the functions covered by the particular standardized procedure.
 4. Specify any experience, training or special education requirements for performance of the standardized procedures.
 5. Establish a method of initial and continuing evaluation of the competence of those registered nurses authorized to perform the standardized procedures.
 6. Provide for a method of maintaining a written record of those persons authorized to perform the standardized procedures.
 7. Specify the nature and scope of review and/or supervision required for the performance of the standardized procedures; for example, if the standardized procedure is to be performed only under the immediate supervision of a physician, that limitation must be clearly stated. If physician supervision is not required, that fact should be clearly stated.
 8. Set forth any specialized circumstances under which the registered nurse is to communicate immediately with a patient's physician concerning the patient's condition.
 9. State any limitation on settings or departments within the Hospital where the standardized procedure may be performed.
 10. Specify any special requirements for procedures relating to patient record keeping.
 11. Provide for periodic review of the standardized procedure.

3. MEETINGS
As necessary.

G. INSTITUTIONAL REVIEW BOARD – *Enterprise Committee*

1. COMPOSITION

The Institutional Review Board ("IRB") shall be composed in a manner which meets the requirement of the federal Health and Human Services ("HHS") and Food and Drug Administration ("FDA") regulations for the protection of human subjects. The

IRB shall have at least five (5) members, with varying backgrounds to promote complete and adequate review of research activities commonly conducted in the institution. The IRB shall be sufficiently qualified through the experience and expertise of its members, and the diversity of the members' backgrounds, including consideration of the racial and cultural backgrounds of members and sensitivity to such issues as community attitudes, to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects. In addition to possessing the professional competence necessary to review specific research activities, the IRB shall be able to ascertain the acceptability of proposed research in terms of institutional commitments and regulations, applicable law, and standards of professional conduct and practice. The IRB shall, therefore, include persons knowledgeable in these areas. If an IRB regularly reviews research that involves a vulnerable category of subjects, including but not limited to subjects covered by specific regulations, the IRB shall include one or more individuals who are primarily concerned with the welfare of these subjects.

The IRB may not consist entirely of men or entirely of women, or entirely of members of one profession. It shall include at least one (1) member whose primary concerns are in nonscientific areas (for example: lawyers, ethicists, members of the clergy), and at least one (1) member who is not otherwise affiliated with the institution or part of the immediate family of a person who is affiliated with the institution. No member may participate in the IRB's initial or continuing review of any project in which the member has a conflicting interest, except to provide information requested by the IRB. The IRB may, in its discretion, invite individuals with competence in special areas to assist in the review of complex issues which require expertise beyond or in addition to that available on the IRB. These individuals may not vote with the IRB.

2. DUTIES

- (a) The IRB must adopt and follow written procedures for carrying out the duties imposed by the HHS and FDA regulations, including procedures for:
 1. Conducting its initial and continuing review of research and for reporting its findings and actions to the investigator and to the institution.
 2. Determining which projects require review more often than annually, which projects need verification from sources other than the investigators, and that no material changes have occurred since previous IRB review.
 3. Assuring prompt reporting to the IRB of proposed changes in a research activity, and for assuring that changes in approved research, during the period for which IRB approval has already been given, may not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subject.
 4. Assuring prompt reporting to the IRB of unanticipated problems involving risks to subject or others.
 5. For research subject to HHS or FDA regulations, assuring prompt reporting of unanticipated problems involving risks to subjects or others by filing reports with the appropriate federal agency.
 6. Assuring timely reporting to the appropriate institutional officials of any serious or continuing noncompliance by investigators with the

requirements and determinations of the IRB. For research subject to the HHS and FDA regulations, these reports must also be made to HHS, or to the FDA, as appropriate.

- (b) Except when an expedited review procedure is used, the IRB shall review proposed research at convened meetings at which a majority of the members of the IRB are present, including at least one (1) member whose primary concern is in nonscientific areas. This review must be conducted in accordance with the provisions set forth in Paragraph (c) below. In order for the research to be approved it must meet the criteria set forth in California law and federal regulations and it must receive the approval of a majority of those members present at the meeting. Research which is approved by the IRB may be subject to further appropriate review and approval or disapproval by officials of the institution, but such review is not required. However, those officials may not approve any research subject to the California law and/or federal regulations referenced herein if it has not been approved by an IRB.
- (c) The Institutional Review Board shall:
 - 1. Review and have authority to approve, require modifications in (to secure approval), or disapprove all research activities covered by HHS, FDA, or California law and regulations.
 - 2. Require that information given to subjects as part of the informed consent process complies with the provisions of the applicable law or regulations. The IRB may require that information, in addition to that specifically mentioned in the law or regulations, be given to the subjects when, in the IRB's judgment, the information would meaningfully add to the protection of the rights and welfare of subjects.
 - 3. Require documentation of informed consent or waive documentation in accordance with the provisions of applicable law or regulations.
 - 4. Notify the investigator in writing of its decision to approve or disapprove a proposed research activity, or of modifications required to secure IRB approval of the research activity. If the IRB decides to disapprove a research activity, it shall include in its written notification a statement of the reasons for its decision and give the investigator an opportunity to respond in person or in writing.
 - 5. Conduct continuing review of research covered by these regulations at intervals appropriate to the degree of risk, but not less than once per year, and shall have authority to observe or have a third party observe the consent process and the research.
 - 6. Have authority to suspend or terminate approval of research that is not being conducted in accordance with the IRB's requirements or that has been associated with unexpected serious harm to subjects. Any suspension or termination of approval shall include a statement of all reasons for the IRB's action and shall be reported promptly to the investigator, appropriate institutional officials, and appropriate regulatory authorities.

- 3. MEETINGS
At least quarterly.

H. JOINT CONFERENCE COMMITTEE – *Enterprise Committee*

1. COMPOSITION:

Chief Executive Officer or designee, Chiefs of Staff, Vice Chiefs of Staff, Immediate Past Chiefs of Staff, Board of Directors' representative, Medical Director of Quality Assessment/Utilization Management, Chief Nursing Officer, Senior Director of Quality and Patient Safety.

2. DUTIES

The Joint Conference Committee shall constitute a forum for the discussion of matters of hospital and Medical Staff policy, practice and planning, conflict resolution, and a forum for interaction between the Board of Directors and the Medical Staff on such matters as may be referred by the Medical Staff Executive Committee or the Board of Directors. The Joint Conference Committee shall exercise any other responsibilities set forth in these bylaws.

3. MEETINGS:

As needed.

I. MEDICAL ETHICS COMMITTEE – *Enterprise Committee*

1. COMPOSITION

The committee will be multi-disciplinary with at least representatives from Medical Staff and Patient Care Services. It may also include members of other professions or the public.

2. DUTIES

- (a) Provide counsel to physicians, hospital staff, administration in the understanding, delineations and clarification of medical ethical dilemmas.
- (b) Provide regular educational activities on medical ethical dilemmas to the institution.
- (c) Assist in the development of ethical guidelines where appropriate.
- (d) Submit recommendations to the department executive committee or Medical Staff Executive Committee as appropriate.

3. MEETINGS

As needed and no less than annually.

J. MEDICAL STANDARDS FOR INFORMATION TECHNOLOGY (MSIT) COMMITTEE – *Enterprise Committee*

1. COMPOSITION

The MSIT Committee shall be chaired by the. Members will consist of physicians selected by the Chief of Staff and one representative each from nursing, the Health Information Management Department, Administration, and Information Systems.

2. DUTIES

The duties of the MSIT shall include:

- (a) Review and evaluation of the electronic medical record, or a representative sample, to determine whether they: 1) properly describe the condition and diagnosis, the progress of the patient during hospitalization and at the time of discharge, the treatment and tests provided, the results thereof, and adequate identification of individuals responsible for orders given and

treatment rendered; and 2) are sufficiently complete at all times to facilitate continuity of care and communications between individuals providing patient care services in the hospital;

- (b) Review and make recommendations for Medical Staff and hospital policies, rules and regulations relating to the electronic medical record, including completion, forms and formats, filing, indexing, storage, destruction, availability, and methods of enforcement;
- (c) Provide liaison with hospital administration and Health Information personnel in the employ of the hospital on matters relating to practices involving the electronic medical record;
- (d) Incorporate Medical Staff input into information systems planning and decisions, such as internet, intranet, e-mail, software applications, and Medical Information Systems (MIS) development, maintenance and upgrade, and other clinical data systems;
- (e) Review the hospital-wide Information Management Plan on an annual basis and recommend additions or revisions as may be warranted based upon clinical needs assessment;
- (f) Review the Medical Staff clinical data collections applications and recommend changes or upgrades as may be warranted.

3. MEETINGS

Will meet at the discretion of the chair and report annually to the Medical Staff Executive Committee.

K. PERFORMANCE IMPROVEMENT (PI)/SAFETY COMMITTEE – *Enterprise Committee*

1. COMPOSITION

The Performance Improvement/Safety Committee shall be composed of the Chief Nursing Officer, Chief Medical Officer, Senior Director of Quality and Patient Safety, Physician members of the Medical Staff, Nurse Managers, Infection Control Practitioner, Manager of QI/PI, Safety Management Specialist, and the Risk Manager.

2. CHAIRS

The committee will be co-chaired by the Chief Nursing Officer and one of the physician members (to be determined by the Chief of Staff).

3. DUTIES

- (a) Oversee PI/Safety Teams
- (b) Assess goals and monitor performance of the PI/Safety Teams
- (c) Ensure PI/Safety Teams have adequate resources
- (d) Identify gaps in hospital safety and performance – set targets for improvement

4. MEETINGS

The committee shall meet quarterly, or at the discretion of the chairs.

L. PERINATAL COMMITTEE – *Enterprise Committee*

1. COMPOSITION

This committee will be multi-disciplinary and at least composed of representatives from Pediatrics, OB/GYN, Neonatology, Anesthesia, Care Coordinator and Chief Nursing Officer.

2. DUTIES
 - (a) Review the ongoing care of patients in Labor and Delivery, NICU, Maternity, and the Nursery.
 - (b) Establish guidelines for the care of patients in Labor and Delivery, NICU, Maternity, and Nursery.
 - (c) Submit recommendations/concerns to Pediatric Department Executive Committee, OB/GYN Department Executive Committee, or Maternal-Child Health Department Executive Committee as appropriate.
3. MEETINGS
Monthly, or at the discretion of the chair.

M. PHARMACY AND THERAPEUTICS COMMITTEE – *Enterprise Committee*

1. COMPOSITION
The Pharmacy and Therapeutics Committee shall consist of at least five (5) representatives from the Medical Staff. Additional voting members shall include one (1) pharmacist, the Chief Nursing Officer or his/her representative, and Administrator or his/her representative.
2. DUTIES
The Pharmacy and Therapeutics Committee shall:
 - (a) Assist in the formulation of broad professional policies regarding the procurement, evaluation, selection, storage, distribution, dispensing, use, safety procedures, administration and all other matters relating to drugs and diagnostic testing materials in the Hospital.
 - (b) Advise the Medical Staff and the Hospital's Pharmaceutical Department on matters pertaining to the choice of available drugs and review all significant untoward drug reactions.
 - (c) Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.
 - (d) Develop and review periodically a formulary or drug list for use in the Hospital.
 - (e) Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.
 - (f) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.
 - (g) Perform an annual review of all Standing Orders.
 - (h) Perform such other duties as assigned by the Chief of Staff or the Medical Staff Executive Committee.
3. MEETINGS
At least quarterly.

N. QUALITY STEERING COMMITTEE – *Enterprise Committee*

1. COMPOSITION
The Quality Steering Committee shall be composed of the Chief of Staff, Vice Chief of Staff, Immediate Past Chief of Staff, two members of the Board of Directors (including the Chairman of the Board), Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer, Associate Chief Medical Officer, Medical Director of Quality and Patient Safety, Senior Director Clinical Quality and Patient Safety,

Manager QA/PI, Director Medical Staff Services

2. CHAIRS

The committee will be co-chaired by the Chief of Staff and the Chairman of the Board.

3. DUTIES

- (a) Set overall direction for QI activities at El Camino Hospital
- (b) Align medical staff and hospital QI activities
- (c) Align service line development and hospital growth initiatives with medical staff and hospital QI activities
- (d) Continually review committees and reporting structures to ensure collaboration and teamwork with regard to QI activities.

4. MEETINGS

The committee shall meet quarterly, or at the discretion of the chairs.

O. RADIATION SAFETY COMMITTEE - *Enterprise Committee*

1. COMPOSITION

The Committee shall consist of members from the departments of Medicine and Surgery, Radiology, a physician experienced in the safe handling of radioisotopes and in determining radioisotope dosage for various patients, studies or treatments. Other members should include a Radiation Safety Officer, Nuclear Medicine Supervisor and Administration.

2. DUTIES

- (a) Establish radiation safety guidelines for staff and patients at El Camino Hospital.
- (b) Review ongoing activities relative to radiation safety.
- (c) Review proposals for diagnostic and therapeutic uses of unsealed radio nuclides.
- (d) Review regulations for the use, transport, storage and disposal of radioactive materials used in Nuclear medicine
- (e) Recommend remedial action when there is a failure to observe protection recommendations, rules and regulations.

3. MEETINGS

Meet every six months.

P. SPECIAL SERVICES COMMITTEE – *MV Campus*

1. COMPOSITION

The committee shall be multi-disciplinary and shall be composed of at least the physician representatives from Medical Staff, Care Coordinator and Chief Nursing Officer.

2. DUTIES

- (a) Establish guidelines for care of patients on the critical care units
- (b) Perform ongoing review of patient care on the critical care units
- (c) Review of cases as brought to the Committee by the Medical Director or any member. Refer as appropriate to the Care Review Committee or the Department Executive Committee.

- (d) Participate in evaluation and selection of equipment purchases.
- (e) Review cases referred from other medical/staff committees as requested.

3. MEETINGS

As least quarterly.

Q. TISSUE REVIEW FUNCTION – *Enterprise Committee*

The tissue review function shall include review of surgical cases in which a specimen (tissue or non-tissue) is removed, as well as from those cases in which no specimen is removed. In the latter case, however, a screening mechanism based upon pre-established criteria may be established. The review shall include the indications for surgery and all cases in which there is a major discrepancy between the pre-operative and post-operative (including pathologic) diagnosis. The Medical Staff Executive committee may describe a system by which the tissue review function shall be coordinated with departmental surgical case review.

A report will be made to the Medical Staff Executive Committee as needed, but at least annually.

R. UTILIZATION REVIEW COMMITTEE – *Enterprise Committee*

1. COMPOSITION

The utilization review committee shall consist of a sufficient number of members to afford fair representation. Subcommittees may be appointed by the committee for departments or divisions as the committee may deem appropriate.

2. DUTIES

The duties of the utilization review committee shall include:

- (a) conducting utilization review studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and related factors which may contribute to the effective utilization of services. The committee shall communicate the results of its studies and other pertinent data to the Medical Staff Executive committee and shall make recommendations for the utilization of resources and facilities commensurate with quality patient care and safety;
- (b) establishing a utilization review plan which shall be approved by the Medical Staff Executive committee; and
- (c) obtaining, reviewing, and evaluating information and raw statistical data obtained or generated by the hospital's case management system.

3. MEETINGS

The utilization review committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a record of its findings, proceedings and actions, and shall make a quarterly report of its activities and recommendations to the Medical Executive Committee.