BYLAWS

OF THE

MEDICAL STAFF

KERN MEDICAL CENTER
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Article</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DEFINITIONS ..................................................................................</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>MISSION STATEMENT OF KERN COUNTY HOSPITAL AUTHORITY AND KERN MEDICAL CENTER</td>
<td>6</td>
</tr>
<tr>
<td>Article I</td>
<td>PREAMBLE ..................................................................................</td>
<td>7</td>
</tr>
<tr>
<td>Article II</td>
<td>NAME AND ORGANIZATION OF THE MEDICAL STAFF ..................................</td>
<td>8</td>
</tr>
<tr>
<td>Article III</td>
<td>RESPONSIBILITIES OF THE MEDICAL STAFF ORGANIZATION ........................</td>
<td>9</td>
</tr>
<tr>
<td>Article IV</td>
<td>MEMBERSHIP ..............................................................................</td>
<td>12</td>
</tr>
<tr>
<td>Article V</td>
<td>CATEGORIES OF MEMBERSHIP ..................................................................</td>
<td>20</td>
</tr>
<tr>
<td>Article VI</td>
<td>APPOINTMENT AND REAPPOINTMENT ................................................</td>
<td>29</td>
</tr>
<tr>
<td>Article VII</td>
<td>DELINEATION OF CLINICAL PRIVILEGES .........................................</td>
<td>42</td>
</tr>
<tr>
<td>Article VIII</td>
<td>ALLIED HEALTH PROFESSIONALS .................................................</td>
<td>56</td>
</tr>
<tr>
<td>Article IX</td>
<td>MEDICAL STAFF OFFICERS ..................................................................</td>
<td>60</td>
</tr>
<tr>
<td>Article X</td>
<td>CLINICAL DEPARTMENTS ..................................................................</td>
<td>66</td>
</tr>
<tr>
<td>Article XI</td>
<td>COMMITTEES ..................................................................................</td>
<td>74</td>
</tr>
<tr>
<td>Article XII</td>
<td>PEER REVIEW AND CORRECTIVE ACTION ........................................</td>
<td>80</td>
</tr>
<tr>
<td>Article XIII</td>
<td>HEARINGS AND APPELLATE REVIEWS ...........................................</td>
<td>91</td>
</tr>
<tr>
<td>Article XIV</td>
<td>CONFIDENTIALITY, IMMUNITY AND RELEASES ....................................</td>
<td>104</td>
</tr>
<tr>
<td>Article XV</td>
<td>GENERAL PROVISIONS ......................................................................</td>
<td>108</td>
</tr>
<tr>
<td>Article XVI</td>
<td>ADOPTION AND AMENDMENT OF BYLAWS .........................................</td>
<td>120</td>
</tr>
</tbody>
</table>
DEFINITIONS

ALLIED HEALTH PROFESSIONAL
or AHP means an individual, other than a licensed physician, dentist, clinical psychologist or podiatrist, who exercises independent judgment within the areas of his or her professional competence and the limits established by the Board, the Medical Staff, and the applicable state Practice Act, who is qualified to render direct or indirect medical, dental, psychological, or podiatric care under the supervision or direction of a medical staff member possessing clinical privileges to provide such care in the hospital, and who may be eligible to exercise practice privileges and prerogatives in conformity with the policies adopted by the Medical Staff and the Board, these Bylaws and the Medical Staff Rules and Regulations. AHPs are not eligible for medical staff membership.

BOARD
means the Board of Governors of the Kern County Hospital Authority, a county hospital authority. The Board is the governing body of the Kern Medical Center.

CHIEF EXECUTIVE OFFICER
means the chief executive officer of Kern Medical Center, appointed by and responsible to the Board for the general management of the Kern Medical Center.

CHIEF MEDICAL OFFICER
means a practitioner appointed by the Chief Executive Officer to coordinate the medical services and educational activities of the Medical Center and to serve as a liaison between the Medical Staff and Kern Medical Center administration.

CLINICAL PRIVILEGES
means the permission granted by the Board to a medical staff member to provide patient care at Kern Medical Center.

COUNTY
means the County of Kern, a political subdivision of the state of California.

DENTIST
means an individual who has received a doctor of dental surgery (D.D.S.) degree or a doctor of dental medicine (D.M.D.) degree. Dentists must be licensed to practice dentistry by the California Board of Dental Examiners.
DEPARTMENT or DEPARTMENTS
means an organizational unit of the medical staff organization, headed by a department chair.

DEPARTMENT CHAIR
means a member of the Active Medical Staff in good standing who is qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the department and responsible for the overall supervision of clinical activity within the department.

EX OFFICIO
means service by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

HOSPITAL AUTHORITY
means the Kern County Hospital Authority, a county hospital authority, which owns and operates Kern Medical Center.

HOUSE STAFF
means residents and fellows who are medical doctors or doctors of osteopathy participating in a graduate education program. House Staff may render patient care under the direction and supervision of medical staff members. In matters of professional competence, ethics and scope of practice, House Staff are responsible to the Designated Institutional Official (the “DIO”) or his/her designee. House Staff are not eligible for medical staff membership or clinical privileges or entitled to the procedural or other fair hearing rights specified in these Bylaws for medical staff members or applicants.

INVESTIGATION
means a process specifically initiated by the medical executive committee to determine the validity, if any, to a concern or complaint raised against a member of the Medical Staff, which is a precursor to potential corrective action as contemplated by Article XII of these Bylaws. Investigations do not include the activities of the wellness committee.

MEDICAL CENTER
means Kern Medical Center, a designated public hospital, including the general acute care hospital, affiliated clinics, and other operations.

MEDICAL EXECUTIVE COMMITTEE
means the executive committee of the Medical Staff.

MEDICAL STAFF or STAFF
means those physicians, dentists, podiatrists and clinical psychologists who have been granted membership on the Medical Staff by the Board.

MEDICAL STAFF YEAR
means the period beginning on the first day of July and ending on the 30th day of June.
MEDICAL STUDENTS
means those individuals who are pursuing their clinical educational rotation at the Medical Center. Medical Students may render patient care under the direction and supervision of medical staff members and House Staff. In matters of professional competence, ethics and performance, Medical Students are responsible to the DIO or his/her designee. Medical Students are not eligible for medical staff membership or clinical privileges or entitled to the procedural or other fair hearing rights specified in these Bylaws for medical staff members or applicants.

MEMBER
means, unless otherwise expressly limited, any physician, dentist, podiatrist or clinical psychologist holding a current license to practice within the scope of that license who is a member of the Medical Staff.

NOTICE
means a written communication delivered personally to the addressee or sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the Medical Staff or the Medical Center.

PHYSICIAN
means an individual who has received a doctor of medicine (M.D.) degree or doctor of osteopathy (D.O.) degree as recognized by the Medical Board of California (the “MBC”) or the Osteopathic Medical Board of California (the “OMBC”), and is licensed by either the MBC or OMBC.

PODIATRIST
means an individual who has received a doctor of podiatric medicine (D.P.M.) degree. Podiatrists must be licensed to practice podiatry by the California Board of Podiatric Medicine.

PRACTITIONER
means a physician, dentist, podiatrist or clinical psychologist.

PRESIDENT OF STAFF
means the chief officer of the Medical Staff elected by the Medical Staff.

PSYCHOLOGIST
means an individual who has received an earned doctorate in psychology (a Psy.D. or a Ph.D.) degree. Clinical psychologists must be licensed to practice clinical psychology by the California Board of Psychology.

TELEHEALTH
means (as defined by California Business & Professions Code §2290.5) the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth includes synchronous (a real-time interaction between a patient and a health care provider located at a distant site) interactions and asynchronous (the transmission of a patient’s medical information from an originating site to the health care provider at a distant site without the presence of the patient) store and forward transfers.
TELEMEDICINE
means, for purposes of these Bylaws, that subset of Telehealth services delivered to Kern Medical Center patients by practitioners who have been granted privileges by Kern Medical Center to provide services via Telehealth modalities.

TELEMEDICINE PROVIDERS
means those practitioners granted clinical privileges by Kern Medical Center to provide services via Telehealth modalities.
MISSION STATEMENT
OF
KERN COUNTY HOSPITAL AUTHORITY
AND
KERN MEDICAL CENTER

The Hospital Authority, which owns and operates the Medical Center, was created by the Board of Supervisors of the county of Kern to provide access to affordable, high-quality health care services and to preserve and strengthen the viability of the health care safety net in the county in order to maintain and improve the health status of the people of the county of Kern through an organizational and operational structure that facilitates and improves the Kern Medical Center’s ability to function with flexibility, responsiveness, and innovation. The purpose of the Hospital Authority is to provide maintenance, operation, management, and control of Kern Medical Center and related health care resources, in a manner that continues the viability of Kern Medical Center and constitutes an ongoing material benefit to the County and its residents. As a way to achieve these goals, the Board has caused the organization of the physicians, dentists, podiatrists, and other health professionals expressly granted clinical privileges in Kern Medical Center into a Medical Staff under these Bylaws.
ARTICLE I
PREAMBLE

These Bylaws are adopted in recognition of the mutual accountability, interdependence and responsibility of the Medical Staff and the Board of the Medical Center in protecting the quality of medical care provided at the Medical Center and assuring the competency of the Medical Center’s Medical Staff. The Bylaws provide a framework for self-government, assuring an organization of the Medical Staff that permits the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes, and to account to the Board for the effective performance of Medical Staff responsibilities. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board, and relations with applicants to and members of the Medical Staff.

Accordingly, the Bylaws address the Medical Staff’s responsibility to establish criteria and standards for medical staff membership and clinical privileges, and to enforce those criteria and standards; they establish clinical criteria and standards to oversee and manage quality assurance, utilization review, and other medical staff activities, including, but not limited to, periodic meetings of the Medical Staff, its committees, and departments and review and analysis of patient medical records; they describe the standards and procedures for selecting and removing officers of the Medical Staff; and they address the respective rights and responsibilities of the Medical Staff and the Board.

Finally, notwithstanding the provisions of these Bylaws, the Medical Staff acknowledges that the Board must act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the Medical Center. In adopting these Bylaws, the Medical Staff commits to exercise its responsibilities with diligence and good faith; and in approving these Bylaws, the Board commits to allowing the Medical Staff reasonable independence in conducting the affairs of the Medical Staff. Accordingly, the Board will not assume a duty or responsibility of the Medical Staff precipitously, unreasonably, or in bad faith; and will do so only in the reasonable and good faith belief that the Medical Staff has failed to fulfill a substantive duty or responsibility in matters pertaining to the quality of patient care.
ARTICLE II
NAME AND ORGANIZATION OF THE MEDICAL STAFF

2.1 NAME

The name of this organization is the Medical Staff of Kern Medical Center.

2.2 ORGANIZATION

The Medical Staff organization is structured as follows: The members of the Medical Staff are assigned to a medical staff category depending upon nature and tenure of practice at the Medical Center. All new members of the Medical Staff are assigned to the Provisional Staff. Upon satisfactory completion of the provisional period, the members are assigned to one of the medical staff categories described in Article V of these Bylaws. Members are also assigned to departments and divisions depending upon their specialties. The departments and the divisions of the Medical Staff are listed in the Medical Staff Organizations and Functions Manual. Each department is organized to perform certain functions on behalf of the department, such as credentials review and peer review. There are also medical staff committees, which perform staff-wide responsibilities, and that oversee related activities being performed by the departments and department committees. Oversight of the medical staff organization is provided by the medical executive committee, which is comprised of the elected officers of the Medical Staff, the department chairpersons, two (2) representatives of the Medical Staff elected at large, and the other individuals specified in Section 11.2 of these Bylaws.
ARTICLE III
RESPONSIBILITIES OF THE MEDICAL STAFF ORGANIZATION

3.1 RESPONSIBILITIES

Provision shall be made in these Bylaws or by resolution of the medical executive committee approved by the Board for the effective performance of the medical staff organization functions specified in this Article III and described in the Medical Staff Organization and Functions Manual and of such other medical staff functions as the medical executive committee or the Board shall reasonably require. Medical staff organization functions may be carried out through assignment to departments, medical staff committees, medical staff officers or interdisciplinary medical center committees. The Medical Staff shall be self-governing with respect to the professional work performed in the Medical Center, conduct periodic meetings to review clinical performance of members of the Medical Staff based upon medical records, and facilitate the Medical Center’s obligation to prepare and maintain a complete and accurate record for each patient. The Medical Staff shall exercise its rights and responsibilities in a manner that does not jeopardize the licensure, Medicare or Medi-Cal provider status, accreditation, certification, or tax exempt status of the Medical Center.

3.1.1 MEDICAL STAFF PURPOSES

The purposes of the medical staff organization are:

A. To be the formal organizational structure through which the benefits of membership on the Medical Staff may be obtained by individual practitioners and the obligations of medical staff membership may be fulfilled, and to serve as a means for the Medical Staff, Board, and Medical Center administration to discuss issues of mutual concern and implement education and changes to improve the quality of care.

B. To serve as the primary means for accountability to the Board for the quality and appropriateness of the professional performance and ethical conduct of its members and to strive toward assuring that patient care in the Medical Center is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and the resources available at the Medical Center;

C. To help ensure that all Medical Center patients receive a uniform standard of quality patient care.

D. To provide a means through which the Medical Staff may participate in the policy-making and planning processes of the Medical Center.

E. To support research and educational activities in the interest of improving patient care, the skills of persons providing health services, and the promotion of the general health of the community.
F. To provide education and maintain high educational standards for members of the Medical Staff, House Staff, Medical Students, nursing staff, student nurses and other students compatible with affiliations between the Medical Center and educational institutions, including, but not limited to, the following: University of California, Los Angeles; California State University, Bakersfield; and Kern Community College District.

3.1.2 MEDICAL STAFF RESPONSIBILITIES

The responsibilities of the medical staff organization to be fulfilled through the actions of its officers, departments and committees include:

A. Providing quality patient care.

B. Selecting and removing medical staff officers.

C. Assessing medical staff dues and utilizing those dues as appropriate for the purposes of the Medical Staff and only in a manner that does not jeopardize the licensure, Medicare and/or Medi-Cal provider status, accreditation, certification or tax exempt status of the Kern Medical Center.

D. As appropriate, retention of independent legal counsel at the expense of the Medical Staff.

E. Accounting to the Board for the quality and appropriateness of patient care provided by all practitioners authorized to practice in the Medical Center through the following measures:

1. A credentials program, including mechanisms for appointment and reappointment and the matching of clinical privileges to be exercised with the education, verified credentials, and current demonstrated competence of the applicant or member.

2. A continuing education program, fashioned at least in part on the needs demonstrated by the quality and utilization management programs.

3. A utilization management program that provides for the appropriate use of all medical services and allocates medical and health services based upon patient-specific determinations of individual medical needs.

4. An organization structure that allows continuous monitoring and evaluation of patient care practices.

5. A quality assessment procedure that allows a valid and reliable review of the quality of patient care.
F. Establishing criteria and standards for membership and clinical privileges, enforcing those criteria and standards, and recommending to the Board action with respect to appointments, reappointments, medical staff category, department assignments, clinical privileges and corrective action.

G. Accounting to the Board for the quality, appropriateness and efficiency of patient care rendered to patients through regular reports and recommendations concerning the implementation, operation and results of the quality and utilization management programs.

H. Initiating and pursuing corrective action with respect to practitioners when warranted.

I. Initiating, developing, adopting, administering, and seeking compliance with these Bylaws, the Medical Staff Rules and Regulations, and other patient care related Medical Center policies.

J. Assisting the Medical Center with identification of community health needs and setting appropriate institutional goals and implementing programs to meet those needs.

K. Cooperating with and assisting the Medical Center in maintaining accreditation.

L. Exercising the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities.

M. Providing a framework for cooperation with other community health facilities and/or educational institutions.

The Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management and physical plant safety by providing medical staff representation on Medical Center committees established to perform such functions.
ARTICLE IV
MEMBERSHIP

4.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Medical staff membership and/or clinical privileges may be extended to and maintained by only those professionally competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and the Medical Staff Rules and Regulations. No physician, dentist, podiatrist or clinical psychologist, including those individuals in a medicoadministrative position, shall admit or provide medical or health-related services to patients in the Medical Center unless the practitioner is also a member of the Medical Staff with delineated clinical privileges or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws. Appointment to the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws.

4.2 QUALIFICATIONS FOR MEMBERSHIP

4.2.1 GENERAL QUALIFICATIONS

With the exception of Honorary and Retired Staff categories, in which case these criteria shall only apply as deemed individually applicable by the Medical Staff, only those physicians, dentists, podiatrists and clinical psychologists who continuously meet the following qualifications are eligible for medical staff membership:

A. License. A current, valid, unrestricted license from the state of California to practice medicine or osteopathy, dentistry, podiatry or clinical psychology.

B. DEA Registration. A current, valid DEA certificate, if required by the practitioner’s current clinical privileges.

C. Education. Satisfactory completion of an approved postgraduate residency training program in the specialty in which clinical privileges are requested.

D. Professional Liability Insurance. Current, valid professional liability insurance or its equivalent with coverage equal to the policy limits, which shall not be less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the aggregate per annum. If the insurance required under this section is written on a claims made basis, the insurance policy shall provide an extended reporting period of not less than four (4) years. Members of the Medical Staff who are employed by the Hospital Authority, at the election of the Board in its sole discretion, shall be exempt from this requirement.

E. Medicare and Medicaid Sanctions. Have billing privileges with and be eligible to receive payments from the federal Medicare and state Medicaid
(Medi-Cal) programs, and not be excluded or debarred from participation in such programs.

F. **Availability.** Be located in appropriate proximity (both office and residence) to the Medical Center in order to provide timely care to his or her patients. The permissible distance to the Medical Center may vary depending upon the medical staff category and clinical privileges that are involved and the feasibility of arranging alternative coverage. The availability and proximity requirements set forth in this Section 4.2.1 F shall not apply to those members of the Medical Staff who only have telemedicine privileges.

G. **Felony Convictions.** No record of conviction of a felony related to competency or conduct that could reasonably be expected to impact medical staff responsibilities or the exercise of clinical privileges.

H. **Ethics.** To adhere to the ethics of their respective professions, which includes the prohibition against fee-splitting, disclosing to patients when another physician will be performing surgery, obtaining informed patient consent for procedures, and delegation of patient care and diagnosis to a practitioner qualified to undertake such responsibility.

I. **Attitude.** Must be able to work cooperatively with others so as not to adversely affect patient care.

J. **Maintain Confidentiality of Information.** To keep as confidential, as required by law, all information or records received in the physician-patient relationship.

K. **Medical Staff Functions.** Must be willing to participate in and properly discharge those responsibilities determined by the Medical Staff and Board related to the functions of the Medical Staff.

L. **Exclusive Contracts; Exclusive Use Policy.** If requesting clinical privileges in a department or service line operated by the Medical Center under an exclusive contract or an exclusive use policy, be a member, employee or subcontractor of the group or person that holds the exclusive contract or enjoys the exclusive use.

Persons not fulfilling the requirements of Sections 4.2.1 B, 4.2.1 C, or 4.2.1 G may apply for special consideration and must provide documentation and evidence to the medical executive committee and Board regarding why the required qualification(s) should be waived. The medical executive committee and the Board may act in their sole discretion when determining whether any special consideration and waiver of a required qualification should be provided to any individual. No individual has any right to a waiver of the required qualification(s) and the election of either the medical executive committee or the Board to exercise their respective discretion to either grant or not grant a waiver in any particular
situation shall not give rise to the right to a hearing or appellate review under these Bylaws. Practitioners who were members of the Medical Staff of Kern Medical Center as of June 30, 2016, who do not meet the qualification of Section 4.2.1 C are exempt from such qualification as long as they can otherwise demonstrate competency and continuously remain members of the Medical Staff unless otherwise required by their current clinical responsibilities.

4.2.2 PARTICULAR QUALIFICATIONS

A. Physicians. An applicant for physician membership in the Medical Staff, except for the Honorary and Retired Staff, must hold a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) degree or their equivalent and a valid and unsuspended certificate to practice medicine issued by the Medical Board of California or the Osteopathic Medical Board of California and be certified by or currently qualified and eligible to take the board certification examination of a board recognized by the American Board of Medical Specialties, or a board or association with equivalent requirements approved by the Medical Board of California or Osteopathic Medical Board of California, as appropriate, in the specialty that the practitioner will practice at the Medical Center. The requirement for board certification or board eligibility set forth in this Section 4.2.2 shall not apply to a practitioner who was a member of the Medical Staff of Kern Medical Center as of June 30, 2016, as long as the practitioner has completed a residency program approved by the Accreditation Council for Graduate Medical Education that provided complete training in the specialty or subspecialty that the practitioner will practice at the Medical Center and the Medical Staff determines that the practitioner possesses the necessary background, education, training, and skills necessary to safely exercise the clinical privileges requested. All applicants for medical staff membership and clinical privileges must also have adequate physical and mental health status (subject to any necessary reasonable accommodation) to demonstrate to the satisfaction of the Medical Staff that he or she is sufficiently healthy and professionally and ethically competent so that patients can reasonably expect to receive medical care of a quality consistent with the generally recognized standards of care for this community. Without limiting the foregoing, with respect to communicable diseases and other conditions that could affect the ability to provide safe and quality care, practitioners are expected to know their own health status, to take such precautionary measures as may be warranted under the circumstances to protect patients and others present in the Medical Center, and to comply with all reasonable precautions established by the Medical Center and/or Medical Staff policy respecting safe provision of care and services in the Medical Center.

B. Limited License Practitioners.

1. Dentists. An applicant for dental membership in the Medical Staff, except for the Honorary or Retired Staff, must hold a D.D.S. or
2. **Podiatrists.** An applicant for podiatric membership on the Medical Staff, except for the Honorary or Retired Staff, must hold a D.P.M. degree and a valid and unsuspended certificate to practice podiatry issued by the California Board of Podiatric Medicine.

3. **Clinical Psychologists.** An applicant for clinical psychologist membership on the Medical Staff, except for the Honorary or Retired Staff, must hold a clinical psychologist degree and a valid and unsuspended certificate to practice clinical psychology issued by the California Board of Psychology.

4.3 **EFFECT OF OTHER AFFILIATIONS**

No person shall be entitled to membership in the Medical Staff merely because that person holds a certain degree, is licensed to practice in California or in any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, medical staff membership or clinical privileges at another health care facility.

4.4 **NONDISCRIMINATION**

Medical staff membership or particular clinical privileges shall not be denied on the basis of age, sex, including gender preference, religion, race, creed, color, national origin, or any physical or mental impairment if, after any necessary reasonable accommodation, the applicant complies with these Bylaws, the Medical Staff Rules and Regulations, Medical Staff policies, and the policies and procedures of the Medical Center.

4.5 **BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP**

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

A. Providing patients with quality medical care in an efficient manner that is consistent with the professional standards of the Medical Staff of the Medical Center;

B. Abiding by the Medical Staff Bylaws, the Medical Staff Rules and Regulations, and all other standards and policies of the Medical Staff;

C. Abiding by all Kern Medical Center bylaws, policies and procedures;

D. Discharging in a responsible and cooperative manner such responsibilities and assignments for which the member is responsible by appointment, election or otherwise;
E. Preparing and completing in timely fashion medical records for all the patients to whom the member provides care in the Medical Center;

F. Assuring the completion of a physical examination and medical history on all patients within twenty-four (24) hours after the patient’s admission or immediately before the patient’s admission to the Medical Center. This requirement may be satisfied by a complete history and physical that has been performed within the thirty (30) days prior to admission (the results of which are recorded in the patient’s Medical Center medical record) as long as an examination for any changes in the patient’s condition is completed and documented in the patient’s medical record within twenty-four (24) hours after admission to the Medical Center;

G. Complying with all federal and state laws and regulations regarding fraud and abuse;

H. Complying with all applicable accreditation standards of The Joint Commission and any other organization that provides accreditation and/or certification for the Medical Center, any of its programs and/or facilities.

I. Making appropriate arrangements for coverage of that member’s patients as determined by the Medical Staff and Board;

J. Properly supervising healthcare professionals under the member’s supervision, including House Staff, Medical Students and Allied Health Professionals;

K. Aiding in any educational programs for the Medical Staff, Medical Students, interns, resident physicians, resident dentists, nurses and other personnel when so assigned;

L. Refusing to engage in improper inducements for patient referral;

M. Participating in continuing education programs as determined by the Medical Staff and completing continuing medical education (“CME”) that meets all licensing requirements and is appropriate to the member’s specialty;

N. Participating in such emergency service coverage and/or in-house consultation panels as may be determined by the medical executive committee and/or the Board;

O. Assisting the Medical Center in fulfilling its uncompensated or partially compensated patient care obligations within the areas of the member’s professional competence and credentials;
P. Refraining from delegating the responsibility for diagnosis or care of hospitalized patients to a practitioner or AHP who is not qualified to undertake this responsibility or who is not adequately supervised;

Q. Actively participating in and regularly cooperating with the Medical Staff in assisting the Medical Center to fulfill its obligations related to patient care, including, but not limited to, continuous organization-wide quality measurement, assessment, and improvement, peer review, utilization management, quality evaluation, ongoing and focused professional practice evaluations ("OPPE" and "FPPE," respectively) and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time by the medical executive committee or the Board;

R. Recognizing the importance of communicating with appropriate department chairs or medical staff officers when the member obtains credible information indicating that a fellow medical staff member may have engaged in unprofessional or unethical conduct or may have a health condition that poses a significant risk to the well-being or care of patients, and then cooperate as reasonably necessary toward the appropriate resolution of any such matter;

S. Working cooperatively with other members of the Medical Staff, nurses, Medical Center administration and others so as not to adversely affect patient care;

T. Notifying the medical staff office in writing immediately, and in all cases within three (3) business days, following any action taken regarding the member’s license, DEA registration, clinical privileges at other facilities, changes in professional liability insurance coverage, any report filed with the National Practitioner Data Bank, or any other action that could affect the member’s medical staff standing and/or clinical privileges at the Medical Center;

U. Discharging such other medical staff obligations as may be lawfully established from time to time by the Medical Staff or medical executive committee; and

V. Continuously meeting the qualifications for and performing the responsibilities of membership as set forth in these Bylaws. A member may be required to demonstrate continuing satisfaction of any of the requirements of these Bylaws upon the reasonable request of the medical executive committee. This shall include, but is not limited to, mandatory health or psychiatric evaluation and mandatory drug and/or alcohol testing, the results of which shall be reportable to the medical executive committee and the wellness committee.
4.6 STANDARDS OF CONDUCT

Members of the Medical Staff are expected to adhere to these medical staff standards of conduct, including, but not limited to, the following:

4.6.1 GENERAL

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

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

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

4.6.2 CONDUCT GUIDELINES

A. Upon receiving medical staff membership and/or clinical privileges at the Medical Center, the member enters a common goal with all members of the organization to endeavor to maintain the quality of patient care and appropriate professional conduct.

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

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

D. Complaints and disagreements among the Medical Staff and between members of the Medical Staff and others shall be aired constructively, in a non-demeaning manner, and through official channels.

E. Members of the Medical Staff shall not engage in conduct that is offensive or disruptive, whether it is written, oral or behavioral.
ARTICLE V
CATEGORIES OF MEMBERSHIP

5.1 CATEGORIES

The Medical Staff has categories of membership that describe the qualifications and prerogatives of the members within each category. Categories generally describe a medical staff member’s level of participation in patient care at the Medical Center as well as the opportunity to be involved in or to take a leadership role in medical staff organization functions. The categories of the Medical Staff shall include the following: Active, Courtesy, Consulting, Provisional, Honorary, Retired, Advisory, Associate, and Administrative.

5.2 ACTIVE STAFF

5.2.1 QUALIFICATIONS

The Active Staff shall consist of members who:

A. Meet the general qualifications for membership set forth in Section 4.2.

B. Regularly admit, or are otherwise regularly involved in the care of, at a minimum, twenty-five (25) patients during each appointment cycle of twenty-four (24) months. Patient contacts for purposes of determining whether a member of the Medical Staff is involved in the care of a patient include inpatient admissions, inpatient and outpatient surgery or special procedures, and consultations.

C. Except for good cause shown as determined by the medical executive committee, have satisfactorily completed their designated term in the Provisional Staff category.

5.2.2 PREROGATIVES

The Active Staff member shall be entitled to:

A. Admit patients and exercise such clinical privileges as are granted pursuant to Article VII;

B. Attend and vote on matters presented at general and special meetings of the Medical Staff and of the department and committees to which the member is duly appointed; and

C. Hold medical staff, division, or department office and serve as a voting member of committees to which the member is duly appointed or elected by the Medical Staff or duly authorized representative thereof.
5.2.3 TRANSFER OF ACTIVE STAFF MEMBER

After two (2) consecutive years in which a member of the Active Staff fails to care for patients regularly in the Medical Center, as defined in Section 5.2.1, or be regularly involved in medical staff functions as determined by the medical executive committee, that member shall be automatically transferred to the appropriate category, if any, for which the member is qualified.

5.3 COURTESY STAFF

5.3.1 QUALIFICATIONS

The Courtesy Staff shall consist of members who:

A. Meet the general qualifications for membership set forth in Section 4.2.

B. Admit, or are otherwise involved in the care of, fewer than twenty-five (25) patients during each appointment cycle of twenty-four (24) months. Patient contacts for purposes of determining whether a member of the Medical Staff is involved in the care of a patient include inpatient admissions, inpatient and outpatient surgery or special procedures, and consultations.

C. Are members in good standing of the active or associate medical staff of another California licensed hospital, although exceptions to this requirement may be made by the medical executive committee and the Board for good cause as determined by the medical executive committee and the Board in their respective sole discretion. The failure of the medical executive committee and/or the Board to exercise their discretion and grant an exception to the requirement for membership in the active or associate medical staff of another licensed California hospital shall not give rise to any review, hearing or appellate rights under these Bylaws.

D. Have satisfactorily completed appointment in the Provisional Staff category.

5.3.2 PREROGATIVES

The Courtesy Staff member shall be entitled to:

A. Admit patients to the Medical Center within the limitations established by Section 5.3.1 B and exercise such clinical privileges as are granted pursuant to Article VII.

B. Attend in a non-voting capacity meetings of the Medical Staff and the department in which the individual is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.
Courtesy Staff members shall not be eligible to hold office in the Medical Staff.

5.3.3 TRANSFER OF COURTESY STAFF MEMBER

A member of the Courtesy Staff who admits or otherwise cares for more than twenty-four (24) patients at the Medical Center during an appointment cycle of twenty-four (24) months, as patient contacts and caring for patients are described in Sections 5.2.1 B and 5.3.1 B of these Bylaws, may seek appointment to the Active Staff category.

5.4 CONSULTING STAFF

5.4.1 QUALIFICATIONS

The Consulting Staff shall consist of members who:

A. Are not otherwise members of the Medical Staff and meet the general qualifications set forth in Section 4.2.

B. Possess adequate clinical and professional expertise to meet unmet department needs.

C. Will come to the Medical Center on schedule or promptly respond when called to render clinical services within their area of competence.

D. Are members in good standing of the active or courtesy medical staff of another California licensed hospital, although exceptions to this requirement may be made by the medical executive committee and the Board for good cause. The failure of the medical executive committee and/or the Board to exercise their discretion and grant an exception to the requirement for membership in the active or courtesy medical staff of another licensed California hospital shall not give rise to any review, hearing or appellate rights under these Bylaws.

E. Have satisfactorily completed appointment in the Provisional Staff category.

5.4.2 PREROGATIVES

The Consulting Staff member shall be entitled to:

A. Exercise such clinical privileges as are granted pursuant to Article VII.

B. Attend meetings of the Medical Staff and the department of which that individual is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.
Consulting Staff members shall not be eligible to hold office in the medical staff organization or serve upon committees.

5.5 PROVISIONAL STAFF

5.5.1 QUALIFICATIONS

The Provisional Staff shall consist of members who:

A. Meet the general qualifications of membership set forth in Section 4.2.

B. Immediately prior to their application and appointment were not members (or were no longer members) in good standing of the Medical Staff.

5.5.2 PREROGATIVES

The Provisional Staff member shall be entitled to:

A. Admit patients and exercise such clinical privileges as are granted to the member pursuant to Article VII.

B. Attend meetings of the Medical Staff and the department of which that individual is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

Provisional Staff members shall not be eligible to hold office in the medical staff organization, but may serve upon committees.

5.5.3 OBSERVATION OF PROVISIONAL STAFF MEMBER

Each Provisional Staff member shall undergo a period of observation and evaluation by designated proctors as described in Sections 7.8 and 7.9 of these Bylaws. The purpose of such observation shall be to evaluate the member’s (1) proficiency in the exercise of clinical privileges initially granted and (2) overall eligibility for continued medical staff membership and advancement within medical staff categories. Proctoring shall commence on performance of the first case. Observation of Provisional Staff members shall follow whatever frequency and format each department deems appropriate in order to adequately evaluate the Provisional Staff member, including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records of the observation and evaluation of the Provisional Staff member shall be maintained. The results of the observation and evaluation shall be communicated by the department chair to the credentials committee.
5.5.4 TERM OF PROVISIONAL STAFF STATUS

A member shall remain in the Provisional Staff for a period of six (6) months, unless that status is extended by the medical executive committee for an additional period of up to a total of twenty-four (24) months upon a determination of good cause, which determination by the medical executive committee shall not be subject to review pursuant to Articles XII or XIII of these Bylaws.

5.5.5 ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS

C. If the Provisional Staff member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued membership in the Medical Staff, the member shall be eligible for placement as Active, Courtesy or Consulting Staff, as appropriate, upon recommendation of the medical executive committee.

D. In all other cases, the appropriate department shall advise the credentials committee, which shall make its report to the medical executive committee which, in turn, shall make its recommendation to the Board regarding a modification or termination of clinical privileges or termination of Medical Staff membership.

E. A Provisional Staff member who has no activity at the Medical Center for the entire twenty-four (24) months of his or her provisional status may, upon recommendation of the chair of his or her department, be automatically moved to the Associate Staff category. This change in status shall not be subject to review pursuant to Articles XII or XIII of these Bylaws.

5.6 TELEMEDICINE STAFF

5.6.1 ADDITIONAL TELEMEDICINE DEFINITIONS

A. Distant Site means the site where a Telemedicine Provider who provides health care services is located while providing these services via a telecommunications system.

B. Originating Site means the site where the patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

C. A Telemedicine Provider is an individual provider who uses the telemedicine equipment at the Distant Site to render services to patients who are located at the Originating Site. The Telemedicine Provider is generally a physician, but other health professionals may also be involved as Telemedicine Providers. The Telemedicine Provider would generally contract with (or in the case of non-physicians, be employed by) the entity that serves as the Distant Site.
5.6.2 QUALIFICATIONS

The Telemedicine Staff shall consist of members who:

A. Meet the general qualifications for membership set forth in Section 4.2 other than the residency and proximity requirements set forth in Section 4.2.1 F.

B. Provide diagnostic, consulting or treatment services, from the Distant Site to patients at the Originating Site via telecommunication devices. Telecommunication devices include interactive (involving a real time [synchronous] or near real time [asynchronous store and forward] two-way transfer of medical data and information) telecommunications (but do not include telephone or electronic mail communications) between the Telemedicine Provider at the Distant Site and the patient at the Originating Site.

C. Regularly admit, consult and/or refer inpatients and outpatients to the Medical Center.

5.6.3 PREROGATIVES

The Telemedicine Staff member shall be entitled to:

A. Exercise clinical privileges only within the scope of his or her licensure as granted pursuant to Article VII.

B. Attend meetings of the Medical Staff and the department of which that individual is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

Telemedicine Staff members shall not be eligible to hold office in the medical staff organization, but may serve upon committees.

5.7 HONORARY AND RETIRED STAFF

5.7.1 QUALIFICATIONS

A. Honorary Staff

The Honorary Staff shall consist of physicians, dentists, podiatrists and clinical psychologists who do not actively practice at the Medical Center, 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 service to the Medical Center, and who continue to exemplify high standards of professional and ethical conduct. Honorary Staff members are not required to maintain licensure, DEA
registration, or professional liability insurance to be eligible for such membership in the Medical Staff.

B. Retired Staff

The Retired Staff shall consist of members who have retired from active practice and, at the time of their retirement, were members in good standing of the Active Staff for a period of at least ten (10) continuous years, and who continue to adhere to appropriate professional and ethical standards. Retired Staff members are not required to maintain licensure, DEA registration, or professional liability insurance to be eligible for such membership in the Medical Staff.

5.7.2 PREROGATIVES

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

5.8 ADVISORY STAFF

5.8.1 QUALIFICATIONS

The Advisory Staff shall consist of physicians, dentists, podiatrists and clinical psychologists who do not actively practice at the Medical Center, but who are important resource individuals for medical staff quality assessment and improvement activities. Such individuals shall be qualified to perform the functions for which they are made Advisory Staff members.

5.8.2 PREROGATIVES

Advisory Staff members shall be entitled to attend all meetings of committees to which they have been appointed for the limited purpose of carrying out quality assessment and improvement functions. They shall have no clinical privileges to perform clinical services in the Medical Center. They may not admit patients to the Medical Center, or hold office in the medical staff organization. They may, however, serve on designated committees, with or without vote at the discretion of the medical executive committee, and attend medical staff meetings upon invitation.
5.9 ASSOCIATE STAFF

5.9.1 QUALIFICATIONS

The Associate Staff shall consist of physicians, dentists, podiatrists and clinical psychologists who wish to be members of the Medical Staff for the limited purpose of association with the Medical Center, or whose services on behalf of the Medical Center do not require clinical privileges. Associate Staff members shall meet the general qualifications of medical staff membership set forth in Section 4.2.

5.9.2 PREROGATIVES

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

5.10 MEDICOADMINISTRATIVE STAFF

5.10.1 QUALIFICATIONS AND RESPONSIBILITIES

Medicoadministrative Staff membership shall be held by any physician who is not otherwise eligible for another Medical Staff category and is retained by the Medical Center solely to perform ongoing medical-administrative activities. The Medicoadministrative Staff shall consist of members who:

A. Are charged with assisting the Medical Center and/or Medical Staff in carrying out medicoadministrative functions, including, but not limited to, quality assessment and improvement and utilization review and management.

B. Document their (1) current licensure, (2) adequate experience, education and training, (3) current professional competence, (4) good judgment, and (5) current physical and mental health status, so as to demonstrate to the reasonable satisfaction of the Medical Staff that they are professionally and ethically competent to exercise their duties.

C. Are determined to (1) adhere to the ethics of their respective profession(s), (2) be able to work cooperatively with others so as not to adversely affect their judgment in carrying out the quality assessment and improvement functions, and (3) be willing to participate in and properly discharge those responsibilities.

D. Physicians retained by the Medical Center to perform ongoing medicoadministrative activities, such as the Chief Medical Officer, may be allowed time for clinical responsibilities at the discretion of the Chief
Executive Officer. In such circumstances, the physician shall apply for membership in the Medical Staff and the clinical privileges as may be necessary for the physician to render the clinical services. Membership in the Medical Staff and clinical privileges are separate and distinct from any employment arrangement or similar engagement and must be provided through the mechanisms in these Bylaws for the granting of membership and clinical privileges to all other categories of medical staff membership. Medical staff membership and clinical privileges are subject to proctoring, concurrent oversight, biennial review and the other provisions of these Bylaws, and the Medical Staff Rules and Regulations.

5.10.2 PREROGATIVES

The Administrative Staff shall be entitled to attend meetings of the Medical Staff and various departments, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except to the extent the right to vote is specified at the time of appointment. Administrative Staff members shall not be eligible to hold office in the medical staff organization, admit patients, or exercise clinical privileges at the Medical Center.

5.11 LIMITATION OF PREROGATIVES

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

5.12 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership in the Medical Staff, limited license 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 executive committee.

B. Shall exercise clinical privileges only within the scope of their licensure and as set forth in Section 7.4.

5.13 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the credentials committee, or pursuant to a request by a member under Section 6.15.4, or upon direction of the Board, the medical executive committee may recommend a change in the medical staff category of a member consistent with the requirements of these Bylaws, which determination shall not give rise to hearing, review or appeal rights under Article XIII.
ARTICLE VI
APPOINTMENT AND REAPPOINTMENT

6.1 GENERAL

Except as otherwise specified herein, no person (including persons engaged by the Medical Center for administrative positions) shall exercise clinical privileges in the Medical Center unless and until that person applies for and receives appointment to the Medical Staff or is granted temporary privileges as set forth in these Bylaws. By applying to the Medical Staff for appointment or reappointment (or, in the case of members of the Honorary or Retired Staff, by accepting an appointment to that category), the applicant acknowledges responsibility to review (a) these Bylaws, (b) the Medical Staff Rules and Regulations, Organization and Functions Manual, and policies, and (c) the bylaws, policies and procedures of the Medical Center. The applicant further agrees that throughout any period of membership that he or she will comply with the responsibilities of medical staff membership and with the Medical Staff Bylaws, Rules and Regulations, Organization and Functions Manual, and policies of the Medical Staff as they currently exist and as they may be amended from time to time. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws.

6.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement, or transfer, the applicant or member shall have the burden of producing information for an adequate evaluation of the applicant’s or member’s qualifications and suitability for the clinical privileges and medical staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. Consistent with applicable law, this burden may include submission to a medical or psychiatric examination, at the applicant’s or member’s expense, if deemed appropriate by the medical executive committee. The applicant or member may select the examining physician from an outside panel of three (3) physicians chosen by the medical executive committee. The failure of the applicant or member to sustain this burden shall be grounds for denial of an application or request. The submission of an application with any significant omission or misrepresentation shall be grounds for denial of an application for medical staff membership and/or clinical privileges.

6.3 DURATION OF APPOINTMENT AND REAPPOINTMENT

6.3.1 INITIAL APPOINTMENT

Initial appointments to the Medical Staff shall be for a period of six (6) months to twenty-four (24) months.

6.3.2 REAPPOINTMENT

Reappointment to any category of the Medical Staff shall be for a period not to exceed twenty-four (24) months.
6.4 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

6.4.1 APPLICATION FORM FOR INITIAL APPOINTMENT

A practitioner applying for appointment or reappointment shall complete a written application form developed by the medical executive committee and approved by the Board. The form shall require detailed information, which shall include, but not be limited to, information concerning:

A. The applicant’s qualifications, including, but not limited to, professional training and experience, current licensure, current DEA registration, if required, board certification status and CME information related to the clinical privileges to be exercised by the applicant.

B. Peer references familiar with the applicant’s recent professional competence and ethical character.

C. Requests for membership categories, departments and clinical privileges.

D. Past or pending professional disciplinary action, voluntary or involuntary denial, revocation, suspension, reduction or relinquishment of medical staff membership or clinical privileges or any licensure or registration, and related matters.

E. Past or pending felony convictions.

F. Past or pending Medicare and/or Medicaid sanctions or exclusions.

G. Current physical and mental health status.

H. Final judgments or settlements made against the applicant in professional liability cases, and any filed and served cases pending.

I. Professional liability insurance coverage.

J. Current PPD status.

Each application for initial appointment to the Medical Staff shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. When an applicant requests an application form, he or she shall be given a copy of these Bylaws, the Medical Staff Rules and Regulations, the Medical Staff Organization and Functions Manual, and, as deemed appropriate by the medical executive committee, copies or summaries of any other applicable Medical Staff policies relating to clinical practice in the Medical Center.
6.4.2 EFFECT OF APPLICATION

In addition to the matters set forth in Section 6.1, 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 competency, conduct, qualifications, and performance, and ability to exercise the clinical privileges requested, and authorizes such individuals and organizations to provide all such information candidly.

C. Consents to inspection of records and documents that may be material to an evaluation of the applicant’s qualifications and ability to carry out the 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 extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant.

E. Releases from any liability, to the extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information.

F. Consents to the disclosure to other hospitals, health systems, 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 Medical Center or Medical Staff may have, and releases the Medical Staff and Medical Center from liability for so doing to the extent permitted by law.

G. Acknowledges responsibility for timely payment of any applicable dues and application fees, if such a requirement then exists.

H. Pledges to provide for continuous quality care for patients.

I. Pledges to maintain an ethical practice, including refraining from illegal inducements for patient referrals, 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 patient’s surgery or a particular procedure, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners or AHPs.
J. Pledges to be bound by the Medical Staff Bylaws, the Medical Staff Rules and Regulations, and any Medical Staff policies.

K. Agrees that if membership and clinical privileges are granted, and for the duration of medical staff membership, the applicant has an ongoing and continuous duty to report immediately to the medical staff office, and in all cases within three (3) business days, any and all information that would otherwise correct, change, modify or add to any information provided in the application or most recent reappointment application when such correction, change, modification or addition may reflect adversely on current qualifications or medical staff membership or clinical privileges.

6.4.3 INITIAL APPOINTMENT OF TELEMEDICINE STAFF

The initial appointment of telemedicine privileges may be based upon a medical executive committee recommendation that is based on:

A. The practitioner meeting the general qualifications for membership set forth in Section 4.2 of these Bylaws other than those qualifications pertaining to residency and proximity to the Medical Center set forth in Section 4.2.1 F; and

B. The practitioner’s full compliance with the Medical Center’s credentialing and privileging standards or by using the Medical Center’s privileging standards but relying, in whole or in part, on information provided by a Distant Site hospital or Distant Site telemedicine entity, subject to compliance with 42 C.F.R. § 482.12 and 42 C.F.R. § 482.22, as further described below, at which the practitioner requesting clinical privileges routinely practices.

6.4.4 DISTANT SITE CREDENTIALING OF TELEMEDICINE STAFF

The Medical Staff may credential Telemedicine Staff utilizing the information obtained through the second option set forth in Section 6.4.3 B above only if the practitioner agrees to and does provide services in accordance with a written services agreement between the Medical Center and either another Medicare participating hospital (a “Distant Site Hospital”) or a telemedicine services entity (a “TSO”) (a “Telemedicine Services Agreement”) for which the applicant exercises clinical privileges. A copy of the applicable Telemedicine Services Agreement is submitted to the medical staff office and includes the following:

A. If the Telemedicine Services Agreement is between the Medical Center and a Distant Site Hospital:

1. A statement that the Distant Site Hospital is a contractor of services to the Medical Center;
2. A statement that the Distant Site Hospital is a Medicare-participating hospital;

3. A statement that the Distant Site Hospital is a Joint Commission-accredited hospital;

4. A statement that the Distant Site Hospital will cooperate with the Medical Center and provide services in a manner that will permit the Medical Center to comply with all applicable Medicare conditions of participation for the contracted services;

5. A statement that it is the responsibility of the Distant Site Hospital’s governing body to meet all of the requirements set forth in 42 C.F.R. § 482.12 (a)(1)-(a)(9) and 42 C.F.R. § 482.22 (a)(1)-(a)(4) with regard to each applicant;

6. A statement that the Distant Site Hospital’s governing body will ensure that each applicant providing services pursuant to the Telemedicine Services Agreement meets the qualifications for medical staff membership and clinical privileges at the Distant Site Hospital and will promptly notify the Medical Center of any changes to such qualifications, membership or clinical privileges;

7. A statement that the Distant Site Hospital will provide the Medical Center with a current list of each applicant’s privileges at the Distant Site Hospital;

8. A statement that the Medical Center will perform periodic review, consistent with the Medical Center’s peer review policy, of each applicant’s performance of any clinical privileges granted at the Medical Center and send to the Distant Site Hospital information that is useful to assess the applicant’s quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the Distant Site practitioner to the Medical Center’s patients and all complaints the Medical Center has received about the Distant Site practitioner; and

9. A statement that all Distant Site Hospital practitioners who will provide telemedicine services for Medical Center patients have and will maintain a valid license to practice medicine in the state of California.

B. If the Telemedicine Services Agreement is with a TSO:

1. A statement that the TSO is a contractor of services to the Medical Center;
2. A statement that the TSO’s credentialing and privileging process meets all of the requirements set forth in 42 CFR § 482.12 (a)(1)-(a)(7), Standards of The Joint Commission MS.06.01.01 through MS.06.01.07 (excluding EP 2 from MS.06.01.03) and 42 CFR § 482.22(a)(1)-(2) with regard to each applicant;

3. A statement that the TSO is a Joint Commission-accredited ambulatory care organization;

4. A statement that the TSO will ensure that each applicant providing services pursuant to the Telemedicine Services Agreement meets the qualifications for medical staff membership and clinical privileges at the TSO and will promptly notify the Medical Center of any changes to such qualifications, membership or clinical privileges;

5. A statement that the TSO will provide a current list of each applicant’s clinical privileges at the TSO;

6. A statement that the TSO will cooperate with the Medical Center and provide services in a manner that will permit the Medical Center to comply with all applicable Medicare conditions of participation for the contracted services;

7. A statement that the Medical Center will perform periodic review, consistent with the Medical Center’s peer review policy, of each practitioner’s performance of any clinical privileges granted at the Medical Center and send to the TSO information that is useful to assess the applicant’s quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the Distant Site practitioner to the Medical Center’s patients and all complaints the Medical Center has received about the Distant Site practitioner; and

8. A statement that all Distant Site practitioners who will provide telemedicine services to Medical Center patients have and will maintain a valid license to practice medicine in the state of California.

C. Credentialing and Privileging Information. The Distant Site Hospital or TSO provides the medical staff office with a current list of the applicant’s clinical privileges at the Distant Site Hospital or TSO, which includes at least those clinical privileges which the applicant is seeking at the Medical Center.

D. License/Registration. The applicant has and must maintain the licensure required by these Bylaws for the category of medical staff membership and
type of clinical privileges granted. An applicant whose licensure or registration is or has been denied, limited, or challenged in any way, is not eligible to be credentialed for telemedicine clinical privileges using this alternative process and must be credentialed in compliance with and using the Medical Center’s standard credentialing procedures and requirements.

6.5 VERIFICATION OF INFORMATION

The applicant shall fill out and deliver an application form to the medical staff office, which shall seek to verify the information submitted. The application will be deemed complete when all necessary verifications have been obtained, including current license, licensing board disciplinary records, specialty board certification status, National Practitioner Data Bank information, DEA certificate if appropriate, verification of all practice from professional school through the present date, current professional liability insurance, and reference letters. The medical staff office shall then transmit the application and all supporting materials to the chair of each department in which the applicant seeks appointment and clinical privileges and to the credentials committee.

6.6 INCOMPLETE APPLICATION

6.6.1 If the medical staff office is unable to verify the information, or if all necessary references have not been received, or if the application is otherwise significantly incomplete, the medical staff office may delay further processing of the application, or may begin processing the application based only on the available information with a decision that further information may be considered upon receipt.

6.6.2 If the processing of the application is delayed by the applicant for more than sixty (60) days and if the missing information is reasonably deemed significant to a fair determination of the applicant’s qualifications, the applicant shall be so informed. The applicant shall then be given the opportunity to withdraw his or her application, or to request the continued processing of the application. If the applicant does not respond within thirty (30) days, he or she shall be deemed to have voluntarily withdrawn the application. If the applicant requests further processing, but then fails to provide or arrange for the provision within forty-five (45) days or any other date mutually agreed to when the extension was granted (whichever is later) or the necessary information that the applicant could obtain using reasonable diligence, the applicant shall be deemed to have voluntarily withdrawn the application.

6.6.3 Any application deemed incomplete and withdrawn under this section may, thereafter, be reconsidered only if all requested information is submitted, and all other information has been updated.
6.7  DEPARTMENT EVALUATION AND RECOMMENDATION

After receipt of the application, the chair of each department to which the application is submitted shall review the application and supporting documentation, and may conduct a personal interview with the applicant at the chair’s discretion. The department chair may request additional information. The chair shall evaluate all matters deemed relevant to a recommendation, including information concerning the general competencies identified by the ACGME and The Joint Commission, the provision of services within the scope of clinical privileges granted, and the participation in relevant continuing education and shall transmit to the credentials committee a written report and recommendation as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached. The chair may also request that the medical executive committee defer action on the application.

6.8  CREDENTIALS COMMITTEE EVALUATION AND RECOMMENDATION

The credentials committee shall review the application, evaluate and verify the supporting documentation, the department chair’s report and recommendations, and other relevant information. The credentials committee may elect to interview the applicant and seek additional information. As soon as practicable, the credentials committee shall transmit to the medical executive committee a written report and its recommendations as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The committee may also recommend that the medical executive committee defer action on the application.

6.9  MEDICAL EXECUTIVE COMMITTEE EVALUATION AND RECOMMENDATION

At its next regular meeting after receipt of the credentials committee report and recommendation, or as soon thereafter as is practicable, the medical executive committee shall consider the report and any other relevant information. If there is any disagreement between the recommendations of the department chair and the credentials committee, the department chair and the credentials committee chair shall have the opportunity to present the rationale for their recommendations during the medical executive committee meeting. The medical executive committee may request additional information, return the matter to the credentials committee for further investigation, and/or elect to interview the applicant. The medical executive committee shall forward to the Chief Executive Officer, for prompt transmittal to the Board, a written report and recommendation as to medical staff appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The committee may also defer action on the application. The reasons for each recommendation shall be stated.
6.10 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

6.10.1 FAVORABLE RECOMMENDATION.

When the recommendation of the medical executive committee is favorable to the applicant, it shall be promptly forwarded, together with supporting documentation, to the Board.

6.10.2 ADVERSE RECOMMENDATION

When a final recommendation of the medical executive committee is adverse to the applicant, the Board and the applicant shall be promptly informed by written notice. The applicant shall then be entitled to the procedural rights as provided in Article XIII of these Bylaws.

6.11 BOARD ACTION

The Board shall review any favorable recommendation from the Medical Executive Committee and take action by adopting, rejecting, modifying or sending the recommendation back for further consideration. After notice, the Board may also take action on its own initiative if the medical executive committee does not give the Board a recommendation in the required time. The Board may also receive and take action on a recommendation following any applicable procedural rights described in Article XIII of these Bylaws. The Board shall make its final determination giving great weight to the actions and recommendations of the medical executive committee. Further, the Board determination shall not be arbitrary or capricious, and shall be in keeping with its legal responsibilities to act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the Medical Center.

6.12 NOTICE OF FINAL DECISION

Notice of the final decision shall be given to the members of the medical executive committee, the credentials committee, the chair of each department concerned, the applicant, the Chief Medical Officer, and the Chief Executive Officer. A decision and notice to appoint or reappoint shall include, if applicable: (1) the medical staff category to which the applicant is appointed; (2) the department to which the applicant is assigned; (3) the clinical privileges granted; (4) the dates of appointment and expiration of appointment; and (5) any special conditions attached to the appointment.

6.13 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff until after a waiting period that shall be the longer of (a) two (2) years after the final adverse decision or (b) the completion of all judicial proceedings served within two (2) years of the completion of the Medical Center proceedings that are relevant to the adverse action. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional
information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

6.14 TIMELY PROCESSING OF APPLICATIONS

Applications for medical staff appointments shall be considered in a timely manner by all persons and committees required by these Bylaws to act thereon. While special or unusual circumstances may constitute good cause and warrant exceptions, the following maximum time periods provide a guideline for routine processing of applications. These time periods are guidelines only and are not directives that would create any rights for a practitioner to have an application processed within these precise periods:

A. Evaluation, review, and verification of application and all supporting documents by the medical staff office: thirty (30) days from receipt of all necessary documentation.

B. Review and recommendation by the department(s): thirty (30) days after receipt of all necessary documentation from the medical staff office.

C. Review and recommendation by the credentials committee: thirty (30) days after receipt of all necessary documentation from the department(s).

D. Review and recommendation by the medical executive committee: thirty (30) days after receipt of all necessary documentation from the credentials committee.

E. Final action: one hundred eighty (180) days after receipt of all necessary documentation from the medical staff office, except when the review, hearing and appeal rights of Article XIII of these Bylaws apply.

6.15 REAPPOINTMENT AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

Prior to the expiration date of the current medical staff appointment (except for temporary appointments), a reapplication form developed by the medical executive committee and approved by the Board shall be mailed or delivered to the member. At least ninety (90) days prior to such expiration date, the member shall submit to the medical staff office the completed application form for renewal of appointment to the Medical Staff for the coming period, and for renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant, including, but not limited to, the matters set forth in Section 6.4.1, as well as other relevant matters. Upon receipt of the application, the information shall be processed as set forth in these Bylaws commencing at Section 6.5.

6.15.1 BASIS FOR REAPPOINTMENT

Recommendation for reappointment to the Medical Staff and for renewal of clinical privileges shall be based upon a reappraisal of the member’s health status, and
current proficiency in the Medical Center’s general competencies in light of his or her performance at the Medical Center and in other settings. The reappraisal is to include confirmation of adherence to medical staff membership requirements as stated in these Bylaws, the Medical Staff Rules and Regulations, Medical Staff and Medical Center policies, and the applicable department rules. Such reappraisal should also include relevant member-specific information from OPPE, FPPE (if any), performance improvement activities, and, where appropriate, comparisons to aggregate information about performance, judgment and clinical or technical skills, and reappraisal of the Medical Center’s patient care needs and ability to provide adequate support services and facilities for the member. Where applicable, the results of specific peer review activities shall also be considered. If sufficient review data are unavailable, peer recommendations may be used instead or reappointment may be based upon information provided by other hospital(s) where the member routinely practices. As to the members of the Telemedicine Staff, reappointment may be based on information provided by the hospital(s) or TSO(s) where the individual routinely practices, subject to compliance with 42 C.F.R. § 482.12 and 42 C.F.R. § 482.22, as contemplated by Sections 6.4.3 and 6.4.4 of these Bylaws.

6.15.2 LIMITATIONS ON EXTENSION OF APPOINTMENT

If the reappointment application has not been fully processed before the member’s appointment expires, the member’s membership and clinical privileges shall be automatically suspended until the review is completed, unless (i) good cause exists for the care of a specific patient or patients and no other health professional currently privileged possesses the necessary skills and is available to provide care to the specific patient(s), in which case the member’s clinical privileges may be temporarily extended while his or her full credentials information is verified and approved; or (ii) the delay is due to the member’s failure to timely return the reappointment application form or provide other documentation or cooperation, in which case the appointment shall terminate as provided in Section 6.15.7. An extension of an appointment does not create a vested right in the member to be reappointed.

6.15.3 RECOMMENDATIONS AND APPROVALS

The department chair shall review applications, engage in further consideration if appropriate, and make a recommendation to the credentials committee regarding medical staff appointments, reappointments and clinical privileges. The credentials committee shall then review the application and make a recommendation to the medical executive committee. The medical executive committee shall make a recommendation to the Board that is either favorable, adverse or defers the recommendation to a later date.
6.15.4 CHANGE IN STATUS

A medical staff member who seeks a change in medical staff status or modification of clinical privileges may submit such a request at any time upon a form developed by the medical executive committee, except that such application may not be filed within twelve (12) months of the time a similar request has been denied.

6.15.5 EFFECT OF APPLICATION

The effect of an application for reappointment or modification of Medical Staff status or clinical privileges is the same as that set forth in Section 6.4.2.

6.15.6 STANDARDS AND PROCEDURE FOR REVIEW

When a Medical Staff member submits the first application for reappointment, and every two (2) years thereafter, or when the member submits an application for modification of medical staff status or clinical privileges, the member shall be subject to an in-depth review generally following the procedures set forth in Sections 6.5 through 6.14, including a review of applicable clinical performance data.

6.15.7 FAILURE TO SUBMIT REAPPOINTMENT APPLICATION

Except as set forth in Section 6.15.2 above, failure without good cause to timely submit a completed application for reappointment shall result in the automatic termination of the member’s medical staff membership, clinical privileges and prerogatives at the end of the current medical staff appointment, and the member shall be deemed to have resigned membership in the Medical Staff. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article XIII of these Bylaws shall not apply.

6.16 LEAVE OF ABSENCE

6.16.1 REQUEST FOR LEAVE OF ABSENCE

At the discretion of the medical executive committee and upon an affirmative recommendation from the relevant department chair, a medical staff member may obtain a voluntary leave of absence from the Medical Staff upon submitting a written request to the assigned department chair stating the approximate period of leave desired, which may not exceed twelve (12) months. During the period of the leave, the member shall not exercise clinical privileges at the Medical Center, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the medical executive committee.

6.16.2 REQUEST FOR REINSTATEMENT

At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the medical staff member may request reinstatement of clinical
privileges by submitting a written notice to that effect to the assigned department chair. The medical staff member shall submit a summary of relevant activities during the leave, if the department chair or medical executive committee so requests. The department chair shall make a recommendation to the medical executive committee concerning the reinstatement of the member’s clinical privileges and prerogatives, and the procedure provided in Sections 6.1 through 6.14 shall be followed. The medical executive committee may limit the reinstatement or otherwise impose conditions to assure that the member has provided sufficient current information to evaluate his or her qualifications for reinstatement and continued practice. A member who has been on a leave of absence for more than one hundred eighty (180) days or for reasons of illness will undergo a period of focused professional practice evaluation to include proctoring, if indicated, which limitation or condition shall not give rise to review, hearing, or appeal rights under Article XIII of these Bylaws, unless such evaluation would require a report to the National Practitioner Data Bank, the MBC or the OMBC.

6.16.3 FAILURE TO REQUEST REINSTATEMENT

Failure without good cause to request reinstatement of a voluntary leave of absence shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership and clinical privileges. 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.

6.16.4 MILITARY LEAVE OF ABSENCE

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the department chair, medical executive committee and Board. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions of Sections 6.16.2 and 6.16.3, but may be granted subject to focused professional practice evaluations determined by the department chair, medical executive committee and/or Board.
ARTICLE VII
DELINEATION OF CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws or the Medical Staff Rules and Regulations, every practitioner providing direct clinical services at the Medical Center shall be entitled to exercise only those clinical privileges granted to him or her. Practitioners who wish to participate in the delivery of telemedicine services (whether to patients of the Medical Center or to patients of another facility that the Medical Center is assisting via telemedicine technology) must apply for and be granted procedure-specific telemedicine privileges. Practitioners who are not otherwise members of the Medical Center’s medical staff who wish to provide services via telemedicine technology must apply for and be granted membership and clinical privileges as part of the Telemedicine Staff in order to provide telemedicine services to patients of the Medical Center.

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2.1 REQUESTS

Each application for initial membership or renewal of membership to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. A request by a member for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request.

7.2.2 BASIS FOR PRIVILEGES DETERMINATION

A. Requests for clinical privileges shall be evaluated on the basis of the practitioner’s education, training, experience, current physical and mental health status, demonstrated professional competence and judgment, clinical performance, and the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate. Determinations on requests for clinical privileges may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a practitioner exercises or has exercised clinical privileges.

B. No specific clinical privilege may be granted to a practitioner if the task, procedure or activity constituting the clinical privilege is not available within the Medical Center despite the practitioner’s qualifications or ability to perform the requested clinical privilege.

7.2.3 CRITERIA FOR “CROSS-SPECIALTY” PRIVILEGES WITHIN THE MEDICAL CENTER

Any request for clinical privileges that are either new to the Medical Center and/or that overlap more than one department shall initially be reviewed by the
appropriate departments, in order to establish the need for, and appropriateness of, the new procedure or services. The medical executive committee shall facilitate the establishment of hospital-wide credentialing criteria for new or cross-specialty procedures, with the input of all appropriate departments, with a mechanism designed to ensure that quality patient care is provided for by all individuals with such clinical privileges. In establishing the criteria for such clinical privileges, the medical executive committee may establish an ad hoc committee with representation from all appropriate departments.

7.3 SYSTEM AND PROCEDURE FOR DELINEATING PRIVILEGES

The procedure by which a request for clinical privileges is processed is set forth in Sections 6.1 through 6.15 of these Bylaws. Qualifications for specific clinical privileges or groups of privileges are recommended by each clinical department to the credentials committee, and from the credentials committee to the medical executive committee. The medical executive committee shall make a recommendation regarding qualifications for clinical privileges to the Board, and the Board shall then take action on the recommendation of the medical executive committee.

7.4 SPECIAL CONDITIONS FOR DENTAL AND PODIATRIC PRIVILEGES

Surgical procedures performed by dentists or podiatrists will be under the overall supervision of the chair of the department of surgery. All dental and podiatric patients will receive a basic medical appraisal by a physician with appropriate clinical privileges on the Medical Staff. This means that a physician member of the Medical Staff must conduct the admitting history and physical examination (except the portion related to dentistry or podiatry) for patients of dentists and podiatrists. The physician member of the Medical Staff who conducts the history and physical examination will also be responsible for the care of any medical problem that may be present on admission or that may arise during medical hospitalization which are outside of the lawful scope of practice and delineated clinical privileges of the podiatrist or dentist.

7.5 TEMPORARY PRIVILEGES

7.5.1 CIRCUMSTANCES

Temporary privileges may be granted after appropriate application:

A. For thirty (30) day periods, subject to renewal during the pendency of an application, not to exceed a total of one hundred twenty (120) days;

B. For the care of up to four (4) specific patients each consecutive twelve (12) months;

C. For practitioners who will serve as locum tenens for a medical staff member for up to thirty (30) days at a time, subject to renewal for a total of one hundred (120) days in any consecutive twelve (12) months (if a locum tenens serves more than four (4) times in a calendar year, or for greater than
one hundred twenty (120) days in a calendar year, he or she shall be required to apply for regular medical staff membership if he or she desires to exercise clinical privileges at the Medical Center; or

D. As otherwise necessary to fulfill an important patient care need.

Temporary members of the Medical Staff, who are granted temporary membership for purposes of serving on standing or ad hoc committees for investigation proceedings, are not, by virtue of such membership, granted temporary clinical privileges.

7.5.2 APPLICATION PROCEDURE

Temporary privileges may be granted after the applicant completes the application procedure and the medical staff office completes the application review process. The following conditions apply:

A. There must first be verification of:

1. Current licensure;
2. Relevant training or experience;
3. Current competence;
4. Ability to perform the privileges requested.

B. The results of the National Practitioner Data Bank and applicable Medical Board of California queries have been obtained and evaluated.

C. The applicant has:

1. Filed a complete application with the medical staff office;
2. No current or previously successful challenge to licensure or registration;
3. Not been subject to involuntary termination of medical staff membership at another organization; and
4. Not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges at another organization.

7.5.3 REVIEW OF APPLICATION

A. There is no right to temporary privileges. Temporary privileges should not be granted unless the available information supports, with reasonable certainty, a favorable determination regarding the requesting applicant’s or
Allied Health Professional’s qualifications, ability and judgment to exercise the clinical or practice privileges requested.

B. If the available information is inconsistent or casts any reasonable doubts on the applicant’s qualifications, action on the request for temporary privileges may be deferred until the doubts have been satisfactorily resolved.

C. Temporary privileges may be granted by the Chief Executive Officer (or his/her designee) on the recommendation of the President of Staff (or his/her designee).

D. A determination to grant temporary privileges shall not be binding or conclusive with respect to an applicant’s pending request for appointment to the Medical Staff.

7.5.4 GENERAL CONDITIONS AND TERMINATION

A. Practitioners granted temporary privileges shall be subject to proctoring and supervision in accordance with the focused professional practice evaluation requirements specified in these Bylaws, the Medical Staff Rules and Regulations, and/or the Medical Staff policies.

B. Temporary privileges shall automatically terminate at the end of the designated period, unless affirmatively renewed or earlier terminated as provided in these Bylaws.

C. Temporary privileges may be terminated with or without cause at any time by the President of Staff, or the responsible department chair, Chief Medical Officer or Chief Executive Officer after conferring with the President of Staff (or his/her designee). A person shall be entitled to the procedural rights afforded by these Bylaws only if a request for temporary privileges is refused based upon, or if all or any portion of temporary privileges are terminated or suspended for, a medical disciplinary cause or reason. In all other cases (including a deferral in acting on a request for temporary privileges), the affected practitioner shall not be entitled to any procedural rights based upon any adverse action involving temporary privileges.

D. Whenever temporary privileges are terminated, the appropriate department chair or, in the chair’s absence, the President of Staff (or his or her designee) shall assign a member of the Medical Staff to assume responsibility for the care of the affected practitioner’s patient(s). The wishes of the patient and affected practitioner shall be considered in the choice of a replacement member.

E. All persons requesting or receiving temporary privileges shall be bound by these Bylaws, the Medical Staff Rules and Regulations, and the Medical
Staff policies as well as the bylaws, policies and procedures of the Medical Center to the same extent as a member of the Medical Staff.

7.5.5 TRANSPORT AND ORGAN HARVEST TEAMS

Properly licensed practitioners who individually, or as members of a group or entity, have contracted with the Medical Center to participate in transplant and/or organ harvesting activities may exercise clinical privileges at the Medical Center within the scope of their agreement with the Medical Center.

7.6 EMERGENCY PRIVILEGES

A. In the case of an emergency involving a particular patient, any member of the Medical Staff with clinical privileges to the degree permitted by the scope of the applicant’s license and regardless of department, medical staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of the patient or to save the patient from serious harm provided that the care provided is within the scope of the member’s license. The member shall make every reasonable effort to communicate promptly with the department chair concerning the need for emergency care and assistance by members of the Medical Staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the department chair with respect to further care of the patient at the Medical Center.

B. In the event of an emergency under Section 7.6 A, any person shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to qualified members of the Medical Staff when such care becomes reasonably available.

7.7 DISASTER PRIVILEGES

A. In the case of a disaster in which the disaster plan has been activated and the Medical Center is unable to handle the immediate patient needs, the President of Staff, or in the absence of the President of Staff, the President of Staff Elect or the Immediate Past President of Staff, may grant disaster privileges. In the absence of all of the above, the department chair(s), the Chief Executive Officer of the Medical Center or the Chief Executive’s Officer’s designee may grant disaster privileges as contemplated by this Section. The grant of disaster privileges under this Section shall be on a case-by-case basis at the sole discretion of the individual(s) authorized to grant such disaster privileges.

B. Those individuals authorized under this Section 7.7 to do so may grant disaster privileges upon presentation of a valid picture ID issued by a state, federal or regulatory agency and at least one of the following:
1. A current picture ID card with a clearly identifying professional designation issued by the Medical Center.

2. A current license to practice medicine in the state of California.

3. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (“DMAT”), Kern Medical Center Reserve Corp, the Medical Reserve Corp (the “MRC”), the Emergency System for Advance Registration of Volunteer Health Professionals (the “ESAR-VHP”), or other recognized state or federal agency or organization.

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

5. Verification by current Medical Center staff member(s) with personal knowledge regarding the practitioner’s qualifications.

C. During the disaster situation, the activities of individuals who receive disaster privileges will be managed by members of the Medical Staff. Individuals given disaster privileges will be appropriately identified by the Medical Center.

D. Current professional licensure of those providing care under disaster privileges is verified from the primary source as soon as the immediate situation is under control and completed within seventy-two (72) hours of the disaster privileges being granted, unless extraordinary circumstances prohibit verification, in which case the following is documented:

   1. The reasons verification could not be performed within seventy-two (72) hours.

   2. Evidence of demonstrated ability to continue to provide adequate care, treatment and services.

   3. An attempt to rectify the situation as soon as possible.

E. The verification process of the credentials and clinical privileges of individuals who receive disaster privileges will begin as soon as the immediate situation is under control. This privileging process is identical to the process established under the Medical Staff Bylaws for granting temporary privileges to fulfill an important patient care need.
7.8 PROCTORING REQUIREMENTS

7.8.1 INITIAL APPOINTMENTS

Except as otherwise provided for in these Bylaws or as recommended by the medical executive committee and approved by the Board, all practitioners initially granted membership to the Medical Staff shall complete a period of evaluation and proctoring to determine continued eligibility for clinical privileges. This may include direct observation of the practitioner’s performance and/or chart review. Each practitioner shall be assigned to a department where the practitioner’s performance shall be evaluated and proctored by the chair of the department or designee during the practitioner’s provisional status period. To the extent possible, procedures proctored will be the initial procedures performed by the practitioner. All procedures need not be proctored, but a sample reflective of the complexity of the clinical privileges granted will be selected. The exercise of clinical privileges in any other department shall be subject to the same evaluation and proctoring requirements.

If there is no member of the Medical Staff credentialed in the specialty of or the procedure being performed by the practitioner, proctoring will occur as follows: (1) a practitioner known by a medical executive committee member to be proficient in that procedure may be given temporary privileges to serve as a proctor for the practitioner; (2) proctoring information may be obtained from another hospital if performed within the last twelve (12) months and the practitioner remains in good standing at that institution; or (3) information about the practitioner’s general performance may be obtained from other concurrent or retrospective observers who have knowledge of the case. Cases may be prospectively and/or retrospectively reviewed and sent to an established and respected specialist in the field during the practitioner’s provisional period. The information obtained by this review will be evaluated by the department chair and sent to the credentials committee for review prior to the end of the six (6) month provisional period. Cases in which there is questionable performance will be referred for external review if members of the Medical Staff in the same specialty are unavailable to perform the review.

A practitioner shall remain subject to evaluation and proctoring until the practitioner has furnished the following to the credentials committee:

A. A report, signed by the chair of the assigned department, describing the types and numbers of cases which were evaluated, the procedures proctored, and an evaluation of the practitioner’s performance, a statement that the practitioner meets all of the qualifications, has discharged all of the responsibilities, and has not exceeded or abused the prerogatives of the category to which membership was granted; and

B. A report, signed by the chair of the other departments in which the practitioner seeks clinical privileges, describing the types and number of procedures proctored, an evaluation of the practitioner’s performance and a
statement that the practitioner has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted.

7.8.2 REQUEST FOR ADDITIONAL CLINICAL PRIVILEGES

When recommended by the medical executive committee and approved by the Board, members who request and are granted additional clinical privileges may be required to complete a period of proctoring in accordance with the provisions outlined in Section 7.8.1.

7.8.3 TERM OF EVALUATION AND PROCTORING

A. The term of evaluation and proctoring for initial appointment shall extend for a period up to six (6) months and for a minimum of six (6) cases. The number of cases evaluated and proctored for additional clinical privileges shall be as required by privileging criteria established by the department and approved by the medical executive committee and the Board.

B. Any department may establish, subject to the approval of the medical executive committee and the Board, a policy of evaluation and proctoring which establishes a longer period of time and/or a greater 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 that are involved.

C. If a practitioner new to the Medical Staff fails to have any patient activity at the Medical Center within a period of twenty-four (24) months, his or her clinical privileges shall automatically expire and the practitioner will be transferred to the Associate Staff category (i.e., membership on the Medical Staff with no clinical privileges).

D. If a medical staff member requesting additional clinical privileges fails to complete proctoring requirements within a period of twelve (12) months, the additional clinical privileges shall automatically expire.

E. The medical executive committee shall give the practitioner written notice that his or her clinical privileges have expired because he or she failed to satisfactorily complete proctoring requirements or has had no clinical activity. In such circumstances, the affected practitioner shall have no right to request a hearing pursuant to Article XIII of these Bylaws and shall not be entitled to the hearing, review and appeal rights set forth in Article XIII unless the practitioner’s failure to complete the proctoring requirement was the result of a medical disciplinary cause or reason.
7.9 PERFORMANCE EVALUATION AND MONITORING

7.9.1 GENERAL OVERVIEW OF PERFORMANCE EVALUATION AND MONITORING ACTIVITIES

The credentialing and privileging processes described in Article VI and Article VII of these Bylaws require that the Medical Staff develop ongoing performance evaluation and monitoring activities to ensure that decisions regarding appointment to and membership in the Medical Staff and granting or renewing of clinical privileges are, among other things, detailed, current, accurate, objective and evidence-based, and also incorporate performance evaluation and monitoring activities to help ensure that problems that may arise in the ongoing provision of services by a practitioner in the Medical Center are identified timely.

7.9.2 PERFORMANCE MONITORING GENERALLY

A. Except as otherwise determined by the medical executive committee and the Board, the Medical Staff shall regularly monitor all members’ clinical privileges in accordance with the provisions set forth in these Bylaws and such performance monitoring policies as may be developed by the Medical Staff and approved by the medical executive committee and the Board.

B. Performance monitoring is not viewed as a disciplinary measure, but rather is an information-gathering activity. Performance monitoring does not give rise to the procedural rights described in Article XIII of these Bylaws (unless the form of monitoring becomes a restriction of privileges because procedures cannot be done unless a proctor is present and proctors are not available after reasonable attempts to secure a proctor).

C. The Medical Staff shall clearly define how information gathered during performance monitoring shall be shared in order to effectuate change and additional action, if determined to be necessary.

D. Performance monitoring activities and reports shall be integrated into other quality improvement activities.

E. The results of any practitioner-specific performance monitoring shall be considered when granting, renewing, revising or revoking clinical privileges of that practitioner.

7.9.3 ONGOING PROFESSIONAL PRACTICE EVALUATION (“OPPE”)

A. Each department shall recommend, for medical executive committee and Board approval, the criteria to be used in the conduct of ongoing professional practice evaluation for its practitioners.

B. Methods that may be used to gather information for ongoing professional practice evaluation include, but are not limited to:
1. Periodic chart review;
2. Direct observation;
3. Monitoring of diagnostic and treatment techniques; and
4. Discussion with other individuals involved in the care of each patient, including consulting physicians, assistants at surgery, nursing and administrative personnel.

C. Ongoing performance reviews shall be factored into the decision to maintain, revise or revoke a practitioner’s existing clinical privileges.

7.9.4 FOCUSED PROFESSIONAL PRACTICE EVALUATION (“FPPE”)  

A. The Medical Staff is responsible for developing a focused professional practice evaluation process that will be used in predetermined situations to evaluate, for a time-limited period, a practitioner’s competency in performing one or more specific clinical privileges. The Medical Staff may supplement these Bylaws with policies, for approval by the medical executive committee and the Board, that will clearly define the circumstances when a focused evaluation will occur, what criteria and methods should be used for conducting the focused evaluation, the duration of the evaluation period, requirements for extending the evaluation period, and how the information gathered during the evaluation process will be analyzed and communicated.

B. Information for a focused evaluation process may be gathered through a variety of measures including, but not limited to:

1. Retrospective or concurrent chart review;
2. Monitoring clinical practice patterns;
3. Simulation;
4. External peer review;
5. Discussion with other individuals involved in the care of each patient; or
6. Proctoring, as more fully described in Section 7.8 and below.

C. A focused professional practice evaluation shall be used in at least the following situations:

1. All initial appointees to the Medical Staff and all members granted additional clinical privileges shall be subject to a period of focused
professional practice evaluation in accordance with these Bylaws and any rules of the department in which the applicant or member will be exercising those privileges. Such focused evaluation will generally include a period of initial proctoring in accordance with Section 7.8, unless additional circumstances appear to warrant a higher level of proctoring, as described below.

2. In special instances, focused evaluation will be imposed as a condition of renewal of clinical privileges (for example, when a member requests renewal of a privilege that has been performed so infrequently that it is difficult to assess the member’s current competency in that area). Such evaluation will generally consist of initial proctoring in accordance with Section 7.8, unless additional circumstances appear to warrant a higher proctoring level, as described below.

3. When questions arise regarding a practitioner’s competency in performing specific clinical privileges at the Medical Center as a result of specific concerns or circumstances, a focused evaluation may be imposed.

4. Nothing in the foregoing precludes the use of FPPE tools other than those identified in these Bylaws, in addition to or in lieu of proctoring, as deemed warranted by the circumstances.

D. Proctoring

1. Overview of Proctoring

Three types of focused reviews (or proctoring) are described below:

a. Initial proctoring (focused review at the time of initial appointment or request of new privileges) shall be considered routine and is generally implemented as a means to review initially requested clinical privileges in accordance with Section 7.8, and for review of infrequently used clinical privileges.

b. During the course of ongoing professional practice reviews, if a focused review is warranted but the circumstances do not involve a medical disciplinary cause or reason or where the focused review does not constitute a restriction on the practitioner’s privilege(s) (e.g., the practitioner is required to participate in proctoring and to notify either the proctor or other designated individual(s) prior to providing services, but is permitted to proceed without the proctor if one is not available or a focused retrospective chart review is considered), a “focused practice review” is appropriate.
c. Reinstatement of proctoring is appropriate in situations where a practitioner’s competency or performance is called into question due to a medical disciplinary cause or reason in accordance with these Bylaws, and where the form of proctoring is a restriction on the practitioner’s clinical privileges (e.g., the practitioner may not perform a procedure or provide care in the absence of the proctor). Upon imposition of this type of proctoring, the practitioner is entitled to the procedural rights as provided in Article XIII of these Bylaws.

2. Overview of Proctoring Procedures

a. Whenever proctoring is imposed, the number and types of procedures to be proctored shall be delineated along with the duration of the proctoring.

b. During the proctoring, the practitioner must demonstrate he or she is qualified to exercise the clinical privileges that were granted and is carrying out the duties of the assigned medical staff category.

3. Proctor – Scope of Responsibility

a. All members who act as proctors of practitioners and/or members of the Medical Staff are acting at the direction of the department, the medical executive committee and the Board. When possible, no business relationship shall exist between the proctor and the practitioner or member being proctored.

b. The intervention of a proctor shall be governed by the following guidelines:

(1) A member who is serving as a proctor does not act as a supervisor of the member or practitioner he or she is observing. The proctor’s role is to observe and record the performance of the member or practitioner being proctored, and report his or her evaluation to the department chair and/or the credentials committee.

(2) A proctor is not mandated to intervene when he or she observes what could be construed as deficient performance on the part of the practitioner or member being proctored.
(3) In an emergency situation, a proctor may intervene, even though he or she has no legal obligation to do so, and by intervening in such a circumstance, the proctor acting in good faith should be deemed a Good Samaritan within the “Good Samaritan” laws of the state of California.

4. Completion of Proctoring

The practitioner shall remain subject to such proctoring until the medical executive committee has been furnished with:

a. A report signed by the chair of the department to which the practitioner is assigned describing the types and numbers of cases observed and the evaluation of the practitioner’s performance, a statement that the member appears to meet all of the qualifications for unsupervised practice in the Medical Center, has discharged all of the responsibilities of medical staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made; and

b. A report signed by the chair of such other department(s) in which the practitioner may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the member’s performance and a statement that the member has satisfactorily demonstrated the ability to exercise the clinical privileges granted in those departments.

5. Failure to Satisfactorily Complete Proctoring

If a practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring, the practitioner’s medical staff membership may be terminated (or the relevant clinical privileges may be revoked), and the practitioner shall be afforded the procedural rights as provided in Article XIII of these Bylaws. In the event procedural rights are invoked by the practitioner when proctoring was not successfully completed, the practitioner who has not successfully completed proctoring shall be deemed an “applicant” for purposes of these Bylaws and any hearing and appeal rights available to the practitioner.

6. Effect on Advancement

The failure to complete proctoring for any specific privilege shall not, by itself, preclude advancement from Provisional Staff. If advancement is approved prior to completion of proctoring, the
proctoring will continue for the specified privileges. The specific privileges may be voluntarily relinquished or terminated if proctoring is not completed thereafter within two (2) reappointment cycles, without such action giving rise to hearing, review or appeal rights under Article XIII of these Bylaws.
ARTICLE VIII
ALLIED HEALTH PROFESSIONALS

8.1 QUALIFICATIONS OF ALLIED HEALTH PROFESSIONALS

Allied Health Professionals (AHPs) are not eligible for medical staff membership. They may be granted practice privileges if they hold a license, certificate or other credential in a category of AHPs that the Board (after securing medical executive committee comments) has identified as eligible to apply for practice privileges, and only if the AHPs are professionally competent and continuously meet the qualifications, standards and requirements set forth or otherwise referenced in the Medical Staff Bylaws, the Medical Staff Rules and Regulations, and/or the Interdisciplinary Practice Manual.

8.2 CREDENTIALING CRITERIA: BASIC REQUIREMENTS

A. The applicant must belong to an Allied Health Professional category approved for practice in the Medical Center by the Board.

B. If required by law, the applicant must hold a current, unrestricted state license or certificate.

C. Independent contractors of the Medical Center shall meet all conditions of their contract with the Medical Center.

D. The applicant must document his or her experience, education, background, training, demonstrated ability, judgment and physical and mental health status with sufficient adequacy to demonstrate that any patient he or she treats will receive care of the generally recognized professional level of quality and efficiency in the community and as established by the Medical Center and Medical Staff, and that he or she is qualified to exercise practice privileges within the Medical Center.

E. The applicant must maintain in force professional liability insurance or its equivalent for the practice privileges granted with coverage equal to the policy limits, which shall not be less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) in the aggregate per annum. If the insurance required under this section is written on a claims made basis, the insurance policy shall provide an extended reporting period of not less than four (4) years. Allied Health Professionals who are employed by the Hospital Authority, at the election of the Board in its sole discretion, shall be exempt from this requirement.

F. The applicant must submit a minimum of two (2) letters of reference from either licensed physicians or adequately trained professionals in the appropriate field and who are familiar with the applicant’s professional work and have demonstrated competency to assess the applicant’s skills and qualifications.
G. The applicant must be determined, on the basis of documented references, to adhere strictly to the lawful ethics of his or her profession, work cooperatively with others in the hospital setting so as not to adversely affect patient care, and be willing to participate in and properly discharge responsibilities as determined by the Medical Staff.

H. In addition to meeting the basic requirements outlined above, applicants must meet any specific requirements established by the Medical Staff for his or her category of AHP.

8.3 CATEGORIES

The Board shall determine, based upon comments of the medical executive committee and such other information as it has before it, those categories of AHPs that shall be eligible to exercise practice privileges in the Medical Center. Such AHPs shall be subject to the supervision requirements developed in each department and approved by the interdisciplinary practice committee (the “IPC”), the medical executive committee, and the Board.

8.4 PRIVILEGES AND DEPARTMENT ASSIGNMENT

AHPs may exercise only those practice privileges granted to them by the Board. The range of practice privileges for which each AHP may apply, and any special limitations or conditions to the exercise of such practice privileges, shall be based on recommendations of the IPC, subject to approval by the medical executive committee and the Board.

A. An AHP must apply and qualify for practice privileges, and practitioners who desire to supervise or direct AHPs who provide dependent services must apply and qualify for clinical privileges to supervise approved AHPs. Applications for initial granting of practice privileges and biennial renewal thereof shall be submitted by the AHP and processed in a similar manner to that provided for practitioners, unless otherwise specified in these Bylaws.

B. Each AHP shall be assigned to the department or departments appropriate to his or her occupational or professional training and, unless otherwise specified in these Bylaws, shall be subject to terms and conditions similar to those specified for practitioners as they may logically be applied to AHPs generally and, as may be appropriate for the circumstances, a particular category of AHP.

8.5 PREROGATIVES

The prerogatives which may be extended to an AHP shall be defined in Medical Center policies. Such prerogatives may include:

A. Provision of specified patient care services under the supervision or direction of a medical staff member and consistent with the practice
privileges granted to the AHP and within the scope of the AHP’s licensure or certification.

B. Service on the medical staff department and Medical Center committees.

C. Attendance at the meetings of the department to which the AHP is assigned, as permitted by the department rules, and attendance at Medical Center education programs in the AHP’s field of practice.

8.6 RESPONSIBILITIES

Each AHP shall:

A. Meet those basic requirements set forth in Section 8.2.

B. Retain appropriate responsibility within the AHP’s area of professional competence for the care and supervision of each patient in the Medical Center for whom the AHP is providing services.

C. Participate in peer review and quality improvement and in discharging such other functions as may be required from time to time by the Medical Center, the Medical Staff, or the IPC.

8.7 PROCEDURAL RIGHTS OF ALLIED HEALTH PROFESSIONALS

8.7.1 FAIR HEARING AND APPEAL

Denial, revocation, or modification of an AHP’s practice privileges shall be the prerogative of the Interdisciplinary Practice Committee as outlined in the Interdisciplinary Practice Manual. The procedural rights of AHPs to challenge a denial, revocation, or modification of an AHP’s practice privileges shall be set forth in the Interdisciplinary Practice Manual.

8.7.2 AUTOMATIC TERMINATION

An AHP’s practice privileges shall automatically terminate, without review, in the event:

A. The medical staff membership of the supervising practitioner is terminated, whether such termination is voluntary or involuntary;

B. The supervising practitioner no longer agrees to act as the supervising practitioner for any reason, or the relationship between the AHP and the supervising practitioner is otherwise terminated, regardless of the reason therefor; or

C. The AHP’s certification or license expires, is revoked, or is suspended.
8.8 REVIEW OF CATEGORY DECISIONS

The rights afforded by this Article VIII and the Interdisciplinary Practice Manual shall not apply to any decision regarding whether a category of AHP shall or shall not be eligible for practice privileges and the terms, prerogatives, or conditions of such decision. Those questions shall be submitted for consideration to the Board, which has the discretion to decline to review the request or to review it using any procedure the Board deems appropriate.
ARTICLE IX
MEDICAL STAFF OFFICERS

9.1 IDENTIFICATION

The general officers of the Medical Staff shall be the President of Staff, the President of Staff Elect, and the Immediate Past President of Staff.

9.2 QUALIFICATIONS

Officers must be members of the Active Staff for at least two (2) consecutive years 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. Officers must be practitioners with demonstrated competence in their fields of practice and must have demonstrated leadership abilities. All medical staff officers shall:

A. Understand the purposes and functions of the Medical Staff and demonstrate willingness to ensure that patient welfare always takes precedence over other concerns;
B. Understand and be willing to work toward attaining the Medical Center’s lawful and reasonable policies and requirements;
C. Have administrative ability as applicable to the respective office;
D. Be able to work with and motivate others to achieve the objectives of the Medical Staff and Medical Center;
E. Demonstrate clinical competence in his or her field of practice;
F. Observe and comply with all applicable county, state and federal laws, ordinances, rules and regulations regarding conflicts of interest; and
G. Not have any conflict of interest prohibited by the Hospital Authority policy on conflicts or the Hospital Authority Conflict of Interest Code.

9.3 DISCLOSURE OF CONFLICTS OF INTEREST

All nominees for election or appointment to medical staff offices (including those nominated by petition of the Medical Staff pursuant to Section 9.4.1 C) shall, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the medical executive committee (a) those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff, and (b) any potential and actual conflicts of interest required to be disclosed by the Hospital Authority policy on conflicts or the Hospital Authority Conflict of Interest Code. Generally, a conflict of interest arises when there is a divergence between an individual’s private
interests and his or her professional obligations, such that an independent observer might reasonably question whether the individual’s professional actions or decisions are determined by those private interests. A conflict of interest depends on the situation and not on the character of the individual. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. The medical executive committee shall evaluate such disclosures and discuss any conflicts of interest with the nominee. If a nominee with a conflict of interest remains on the ballot, the nature of his or her conflict of interest shall be disclosed in writing and circulated with the ballot.

9.4 NOMINATIONS AND ELECTIONS

9.4.1 NOMINATIONS AND ELECTION PROCEDURES FOR PRESIDENT OF STAFF AND PRESIDENT OF STAFF ELECT

A. The Medical Staff shall elect a President of Staff Elect and two (2) “at large” members to the medical executive committee every two (2) years, beginning with the year of adoption of these Bylaws. New officers shall assume their positions on July 1 of even-numbered years.

B. The nominating committee shall consist of the Immediate Past President of Staff, the President of Staff, the President of Staff Elect, the Chief Medical Officer (as a non-voting member), two (2) members of the Active Staff previously elected by the Medical Staff as “at large” members of the medical executive committee, and the Chief Executive Officer of the Medical Center (as a non-voting member). The nominating committee shall nominate one (1) or more nominees for President of Staff Elect and two or more Active Staff members for “at large” membership on the medical executive committee. The nominations of the nominating committee shall be reported to the medical executive committee at least thirty (30) days prior to the annual medical staff meeting. The nominations shall be circulated with the notice of the annual meeting.

C. The Medical Staff may also nominate candidates for available office by a petition signed by at least twenty (20) members of the Medical Staff who are eligible to vote and a statement from the candidate(s) signifying willingness to run. Such nominations must be received by the President of Staff at least thirty (30) days prior to the scheduled election.

D. The President of Staff Elect and the two “at large” members of the medical executive committee shall be elected at the annual meeting of the Medical Staff. Voting shall be by secret written ballot. Written ballots shall include handwritten signatures on the envelope for comparison with signatures on file, when necessary. A quorum shall not be required for the vote for medical staff officers at the annual medical staff meeting. A nominee shall be elected upon receiving a majority of the votes cast at the meeting by members of the Medical Staff eligible to vote. If no candidate for an office
receives a majority vote on the first ballot, a run-off election shall be held promptly between the two (2) candidates receiving the highest number of votes for the office. In the case of a tie on the second ballot, the majority vote of the medical executive committee shall decide the election by secret written ballot at its next meeting or a special meeting called for that purpose.

As to the election of the two (2) “at large” members to the medical executive committee, if there are more than two (2) candidates for the “at large” positions on the medical executive committee, the two (2) candidates with the highest number of votes during the election shall be elected to those positions. If one (1) candidate has the highest number of votes and there is a tie between two (2) or more candidates for the second highest number of votes, then the candidate who received the highest number of votes shall take office and there shall be a run-off election between those candidates who tied for the second highest number of votes. The candidate with the highest number of votes in the run-off election shall then take office as the second “at large” member of the medical executive committee. If there is a tie in the run-off election for the highest number of votes, the majority vote of the medical executive committee shall decide the election of the second “at large” member to the medical executive committee by secret written ballot at its next meeting or at a special meeting called for that purpose. In the event that more than two (2) candidates garner the highest number of votes in the first election for the “at large” members to the medical executive committee, then there shall be a run-off election between all the candidates who garnered the highest number of votes during that first election. The two (2) candidates with the highest number of votes in the run-off election shall then take office. If one candidate has the highest number of votes in the run-off election and there is a tie for the second highest number of votes in the run-off election, then the candidate with the highest number of votes shall take office, and the election for the second “at large” position shall be decided by the majority vote of the medical executive committee by secret written ballot at its next meeting or at a special meeting called for that purpose. In the event that more than two (2) candidates received the highest number of votes during the run-off election, then the majority vote of the medical executive committee shall decide the election by secret written ballot at its next meeting or at a special meeting called for that purpose.

9.5 TERM OF ELECTED OFFICE

Each medical staff officer shall serve a two (2) year term, commencing on the first day of the medical staff year following the election. Each officer shall serve in each office until the end of that officer’s term, or until a successor is elected, unless that officer shall sooner resign or be removed from office. At the end of that officer’s term, the President of Staff Elect shall automatically assume the office of the President of Staff and the President of Staff shall automatically assume the office of Immediate Past President of Staff. The “at large” medical executive committee members shall each serve a term of two (2) years.
9.6  RECALL OF OFFICERS

Any medical staff officer may be removed from office for valid cause, including, but not limited to, a failure to carry out the duties of the office, gross neglect or misfeasance in office, or acts of moral turpitude. Recall of a medical staff officer may be initiated by the medical executive committee or the Medical Staff by a petition signed by at least twenty percent (20%) of the members of the Medical Staff eligible to vote for officers. Recall of medical staff officers may be considered at a special meeting of the Medical Staff or the medical executive committee called for that purpose. Recall shall require a 2/3 supermajority vote of the medical staff members eligible to vote for medical staff officers who actually cast votes, in person, at the special meeting called for that purpose or a 2/3 supermajority vote of the medical executive committee.

9.7  VACANCIES IN ELECTED OFFICE

9.7.1  VACANCIES IN PRESIDENT OF STAFF, PRESIDENT OF STAFF ELECT AND IMMEDIATE PAST PRESIDENT OF STAFF

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer’s loss of membership in the Medical Staff. If there is a vacancy in the office of President of Staff, then the President of Staff Elect shall serve out that remaining term as President of Staff. If there is a vacancy in the office of President of Staff Elect, that office need not be filled by election, but the medical executive committee shall appoint an interim officer to fill this office until the next regular election, at which time the election shall also include the office of President of Staff.

9.8  DUTIES OF OFFICERS

9.8.1  PRESIDENT OF STAFF

The President of Staff shall serve as the chief officer of the Medical Staff. The duties of the President of Staff shall include, but not be limited to:

A.  Enforcing these Bylaws, the Medical Staff Rules and Regulations, and Medical Staff policies;

B.  Promoting quality of care, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;

C.  Serving as chair of the medical executive committee, and in that capacity shall be deemed to the individual responsible for the organization and conduct of the Medical Staff;

D.  Serving as an ex officio member of all other medical staff committees, without vote, unless the membership of the President of Staff in a particular committee is required or otherwise contemplated by these Bylaws;
E. Calling, presiding at, and being responsible for the agenda for all meetings of the medical executive committee;

F. Calling, presiding at and being responsible for the agenda for all annual and special meetings of the Medical Staff;

G. Interacting with the Chief Executive Officer and Board in all matters of mutual concern within the Medical Center;

H. Appointing, in consultation with the Chief Executive Officer, the Chief Medical Officer, and the medical executive committee, committee members for all standing committees other than the medical executive committee, and all special and ad hoc medical staff, liaison, or multi-disciplinary committees, except where otherwise provided by these Bylaws and/or related documents, and, except where otherwise indicated, designating the chairs of these committees;

I. Representing the views and policies of the medical staff organization to the Board and to the Chief Executive Officer;

J. Being a spokesperson for the Medical Staff in external professional and public relations;

K. Performing such other functions as may be assigned to the President of Staff by these Bylaws, the Medical Staff, or by the medical executive committee;

L. Appointing members of the Medical Staff to participate, as medical staff liaisons, in the development of Medical Center policies;

M. Serving on the joint conference committee;

N. Being accountable to the Board, in conjunction with the medical executive committee, for the effective performance, by the Medical Staff, of its responsibilities with respect to the quality and efficiency of clinical services within the Medical Center and for the effectiveness of the quality assurance and utilization review programs;

O. Regularly reporting to the Board on the performance of the medical staff functions and communicating to the Medical Staff any concerns expressed by the Board;

P. In the interim between medical executive committee meetings, performing those responsibilities of the committee that, in his or her reasonable opinion, must be accomplished prior to the next regular or special meeting of the committee;
Q. Serving on liaison committees with the Board and Medical Center administration, as well as outside licensing or accreditation agencies; and

R. Performing such other functions as may be assigned to him or her by these Bylaws, the Medical Staff or the medical executive committee.

9.8.2 PRESIDENT OF STAFF ELECT

The President of Staff Elect shall assume all duties and authority of the President of Staff in his or her absence. The President of Staff Elect shall be a member of the medical executive committee and shall perform such other duties as the President of Staff may assign or as may be delegated by these Bylaws or by the medical executive committee.

9.8.3 IMMEDIATE PAST PRESIDENT OF STAFF

The Immediate Past President of Staff shall be a member of the medical executive committee and shall perform such other duties as may be assigned by the President of Staff or delegated by these Bylaws or by the medical executive committee.

9.8.4 CHIEF MEDICAL OFFICER

A. Appointment. The Chief Medical Officer shall be appointed by the Chief Executive Officer in consultation with the medical executive committee.

B. Responsibilities. The Chief Medical Officer’s duties shall be delineated by the Chief Executive Officer in keeping with the general provisions set forth in this Section 9.8.4. The medical executive committee approval shall be required for any Chief Medical Officer duties that relate to authority to perform functions on behalf of the Medical Staff or directly affect the performance or activities of the Medical Staff. In keeping with the foregoing, the Chief Medical Officer shall: (1) serve as administrative liaison among Medical Center administration, the Board, outside agencies and the Medical Staff; (2) assist the Medical Staff in performing its assigned functions and coordinating such functions with the responsibilities and programs of the Medical Center; and (3) in cooperation and close consultation with the President of Staff and the medical executive committee, supervise the day-to-day performance of the medical staff office and the Medical Center’s quality improvement personnel.

C. Participation in Medical Staff Committees. The Chief Medical Officer shall be an ex officio member – without vote – of all medical staff committees, except any judicial review committee(s), and may attend any meeting of any department or section.
ARTICLE X
CLINICAL DEPARTMENTS

10.1 ORGANIZATION OF DEPARTMENTS

The Medical Staff shall be organized into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a chair selected and entrusted with the authority, duties, and responsibilities specified in Section 10.7.6. At the discretion of the department chair, the department may also have one (1) or more vice-chairs who shall be selected and appointed by the department chair after consultation with the Chief Executive Officer and the medical executive committee. A department may be further divided, as appropriate, into divisions which shall be directly responsible to the department within which it functions, and which shall have a division chief selected and entrusted with the authority, duties and responsibilities specified in Section 10.8.5. The minimum criterion for establishing a division of a department shall be the membership of three (3) or more members of the Active Staff practicing in the same subspecialty. When appropriate, the medical executive committee may recommend to the Medical Staff the creation, elimination, modification, or combination of departments or divisions.

10.2 CURRENT DEPARTMENTS AND DIVISIONS

The current clinical departments and divisions are set forth in the Medical Staff Organization and Functions Manual.

10.3 DEPARTMENT RESTRUCTURING

Circumstances may call for the creation, elimination, modification, or combination of departments and divisions. Petitions by members of the Medical Staff for such changes shall be submitted to the medical executive committee and address the criteria outlined in the Medical Staff Organization and Functions Manual.

10.4 ASSIGNMENT TO DEPARTMENTS

Each member of the Medical Staff shall be assigned by the medical executive committee to one department in which the member conducts the majority of his or her practice, and may be granted clinical privileges upon fulfillment of established criteria. The exercise of clinical privileges is subject to the authority of the department and the department chair.

10.5 FUNCTIONS OF DEPARTMENTS

The primary responsibility delegated to each department by the medical executive committee is to formulate, 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 department members, and to account to the medical executive committee for such actions. The general functions of each department shall include:

A. Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients
within the department. The number of such reviews to be conducted during the
year shall be as determined by the medical executive committee, and shall be conducted in accordance with such procedures as may be adopted by the quality management committee. The department shall routinely collect information about important aspects of patient care provided in the department, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work is subject to such review is a member of that department.

B. Recommending to the medical executive committee by way of the credentials committee criteria for the granting of clinical privileges within that department.

C. Evaluating and making appropriate recommendations regarding the qualifications of applicants seeking membership or renewal of membership and clinical privileges within that department.

D. Conducting, participating and making recommendations regarding continuing education programs pertinent to departmental clinical practice.

E. Reviewing and evaluating department adherence to (1) medical staff policies and procedures and (2) sound principles of clinical practice.

F. Monitoring on a continuing basis adherence to requirements for alternate coverage and consultations.

G. Coordinating patient care provided by the department’s members with nursing and ancillary patient care services.

H. Submitting written reports to the medical executive committee concerning (1) the department’s review and evaluation activities, action taken thereon, and the results of such action, and (2) recommendations for maintaining and improving the quality of care provided in the department and the Medical Center.

I. Meeting, at least monthly, and as needed, for the purpose of considering patient care review findings and the results of the department’s other review and evaluation activities, as well as reports on other department and medical staff functions.

J. Establishing such committees and mechanisms as are necessary and desirable to perform properly the functions assigned to the department or the department chair.
K. Taking or recommending appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified.

L. Formulating recommendations for policies or rules and regulations reasonably necessary for the proper discharge of the department’s responsibilities subject to the approval by the medical executive committee and the Board.

10.6 FUNCTIONS OF DIVISIONS

Subject to approval of the medical executive committee, each division shall perform the functions assigned to it by the department chair. Such functions may include, without limitation, retrospective patient care reviews, evaluation of patient care practices, credentials review and privileges delineation, and continuing education programs. The division shall transmit regular reports to the department chair on the conduct of its assigned functions.

10.7 DEPARTMENT CHAIRS

10.7.1 QUALIFICATIONS

Each department shall have a chair that shall be (and remain during tenure in office) a member of the Active Staff in good standing and shall be qualified by training, experience and demonstrated ability in at least one (1) of the clinical areas covered by the department.

Each department chair shall:

A. Be certified by an appropriate specialty board or, with approval of the medical executive committee, demonstrate comparable competence, through the credentialing process.

B. Have demonstrated clinical competence in his or her field of practice sufficient to maintain the respect of the members of the assigned department.

C. Have an understanding of the purposes and functions of the medical staff organization and a demonstrated willingness to promote patient safety over all other concerns.

D. Have an understanding of and a willingness to work with the Medical Center toward attaining its lawful and reasonable goals.

E. Have an ability to work with and motivate others to achieve the objectives of the medical staff organization in the context of the Medical Center’s lawful and reasonable objectives.
F. Not have any conflict of interest prohibited by the Hospital Authority policy on conflicts or the Hospital Authority Conflict of Interest Code.

10.7.2 SELECTION

A. **Search Committee.** A search committee shall be formed to seek applicants for consideration in filling the position of department chair. The search committee shall be composed of:

1. The Chief Medical Officer.
2. The President of Staff.
3. Two (2) chairs of other departments and one (1) member from the Active Staff appointed by the medical executive committee.
4. One (1) practitioner selected from the membership of the corresponding department of the affiliated medical school, if applicable and if required or requested by the department.
5. The Chief Executive Officer or his/her designee.

The President of Staff and Chief Executive Officer will appoint the chair of the search committee jointly. The search committee shall be responsible for conducting a search for the most desirable candidate, in whatever manner is appropriate, from both local and national sources, and to recommend to the Chief Executive Officer a candidate for appointment as department chair.

B. **Application for medical staff membership.** Should the candidate not be a member of the Medical Staff, the candidate shall apply for membership as set forth in these Bylaws. The chair of the search committee shall be responsible to ensure that the application form and related documents are presented to the search committee and credentials committee.

C. **Unacceptable candidates.** Should the Chief Executive Officer find a candidate unacceptable, the matter will be referred back to the search committee to propose an alternate candidate.

D. **Final decision.** The Chief Executive Officer shall transmit the final decision on appointment to the Board for ratification. The Chief Executive Officer shall then officially notify the medical executive committee and the chosen candidate.

10.7.3 TERM OF OFFICE

Each department chair shall serve until he or she is removed from office as contemplated by and in accordance with Section 10.7.4 of this Article, resigns, or loses his or her medical staff membership or clinical privileges in that department.
10.7.4 REMOVAL

The Chief Executive Officer may remove a department chair at any time with or without cause.

10.7.5 VACANCY

If a vacancy occurs, an acting chair, who shall be a member of the Active Staff in good standing, may be appointed by the Chief Executive Officer. The acting chair shall be vested with all rights and responsibilities of the chair. The acting chair may be removed by the Chief Executive Officer without the hearing, review and/or appeal rights set forth in Article XIII of these Bylaws being afforded to the acting department chair unless such action would result in a report to the National Practitioner Data Bank, the MBC, or the OMBC.

10.7.6 RESPONSIBILITIES AND DUTIES OF DEPARTMENT CHAIRS

Each department shall have a chair that shall be responsible for the overall supervision of clinical activity within the department and for administrative activities of the department, unless otherwise provided by the Medical Center. The Chief Executive Officer shall review service by the department chair no less than biennially. The chair shall be responsible to the Board, through the medical executive committee, for the following:

A. High quality professional management and care of patients under the jurisdiction of the department.

B. Establishing and maintenance of postgraduate medical education programs, if applicable.

C. Establishing systems to monitor the quality of patient care and professional performance in the department through a planned and systematic process.

D. Developing, implementing, and maintaining departmental programs for retrospective patient care review, ongoing monitoring of practice, credentials review and privilege delineation, medical education, utilization review, and quality assessment and improvement.

E. Specific recommendations and suggestions regarding the improvement of patient care, treatment, and services in his or her department.

F. Review of professional performance of all members with respect to clinical privileges.

G. If a department does not have at least one (1) vice-chair, appointing a designee to act as chair of the department in the absence of the chair, with the approval of the Chief Executive Officer and President of Staff.
H. Recommending delineated clinical privileges for each member of the department, including practitioner appointment and classification, reappointment, criteria for clinical privileges, and corrective action.

I. Discipline of members pursuant to Article XII of these Bylaws and others active in the department, as appropriate.

J. Evaluation of all full-time and part-time Medical Staff in the department who are active clinically or teach on an annual basis.

K. Enforcing these Bylaws, the Medical Staff Rules and Regulations, and Medical Staff policies within the department.

L. Promoting clinical research in the department.

M. Implementing within the department actions taken by the medical executive committee.

N. Recommending, creating, deleting, or changing the divisions of the department, and the appointment of division chiefs.

O. Being a member of the medical executive committee, and giving guidance on the overall medical policies of the Medical Staff and Medical Center.

P. Making specific recommendations and suggestions regarding the department involving development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.

Q. Reporting to the medical executive committee and President of Staff regarding all professional activities within the department.

R. Assuring the orientation of all practitioners and others in the department in cooperation with Medical Center administration.

S. Any other activities or functions that would reasonably be the responsibility of a chair of a department of a teaching hospital or as assigned by the Chief Medical Officer or the medical executive committee.

T. Assessing and recommending to the relevant Medical Center authority off-site sources for needed patient care, treatment, and services not provided by the department or the Medical Center.

U. Integration of the department or service into the primary functions of the Medical Center.

V. Coordination and integration of interdepartmental and intradepartmental services.
W. Recommending sufficient number of qualified and competent persons to provide care, treatment, and services in the department.

X. Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide care, treatment, and services.

Y. Continuous assessment and improvement of the quality of care, treatment, and services.

Z. Recommending space and other resources needed by the department or service.

10.8 DIVISION CHIEFS

10.8.1 QUALIFICATIONS

Each division shall have a chief who shall be a member of the Active Staff and a member of the division, and shall be qualified by training, experience, and demonstrated current ability in the clinical area covered by the division. A division chief shall not have any conflict of interest prohibited by the Hospital Authority policy on conflicts or the Hospital Authority Conflict of Interest Code.

10.8.2 SELECTION

Each division chief shall be appointed by the Board after recommendation by the department chair through the Chief Executive Officer and medical executive committee. Vacancies due to any reason shall be filled by the department chair until such time as a new division chief is appointed.

10.8.3 TERM OF OFFICE

Each division chief shall serve until he or she is removed from office as contemplated by and in accordance with Section 10.8.4 of this Article, resigns, or loses his or her medical staff membership or clinical privileges in the department of which the division is a part.

10.8.4 REMOVAL

Removal of a division chief may occur at any time with or without cause upon the recommendation of the department chair to the Chief Executive Officer or by the Chief Executive Officer taking such action on his or her own initiative.

10.8.5 DUTIES

Each division chief shall:

A. Act as presiding officer at division meetings;
B. Assist in the development and implementation, in cooperation with the department chair, of programs to carry out the quality review, and evaluation and monitoring functions assigned to the division;

C. Evaluate the clinical work performed in the division;

D. Conduct investigations and submit reports and recommendations to the department chair regarding the clinical privileges to be exercised within the division by members of or applicants to the Medical Staff; and

E. Perform such other duties commensurate with the office as may from time to time be reasonably requested by the department chair, the President of Staff, or the medical executive committee.
ARTICLE XI
COMMITTEES

11.1 DESIGNATION

The medical executive committee and the other committees described in these Bylaws and the Organization and Functions Manual shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the medical executive committee or a department to perform specified tasks. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the President of Staff, subject to consultation with and approval by the medical executive committee. Medical staff committees shall be responsible to the medical executive committee.

11.2 MEDICAL EXECUTIVE COMMITTEE

11.2.1 COMPOSITION

The medical executive committee shall be composed of the following voting members, of which the majority must be physician members of the Medical Staff:

A. The officers of the Medical Staff.
B. The chairs of the clinical departments.
C. The division chiefs of divisions officially recognized by the Medical Staff and the Board.
D. The chair of the quality committee.
E. Two (2) members of the Active Staff elected at large.

The following are non-voting members of the medical executive committee:

A. The Chief Executive Officer.
B. The Chief Medical Officer.
C. The Chief Academic Officer/DIO.
D. The Director of Medical Education.
E. The Chief Nursing Officer.

The President of Staff shall serve as chair of the medical executive committee. The President of Staff Elect shall serve as the vice chair of the medical executive committee. The vice chair, in the absence of the chair, shall assume all the duties and authority of the chair.
11.2.2 DUTIES

The Medical Staff delegates to the medical executive committee broad authority to oversee the operations of the Medical Staff. With the assistance of the President of Staff, and without limiting this broad delegation of authority, the medical executive committee shall perform in good faith the duties listed below:

A. Representing and acting on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws.

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

C. Receiving and acting upon reports and recommendations from each medical staff department, division, committee, and assigned activity groups, and making recommendations directly to the Board on such matters.

D. Recommending actions to the Board on matters of a medical-administrative nature, including, but not limited to, the Medical Staff’s structure and the process to review credentials and delineate clinical privileges.

E. Assuring that the Medical Staff adopts Medical Staff Bylaws and Medical Staff Rules and Regulations establishing the structure of the Medical Staff, the mechanism to review credentials and delineate individual clinical privileges, the granting of individual medical staff membership and clinical privileges, the organization of the quality assessment and performance improvement activities of the Medical Staff as well as the mechanism used to conduct, revise and evaluate such activities, the mechanism used for termination of medical staff membership and fair hearing procedures, needed changes to these Bylaws, as well as other matters relevant to the operation of an organized medical staff.

F. Evaluating the medical care rendered to patients in the Medical Center and fulfilling the Medical Staff’s responsibility of accountability to the Board for the medical care provided to patients in the Medical Center.

G. Participating in the development and implementation of all Medical Staff and Medical Center, as such matters pertain to the Medical Staff, policies, practices, and planning.

H. Regularly report to the Board, through the President of Staff, and the Chief Executive Officer on at least the following:

1. The outcomes of medical staff quality improvement programs with sufficient background and detail to assure the Board that the quality of care at the Medical Center is consistent with professional standards; and
2. The general status of any medical staff disciplinary or corrective actions in progress.

I. With the assistance of the President of Staff, supervise the Medical Staff’s compliance with:

1. The Medical Staff Bylaws, Rules and Regulations and policies;
2. The Medical Center’s bylaws, rules, and policies;
3. State and federal laws and regulations; and
4. Applicable standards and requirements of The Joint Commission and any other organization or entity that accredits or certifies the Medical Center and/or any of the Medical Center’s facilities or programs.

J. Reviewing the qualifications, credentials, performance and professional competence, and character of applicants and medical staff members, and make regular recommendations to the Board regarding medical staff membership and renewal of membership, assignments to departments, clinical privileges, and corrective action.

K. Initiate focused professional practice evaluation and/or pursue disciplinary or corrective actions affecting medical staff members, when indicated.

L. Reviewing and making recommendations to the Chief Executive Officer regarding quality of care issues related to exclusive contract arrangements for professional medical services. In addition, the medical executive committee shall assist the Medical Center in reviewing and advising on sources of clinical services provided by consultation, contractual arrangements or other agreements, in evaluating the levels of safety and quality of services provided via consultation, contractual arrangements, or other agreements, and in providing relevant input to notice-and-comment proceedings or other mechanisms that may be implemented by Medical Center administration in making exclusive contracting decisions.

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

N. Taking reasonable steps to develop continuing education activities and programs for the Medical Staff and prioritize such initiatives to ensure that the educational programs incorporate the recommendations and results of medical staff quality assessment and improvement activities.
O. Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the President of Staff.

P. Appointing such special or ad hoc committees as may seem necessary or appropriate to assist the medical executive committee in carrying out its functions and those of the Medical Staff.

Q. Establishing the date, place, time and program of the regular meetings of the Medical Staff.

R. Assisting in obtaining and maintenance of applicable accreditation(s) and/or certification(s) of the Medical Center and/or Medical Center’s facilities and programs.

S. Providing guidance and assistance to department chairs in the organization and supervision of the clinical activities of the department.

T. Developing and maintenance of methods for the protection and care of patients and others in the event of internal or external disaster.

U. Providing liaison among the Medical Staff, the Chief Executive Officer and the Board.

V. Representing and acting on behalf of the Medical Staff between meetings of the Medical Staff.

W. Affirmatively implementing, enforcing and safeguarding the self-governance rights of the Medical Staff.

X. Taking such actions as may be reasonably deemed necessary in the best interest of the Medical Staff and the Medical Center.

Y. Adopting and amending Medical Staff Rules and Regulations and Medical Staff policies.

11.2.3 MEETINGS

The medical executive committee shall meet as often as necessary, but at least ten (10) times per year and shall maintain a record of its proceedings and actions.

11.3 JOINT CONFERENCE COMMITTEE

11.3.1 COMPOSITION

The joint conference committee shall consist of the following:

A. Two (2) members of the Board.
B. Three (3) medical staff officers, specifically the President of Staff, President of Staff Elect, and the Immediate Past President of Staff or their designees appointed by the medical executive committee.

C. Chief Executive Officer or his/her designee.

D. Chief Medical Officer (without vote).

E. Chief Nursing Officer.

The chair of the joint conference committee will alternate annually each July 1 between a member of the Board and the President of Staff.

11.3.2 DUTIES

The duties of the joint conference committee are:

A. To promote communication among the Board, medical executive committee, Medical Staff and the Chief Executive Officer.

B. To inform each group of the activities and proposed activities of the other in order to improve understanding.

C. To provide a forum in which plans and proposals regarding the future growth of and changes in the Medical Center may be discussed.

D. To provide a medium in which matters of interest to all groups may be discussed in the interest of mutual understanding.

E. As requested by the Board and/or the Medical Staff, to review the status of the Medical Center’s ongoing method of meeting the standards of The Joint Commission and state and federal laws and regulations.

F. As requested by the Board and/or the Medical Staff, to review the pertinent findings of quality assessment activities throughout the Medical Center, as compiled by the committees assigned responsibility for oversight of quality, patient safety, compliance, risk management and patient satisfaction.

G. To serve as the initial forum for exercise for the meet and confer provisions contemplated by Section 15.14 of these Bylaws; provided, however, that upon request of at least three (3) joint conference committee members (which three (3) must be comprised of at least two (2) medical staff officers and one (1) Board member, or of at least two (2) Board members and one (1) medical staff officer), a neutral mediator, acceptable to both contingents, shall be engaged to assist in dispute resolution.
11.3.3 MEETINGS

The joint conference committee shall meet as necessary at the request of the Board, the Medical Staff, and/or Medical Center administration when the Board, the Medical Staff, and/or Medical Center administration wish the joint conference committee to be consulted about, provide guidance on, or engage in any of the activities specified in Section 11.3.2 of these Bylaws. The Chief Executive Officer shall maintain or arrange for the maintenance of a record of all proceedings and actions of the joint conference committee.

11.3.4 ACCOUNTABILITY

The joint conference committee is directly accountable to the medical executive committee and the Board.

11.4 PARTICIPATION IN INTERDISCIPLINARY MEDICAL CENTER COMMITTEES

Medical staff functions and responsibilities relating to liaison with the Board and Medical Center administration, Medical Center accreditation, disaster planning, facility and services planning, and financial management shall be discharged by the appointment of medical staff members to such Medical Center functions by the medical executive committee.
ARTICLE XII
PEER REVIEW AND CORRECTIVE ACTION

12.1 MONITORING AND EDUCATION

12.1.1 RESPONSIBILITY

It shall be the responsibility of the chairs of the clinical departments and chiefs of the specialty divisions to design and implement an effective program (a) to monitor and assess the quality of professional practice in each department and division, and (b) to promote high quality of practice in each department and division by (1) providing education and counseling, (2) issuing letters of admonition, warning or censure, as necessary, and (3) resuming concurrent observation when deemed appropriate by the department or division committees.

12.1.2 INFORMAL CORRECTIVE ACTION ACTIVITIES

A. Each department or division committee shall conduct regular patient care reviews and studies of practice within the department or division in conformity with the Medical Center’s general quality assessment plan and as set forth in Section 7.9 of these Bylaws.

B. In order to assist department or division members to conform their conduct or professional practice to the standards of the Medical Staff and Medical Center, department or division chairs may issue informal comments or suggestions, either orally or in writing, a summary of which is noted in the member’s file. Any member of a department may issue informal comments or suggestions, either orally or in writing to the Chief Medical Officer about his or her department chair, the summary of which shall be noted and maintained in the Chief Medical Officer’s office. Such comments or suggestions shall be subject to the confidentiality requirements of all medical staff information and may be issued by department or division chairs or the Chief Medical Officer after prior discussion with the recipient and with or without consultation with the department or division committee. Such comments or suggestions shall not constitute a restriction of clinical privileges, shall not be considered to be corrective action as provided in Section 12.2 of this Article, and shall not give rise to hearing, review or appeal rights under Article XIII of these Bylaws.

C. Following discussion of identified concerns with any department or division member, any department or division committee may authorize the chair to issue a letter of admonition or warning, or to require such member to be subject to focused professional practice evaluation as set forth in Section 7.9 of these Bylaws, for such time as may appear reasonable. In the event the concern is regarding the chair of the department, a committee of the chairs and elected officers will be appointed by the medical executive committee, who may then authorize the Chief Medical Officer, or the President of Staff
in the absence of the Chief Medical Officer, to issue a letter of admonition or warning, or to require the chair to be subject to focused professional practice evaluation for such time as may be reasonable. The term “focused professional practice evaluation,” as used in this Section, shall mean review of a member’s practice for which the member’s only obligation is to provide reasonable notice of admissions, procedures or other patient care activity. All members of the Medical Staff, regardless of status, shall be subject to ongoing professional practice evaluation as set forth in Section 7.9 of these Bylaws. The discussion of such actions with individual members shall be informal. Such action shall not constitute a restriction of clinical privileges, shall not be considered to be corrective action as provided in Section 12.2 of this Article, and shall not give rise to any hearing, review or appeal rights under Article XIII of these Bylaws.

D. Actions taken pursuant to Section 12.1.2 B or 12.1.2 C of this Article shall be reported to the medical executive committee after such actions are taken.

12.2 FORMAL CORRECTIVE ACTION

12.2.1 EXPEDITED INITIAL REVIEW

A. Whenever information suggests that corrective action may be warranted, the President of Staff or designee may, on behalf of the medical executive committee, immediately investigate and conduct whatever interviews may be indicated. The information developed during this initial review shall be presented to the medical executive committee, which shall decide whether to initiate a corrective action investigation.

B. In cases of complaints of harassment or discrimination involving a medical staff member, an expedited initial review shall be conducted by the President of Staff or designee, together with representatives of Medical Center Administration, or by an attorney for the Medical Center. Harassment or discrimination reviews conducted by an attorney for the Medical Staff shall not be construed as a medical staff proceeding. The information gathered from an attorney’s review may be referred to the medical executive committee if it is determined that corrective action may be indicated against a medical staff member, and all further review would be conducted as medical staff proceedings.

12.2.2 CRITERIA FOR INITIATION

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members. Such information may be provided to the President of Staff, any medical staff officer or department chair, any medical staff committee, the Board, the Chief Medical Officer or the Chief Executive Officer. 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 Medical Center; (2) unethical; (3) contrary to these Bylaws, the Medical Staff Rules and Regulations, or other applicable Medical Center or Medical Staff policies, procedures or requirements; (4) below applicable professional standards; (5) disruptive of medical staff or Medical Center operations; or (6) an improper use of Medical Center resources, a request for an investigation or action against such member may be initiated by the President of Staff, any other medical staff officer, a department chair, the medical executive committee, the Board, the Chief Medical Officer or the Chief Executive Officer.

12.2.3 INITIATION

A request for an investigation shall be submitted to the medical executive committee in writing, and supported by reference to specific activities or conduct alleged. If the medical executive committee initiates the request, it shall make an appropriate recordation of the reasons. An investigation, as that term is used in these Bylaws with regard to corrective action as contemplated by this Article XII, will not be deemed to have commenced until such time as the medical executive committee has authorized the investigation.

12.2.4 FORMAL INVESTIGATION

A. If the Medical Executive Committee concludes action is indicated but that no further investigation is necessary, it may proceed to take action without further investigation.

B. If the medical executive committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The medical executive committee may conduct the investigation itself, or may assign the task to an appropriate medical staff officer, medical staff department, or standing or ad hoc committee of the Medical Staff. The investigating body should not include partners, associates, or relatives of the individual being investigated. The medical executive committee in its discretion may appoint practitioners who are not members of the Medical Staff as advisory members of the Medical Staff for the sole purpose of serving on a standing or ad hoc committee, and not for the purpose of granting these practitioners temporary clinical privileges under Section 7.5 of these Bylaws. If the investigation is delegated to an officer or committee other than the medical executive committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the medical executive committee as soon as practicable. The report may include recommendations for appropriate corrective action. The member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a “hearing” as that
term is used in Article XIII of these Bylaws, nor shall the procedural rules with respect to hearings, reviews or appeals set forth in that Article XIII apply. Despite the status of any investigation, at all times the medical executive committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including, without limitation, summary suspension, termination of the investigative process, or other action. The provisions of this Section 12.2.4 (including a determination to dispense with formal investigation and proceed immediately to further action pursuant to Section 12.2.4 A) shall demark the point at which a pending “investigation” is deemed to have commenced within the meaning of Business and Professions Code Section 805(c). Outside reviewers may, but need not be, engaged by the medical executive committee or its designee(s) conducting an investigation if deemed appropriate and helpful to the investigation.

12.2.5 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as practicable after the conclusion of the investigation, the medical executive committee shall take action, which may include, without limitation:

A. Determining no corrective action should be taken and, if the medical executive committee determines there was no credible evidence for the complaint in the first instance, clearly documenting those findings in the member’s file.

B. Deferring action for a reasonable time where circumstances warrant.

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

D. Recommending the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring.

E. Recommending reduction, modification, suspension or revocation of clinical privileges. If suspension is recommended, the terms and duration of the suspension and the conditions that must be met before the suspension is ended shall be stated

F. Recommending reduction of membership status or limitation of any prerogatives directly related to the member’s delivery of patient care.

G. Recommending suspension, revocation or probation of medical staff membership. If suspension or probation is recommended, the terms and
duration of the suspension and the conditions that must be met before the suspension is ended shall be stated.

H. Referring the member to the wellness committee for evaluation and follow-up as appropriate.

I. Taking other actions deemed appropriate under the circumstances.

J. If the medical executive committee takes any action that might give rise to a hearing pursuant to Article XIII of these Bylaws, it shall also make a determination whether the action is a “medical disciplinary” action or an “administrative disciplinary” action. A medical disciplinary action is one taken for cause or reason that involves that aspect of a practitioner’s competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care. All other actions are deemed administrative disciplinary actions. In some cases, the reason may involve both medical disciplinary and administrative disciplinary cause or reason, in which case, the matter shall be deemed medical disciplinary in nature for purposes of determining whether the rights to a hearing, review, and appeal pursuant to these Bylaws shall apply.

K. If the medical executive committee makes a determination that the action is medical disciplinary in nature, it shall also determine whether the action is taken for any of the reasons required to be reported to the Medical Board of California or Osteopathic Medical Board of California pursuant to Business and Professions Code Section 805.01 or to the National Practitioner Data Bank.

12.2.6 TIME FRAMES

Insofar as feasible under the circumstances, informal corrective action and formal investigations should be conducted expeditiously, as follows:

A. Informal corrective action activities should be completed and the results should be reported to the medical executive committee within sixty (60) days.

B. Expedited initial reviews should be completed and the results should be reported to the medical executive committee within thirty (30) days.

C. Formal investigations should be completed and the results should be reported to the medical executive committee within ninety (90) days.

12.2.7 PROCEDURAL RIGHTS

A. If, after receipt of a request for formal corrective action pursuant to these Bylaws and Section 12.2.4 above, the medical executive committee determines that no corrective action is required or only a letter of warning,
admonition, reprimand or censure should be issued, the decision shall be transmitted to the Board. The Board may affirm, reject or modify the action. The Board shall give great weight to the medical executive committee’s decision and initiate further action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the medical executive committee and the medical executive committee still has not acted. The decision shall become final if the Board affirms it or takes no action on it within sixty (60) days after receiving the notice of decision.

B. If the medical executive committee recommends an action that is a ground for a hearing under Section 13.2 of these Bylaws, the President of Staff shall give the practitioner special notice of the adverse recommendation and of any right to request a hearing. The Board may be informed of the recommendation, but shall take no action until the member has either waived his or her right to a hearing or completed the hearing.

12.2.8 INITIATION BY BOARD

The Medical Staff acknowledges that the Board must act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the Medical Center in the event that the Medical Staff fails in any of its substantive duties or responsibilities. Accordingly, if the medical executive committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Board may direct the medical executive committee to initiate an investigation or disciplinary action, but only after consulting with the medical executive committee. If the medical executive committee fails to act in response to the Board’s direction, the Board may, in furtherance of the Board’s ultimate responsibilities and fiduciary duties, initiate corrective action, but must comply with applicable provisions of Articles XII and XIII of these Bylaws. The Board shall inform the medical executive committee in writing what it has determined to do and the actions that it has taken.

12.3 SUMMARY RESTRICTION OR SUSPENSION

12.3.1 CRITERIA FOR INITIATION

Whenever a member’s conduct or clinical performance appears to require that immediate action be taken to prevent imminent danger to the health of any individual, the President of Staff or other medical staff officer, the medical executive committee, the Chief Medical Officer or the department chair in which the member holds clinical 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 Board, the medical executive committee, and the Chief Executive Officer. In addition, the affected medical staff member shall be provided with a written notice
of the action, which notice fully complies with the requirements of Section 12.3.2 below. 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 chair or by the President of Staff, considering, where feasible, the wishes of the patient in the choice of a substitute member.

12.3.2 WRITTEN NOTICE OF SUMMARY SUSPENSION

Within two (2) working days of imposition of a summary suspension, the affected medical staff member shall be provided with written notice of such suspension. This initial written notice shall include a statement of facts demonstrating that the suspension was necessary because failure to suspend or restrict the practitioner’s privileges summarily could reasonably result in imminent danger to the health of an individual. The statement of facts provided in this initial notice shall also include a summary of one (1) or more particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for, but is in addition to, the notice required under Section 13.3.1 (which applies in all cases where the medical executive committee does not immediately terminate the summary suspension). The notice under Section 13.3.1 may supplement the initial notice provided under this section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

12.3.3 MEDICAL EXECUTIVE COMMITTEE ACTION

The medical executive committee (or a subcommittee appointed by the President of Staff) shall be convened as soon as reasonably possible and in no event later than one (1) week after the summary action to review and consider the summary action taken. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the medical executive committee may impose, although in no event shall any meeting of the medical executive committee, with or without the member, constitute a “hearing” within the meaning of Article XIII of these Bylaws, nor shall any procedural rules set forth in that Article XIII apply. The medical executive committee may modify, continue or terminate the summary restriction or suspension, but in any event the medical executive committee shall furnish the member with notice of its decision within two (2) working days of the meeting. The member shall not have a right to have counsel present during any meeting with the medical executive committee or a subcommittee thereof as contemplated by this Section 12.3.3.

12.3.4 PROCEDURAL RIGHTS

Unless the medical executive committee terminates the summary restriction or suspension, it shall remain in effect during the pendency and completion of the corrective action process and of the hearing and appellate review process. When a summary action is continued, the affected practitioner shall be entitled to the
procedural rights afforded by Article XIII of these Bylaws, but the hearing on the
summary action shall be consolidated with the hearing on any corrective action that
is recommended so long as the hearing commences within sixty (60) days after the
hearing on the summary action was requested.

12.3.5 INITIATION BY THE BOARD

If no one authorized under Section 12.3.1 to take a summary action is available to
summarily restrict or suspend a member’s membership or clinical privileges, the
Board or Chief Executive Officer may immediately suspend or restrict a member’s
privileges if a failure to act immediately may result in imminent danger to the
health of any individual, provided that the Board or Chief Executive Officer made
reasonable attempts to contact the President of Staff, medical executive committee,
and the chair of the department to which the member is assigned before acting.
Such summary action is subject to ratification by the medical executive committee.
If the medical executive committee does not ratify such summary action within two
(2) working days, excluding weekends and holidays, the summary action shall
terminate automatically.

12.4 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the member’s clinical privileges or membership may be
suspended or limited as described, and an informal interview with the medical
executive committee, if requested, shall be limited to the question of whether the
grounds for automatic suspension or limitation as set forth below have occurred.
Notice to the member of automatic suspension or limitation shall include the right
to request an informal interview with the medical executive committee upon
written notice to the President of Staff within thirty (30) days of the date of the
notice of such automatic suspension or limitation. The member shall not have a
right to have counsel present during the informal interview(s) contemplated by this
Section 12.4.

12.4.1 LICENSURE

A. **Expiration, Revocation or Suspension.** Whenever a member’s license or
other legal credential authorizing practice in California is expired, revoked,
or suspended, medical staff membership and clinical privileges shall be
automatically revoked as of the date such action becomes effective.

B. **Restriction.** Whenever a member’s license or other legal credential
authorizing practice in California is limited or restricted by the applicable
licensing or certifying authority, any clinical privileges which the member
has been granted at the Medical Center which are within the scope of said
limitation or restriction shall be automatically limited or restricted in a
similar manner, as of the date such action becomes effective and throughout
its term.
C. **Probation.** Whenever a member is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

12.4.2 **CONTROLLED SUBSTANCES**

A. **Revocation, Limitation or Suspension.** Whenever a member’s DEA certificate is revoked, limited, suspended or expires, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its terms.

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

12.4.3 **FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT**

Failure of a member, without good cause, after reasonable notice is given, to appear at a meeting upon request of the medical executive committee shall be a basis for an automatic suspension of medical staff membership and clinical privileges in the sole discretion of the medical executive committee, as well as the basis for further corrective action.

12.4.4 **MEDICAL RECORDS**

Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the medical executive committee. A limited suspension in the form of withdrawal of admitting and other related privileges until all delinquent medical records are completed, shall be imposed by the President of Staff or designee, five (5) business days after notice of delinquency for failure to complete medical records within such period. For purposes of this section, “related privileges” means voluntary on-call service for the emergency department, scheduling surgery, assisting in surgery, consulting on Medical Center cases, and providing professional services within the Medical Center for future patients. Notwithstanding the foregoing, a practitioner who has been suspended for failure to complete medical records timely as contemplated by this Section 12.4.4 shall nonetheless be entitled to continue to treat his or her patients admitted to the Medical Center as of the date of the medical record suspension. Bona fide vacation or illness may constitute an excuse subject to approval by the medical executive committee. The suspension shall continue until lifted by the President of Staff or his/her designee. Failure to complete the medical records within two (2) months after the date a suspension becomes effective shall be deemed to be a voluntary resignation of medical staff membership and clinical privileges by the member.
12.4.5 FAILURE TO PAY DUES/ASSESSMENTS

Failure to pay any required dues or assessments within ninety (90) days following the first written warning of the delinquency shall be deemed a voluntary resignation of a member’s clinical privileges and medical staff membership, unless the dues or assessments are waived for good cause by the medical executive committee.

12.4.6 EXCLUSION FROM PARTICIPATION IN MEDICARE, MEDICAID, AND OTHER HEALTH CARE PROGRAMS

A member’s clinical privileges shall be automatically suspended upon exclusion from participation in or the revocation of billing privileges with the Medicare and/or Medicaid programs pending action by the medical executive committee and the Board to restore such privileges following official reinstatement of eligibility to participate in such programs and/or the right to submit bills and claims to such programs. The medical executive committee shall also be empowered to determine that compliance with certain specific third party payer, government agency, and/or professional review organization rules or policies is essential to Medical Center and/or Medical Staff operations and that compliance with such requirements can be objectively determined. The Medical Staff Rules and Regulations may authorize the automatic suspension of a practitioner who fails to comply with such requirements. This suspension shall be effective until the practitioner complies with such requirements.

12.4.7 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance in the amount required by the Board shall be grounds for automatic and immediate suspension of a member’s clinical privileges, and if within thirty (30) days after written warnings of the delinquency the member does not provide evidence of required professional liability insurance, including coverage of any acts or omissions that may have occurred or arisen during the period of any lapse in coverage, the member’s membership and clinical privileges shall be automatically and immediately terminated.

12.4.8 EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable after action is taken or warranted as described in Section 12.4.1 B, 12.4.1 C, 12.4.2, or 12.4.3, the medical executive committee shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth commencing at Section 12.2.4 of these Bylaws. The medical executive committee review and any subsequent hearings and reviews shall not address the propriety of the licensure or Drug Enforcement Administration action, but instead shall address what, if any, additional action should be taken by the Medical Center. There is no need for the medical executive committee to act on automatic suspensions for failures to complete medical records, maintain professional
liability insurance or comply with government and other third party payer rules and policies. Practitioners whose clinical privileges are automatically suspended and/or who have been deemed to have automatically resigned their medical staff membership shall be entitled to a hearing only if the suspension is reportable to the Medical Board of California or Osteopathic Medical Board of California, as appropriate, or the National Practitioner Data Bank.
ARTICLE XIII
HEARINGS AND APPELLATE REVIEWS

13.1 GENERAL PROVISIONS

13.1.1 EXHAUSTION OF REMEDIES

If adverse action described in Section 12.2 is taken or recommended, the applicant or member must exhaust the remedies afforded by these Bylaws before resorting to legal action.

13.1.2 APPLICATION OF ARTICLE

For purposes of this Article, the term “member” may include “applicant,” as it may be applicable under the circumstances, unless otherwise stated.

13.1.3 TIMELY COMPLETION OF PROCESS

The hearing and appeal process shall be completed within a reasonable time.

13.1.4 FINAL ACTION

Recommended adverse actions described in Section 12.2 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 Board.

13.1.5 INTRA-ORGANIZATIONAL REMEDIES

The hearing and appeal rights established in these Bylaws are strictly “judicial” rather than “legislative” in structure and function. The hearing committees have no authority to adopt or modify rules and standards or to decide questions about the merits or substantive validity of bylaws, rules or policies. However, the Board may, in its sole discretion, entertain challenges to the merits or substantive validity of bylaws, rules or policies and decide those questions. If the only issue in a case is whether a bylaw, rule or policy is lawful or meritorious, the member is not entitled to a hearing or appellate review. In such cases, the member must submit his or her challenge first to the Board and only thereafter may he or she seek judicial intervention.

13.1.6 SUBSTANTIAL COMPLIANCE

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

13.2 GROUNDS FOR HEARING

Any one or more of the following shall be grounds for a hearing except as otherwise expressly provided in these Bylaws:
A. Denial of medical staff membership.
B. Denial of requested advancement in staff membership status, or category.
C. Denial of medical staff reappointment.
D. Suspension of staff membership or clinical privileges for more than thirty (30) days in any twelve (12) month period.
E. Demotion to lower staff category or membership status.
F. Summary suspension of staff membership or clinical privileges for more than fourteen (14) days.
G. Revocation of medical staff membership.
H. Denial of requested clinical privileges.
I. Involuntary reduction of current clinical privileges.
J. Termination of all clinical privileges.
K. Involuntary imposition of significant consultation or monitoring requirements (excluding monitoring incidental to provisional status and Section 7.8 or resumption of concurrent observation incident to focused review).
L. Any other “medical disciplinary” action or recommendation that must be reported to the applicable licensing or certifying authority under the provisions of Business and Professions Code Section 805 et seq. and/or to the National Practitioner Data Bank.

13.3 REQUESTS FOR HEARING

13.3.1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which action has been taken or a recommendation made as set forth in Section 13.2 of these Bylaws, the President of Staff or designee on behalf of the medical executive committee shall give the member prompt written notice of (1) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the applicable licensing or certifying authority and/or to the National Practitioner Data Bank, if required; (2) the reasons for the proposed action, including the acts or omissions with which the member is charged; (3) the right to request a hearing pursuant to Section 13.3.2, and that such hearing must be requested within thirty (30) days; and (4) a summary of the hearing rights granted to the member pursuant to these Bylaws.
13.3.2 REQUEST FOR HEARING

The member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the President of Staff with a copy to the Chief Executive Officer. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. The practitioner shall notify the Medical Center at the time a hearing is requested by the practitioner if the practitioner shall be represented by counsel and, if so, the practitioner shall provide the name, address, and telephone number of such counsel.

13.3.3 TIME AND PLACE FOR HEARING

Upon timely receipt of a request for hearing, the President of Staff shall schedule a hearing and, within thirty (30) days of receipt of the member’s hearing request, give written notice to the member of the time, place and date of the hearing. Unless extended by the judicial review committee, the date of the commencement of the hearing shall be not less than thirty (30) days nor more than sixty (60) days from the date of receipt of the request by the President of Staff for a hearing; provided, however, that when the request is received from a member who is under summary suspension the hearing shall be held as soon as the arrangements may reasonably be made, so long as the member has at least thirty (30) days from the date of notice to prepare for the hearing or waives this right in writing.

13.3.4 NOTICE OF CHARGES

Together with the notice stating the place, time, and date of the hearing, the President of Staff or designee shall state clearly and concisely in writing the reasons for the adverse proposed action taken or recommended, including the acts or omissions with which the member is charged and a list of the charts in question, where applicable. A supplemental notice may be issued at any time, provided the member is given sufficient time to prepare to respond.

13.3.5 JUDICIAL REVIEW COMMITTEE

When a hearing is requested, the President of Staff shall appoint a judicial review committee. The judicial review committee shall be composed of not less than three (3) members of the Medical Staff. Members of the judicial review committee shall gain no direct financial benefit from the outcome, and shall not have acted as accuser, investigator, fact finder, initial decision maker or otherwise have actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the medical staff from serving as a member of the judicial review committee. In the event that it is not feasible to appoint a judicial review committee from the Active Staff, the President of Staff may appoint members from other staff categories or practitioners who are not members of the Medical Staff. Such appointment shall
include designation of the chair. To the extent reasonably feasible, membership on a judicial review committee shall consist of one (1) member of the Medical Staff who has the same healing arts licensure and practices the same specialty as the member who has requested the hearing. The President of Staff may appoint alternates who meet the standards described above and who can serve if a judicial review committee member becomes unavailable. The fact that an individual practices in the same specialty as a practitioner who is being reviewed does not by itself create a conflict of interest.

13.3.6 HEARING OFFICER

The use of a Hearing Officer to preside at a hearing is mandatory. Unless otherwise agreed upon by the practitioner and the Medical Staff, the following procedure shall be used to select the Hearing Officer:

A. The President of Staff shall select a Hearing Officer from a list of five (5) attorneys provided to the President of Staff by legal counsel to the Medical Center. Legal counsel shall select the attorneys on the list provided to the President of Staff from the hearing officer listing service operated by the California Society for Healthcare Attorneys, or such other hearing officer listing services as may be endorsed for that purpose by the California Medical Association (“CMA”) and the California Hospital Association (“CHA”). If there is no hearing officer listing service endorsed by both the CMA and CHA, then legal counsel for the Medical Center shall provide the President of Staff with a list of five (5) attorneys who meet the qualifications set forth in Section 13.3.6 B below, and the President of Staff shall select an attorney from that list to serve as the Hearing Officer. The engagement of a Hearing Officer by the Medical Center for a particular hearing shall reflect that neither the Medical Center nor the Hospital Authority will engage the Hearing Officer to serve in that same capacity for any other matter until at least three (3) years from the conclusion of the hearing (as measured from the day the judicial review committee first reports its recommendation to the medical executive committee).

B. The Hearing Officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the Medical Center, the Medical Staff or the involved medical staff member or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as 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.

C. The Hearing Officer shall preside over the voir dire process and may question the judicial review committee members directly, and shall make all rulings regarding service by the proposed judicial review committee members or the Hearing Officer. The Hearing Officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be
heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence.

D. The Hearing Officer’s authority shall include, but not be limited to, making rulings with respect to requests and objections pertaining to the production of documents, requests for continuances, designation and exchange of proposed evidence, evidentiary disputes, witness issues including disputes regarding expert witnesses, and setting reasonable schedules for timing and/or completion of all matters related to the hearing.

E. 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, including, but not limited to, limiting the scope of examination and cross-examination and setting fair and reasonable time limits on either side’s presentation of its case. Under extraordinary circumstances, the Hearing Officer may recommend termination of the hearing; however, the Hearing Officer may not unilaterally terminate the hearing and may only issue an order that would have the effect of terminating the hearing (a "termination order") at the direction of the judicial review committee. The terminating order shall be in writing and shall include documentation of the reasons therefor. If a terminating order is against the medical executive committee, the charges against the practitioner will be deemed to have been dropped. If, instead, the terminating order is against the practitioner, the practitioner will be deemed to have waived his/her right to a hearing. The party against whom termination sanctions have been ordered may appeal the terminating order to the Board. The appeal must be requested within ten (10) days of the terminating order, and the scope of the appeal shall be limited to reviewing the appropriateness of the terminating order. The appeal shall be conducted in general accordance with Section 13.5 of these Bylaws. If the Board determines that the terminating order should not have been issued, the matter will be remanded to the judicial review committee for completion of the hearing, the judicial review committee shall reconvene, and the hearing shall be resumed.

F. Upon adjournment of the evidentiary portion of the hearing, the Hearing Officer shall meet with the members of the judicial review committee to assist them with the process for their review of the evidence and preparation of the report of their decision. Upon request from the judicial review committee members, the Hearing Officer may remain during the judicial review committee's full deliberations. During the deliberative process, the Hearing Officer shall act as legal advisor to the judicial review committee, but shall not be entitled to vote.
G. In all matters, the Hearing Officer shall act reasonably under the circumstances and in compliance with applicable legal principles. In making rulings, the Hearing Officer shall endeavor to promote a less formal, rather than more formal, hearing process and also to promote the swiftest possible resolution of the matter, consistent with the standards of fairness set forth in these Bylaws. When no attorney is accompanying any party to the proceedings, the Hearing Officer shall have authority to interpose any objections and to initiate rulings necessary to ensure a fair and efficient process.

H. To the extent that any provision in this section of these Bylaws may conflict with any other provision of the Bylaws (e.g. granting certain duties and authority to the chair of the judicial review committee), this provision shall preempt and control.

13.3.7 FAILURE TO APPEAR OR PROCEED

Failure without good cause of the member who has requested a hearing 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.

13.3.8 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the Hearing Officer on a showing of good cause, or upon agreement of the parties.

13.4 HEARING PROCEDURE

13.4.1 HEARINGS PROMPTED BY BOARD ACTION

If the hearing is based upon an adverse action by the Board, the chair of the Board shall fulfill the functions assigned in this section to the President of Staff.

13.4.2 PREHEARING PROCEDURE

A. The member may inspect and copy (at his or her expense) any documentary information relevant to the charges that the Medical Staff has in its possession or under its control. The medical executive committee may inspect and copy (at its expense) any documentary information relevant to the charges that the member has in his or her possession or under his or her control. The requests for discovery shall be fulfilled as soon as practicable. Failures to comply with reasonable discovery requests at least thirty (30) days prior to the hearing shall be good cause for a continuance of the hearing. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the member under review nor does it create or imply
any obligation to modify or create documents in order to satisfy a request for information.

B. If either side to the hearing requests in writing a list of witnesses, within fifteen (15) days of such request, and in no event less than ten (10) days before commencement of the hearing, each party shall furnish to the other 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. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. The failure to have provided the name of any witness at least ten (10) days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance or for the Hearing Officer to exclude the testimony of the witness.

C. The parties shall be entitled to file motions as deemed necessary to give full effect to rights established by the Bylaws and to resolve such procedural matters as the Hearing Officer determines may properly be resolved outside the presence of the full judicial review committee. Such motions shall be in writing and shall specifically state the motion, all relevant factual information, and any supporting authority for the motion. The moving party shall deliver a copy of the motion to the opposing party, who shall have five (5) working days to submit a written response to the Hearing Officer, with a copy to the moving party. The Hearing Officer shall determine whether to allow oral argument on any such motions. The ruling of the Hearing Officer shall be in writing and shall be provided to the parties promptly upon its rendering. All motions, responses, and rulings thereon shall be entered into the hearing record by the Hearing Officer.

D. Both parties to the hearing shall be entitled to a reasonable opportunity to ask the judicial review committee and Hearing Officer questions, which are directly related to evaluating their qualifications and for challenging such members or the Hearing Officer. Challenges to the impartiality of any judicial review committee member or the Hearing Officer shall be ruled on by the Hearing Officer.

E. It shall be the duty of the parties to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

F. The medical executive committee may object to the introduction of evidence that was not produced during an appointment, reappointment or privilege application review or during corrective action despite the requests of the peer
review body for such information. The Hearing Officer will bar the information from the hearing unless the member can prove he or she previously acted diligently and could not have submitted the information.

13.4.3 REPRESENTATION

The member, at the member’s own cost and expense, shall be entitled to representation by legal counsel in any phase of the hearing, if the member so chooses, and shall receive notice of the right to obtain representation by an attorney at law. 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 executive committee shall appoint a representative who is not an attorney to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions. The medical executive committee shall not be represented at the hearing by an attorney at law if the member is not so represented.

13.4.4 RECORD OF THE HEARING

A certified court reporter shall be present to make a record of the hearing proceedings, and the pre-hearing proceedings if deemed appropriate by the Hearing Officer. The cost of attendance of the certified court reporter shall be borne by the Medical Center, but the cost of the transcript, if any, shall be borne by the party requesting it. The member is entitled to receive a copy of the transcript upon paying the reasonable cost for preparing the record. The Hearing Officer may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

13.4.5 RIGHTS OF THE PARTIES

Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, receive all information made available to the judicial review committee, and submit a written statement at the close of the hearing, so long as these rights are exercised in an efficient and expeditious manner. The member may be called by the medical executive committee and examined as if under cross-examination. The judicial review committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

13.4.6 RULES OF EVIDENCE

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article XIII. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are
accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

13.4.7 BURDENS OF PRESENTING EVIDENCE AND PROOF

A. At the hearing the medical executive committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The member shall be obligated to present evidence in response.

B. An initial applicant for medical staff membership and/or clinical privileges shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, of the applicant’s current qualifications for membership and/or the denied clinical privileges. The applicant must produce information, which allows for adequate evaluation and resolution of reasonable doubts concerning the applicant’s current qualifications for membership and/or the denied clinical privileges.

C. The body whose action precipitated the hearing shall have the burden of demonstrating by the preponderance of evidence that the action was reasonable and warranted, except as expressly provided elsewhere in these Bylaws.

13.4.8 ADJOURNMENT AND CONCLUSION

The Hearing Officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

13.4.9 BASIS FOR DECISION

The decision of the judicial review committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony.

13.4.10 PRESENCE OF JUDICIAL REVIEW COMMITTEE MEMBERS AND VOTE

A majority of the judicial review committee must be present throughout the hearing and deliberations. In unusual circumstances when a judicial review committee member must be absent from any part of the proceedings, he or she shall not be permitted to participate in the deliberation or the decision unless and until he or she has read the entire transcript of the portion of the hearing from which he or she was absent. The final decision of the judicial review committee must be sustained by a majority vote of the number of members appointed.
13.4.11 DECISION OF THE JUDICIAL REVIEW COMMITTEE

Within thirty (30) days after final adjournment of the hearing, the judicial review committee shall render a decision, which shall be accompanied by a report in writing and shall be delivered to the medical executive committee. If the applicant or member is currently under suspension, however, the time for the decision and report shall be fifteen (15) days after final adjournment. Final adjournment shall be when the judicial review committee has completed its deliberations. A copy of the decision shall be forwarded to the Board, the Chief Executive Officer, the medical executive committee, and the member. The report shall contain a concise 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 member and the medical executive committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the judicial review committee shall be considered final subject to such rights of appeal or review as described in these bylaws.

13.5 APPEAL

13.5.1 TIME FOR APPEAL

Within forty (40) days after receipt of the decision of the judicial review committee, either the member or the medical executive committee may request an appellate review. A written request for such review shall be delivered to the President of Staff, the chief executive officer, and the other party in the hearing. If a request for appellate review is not requested within such period, that action or recommendation shall become the final action of the Medical Staff. The Board shall consider the decision within seventy (70) days of the date of the decision, and shall give it great weight.

13.5.2 GROUNDS FOR APPEAL

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be: (a) substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice; or (b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 13.5.5.

13.5.3 TIME, PLACE AND NOTICE

If an appellate review is to be conducted, the appellate review board shall, within thirty (30) days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The appellate review shall commence within sixty (60) days from the date of such notice provided, however, when a request for appellate review concerns a member who is under suspension, which is then in effect, the appellate review should
commence within thirty (30) days from the date the request for appellate review was received. The appellate review board for good cause may extend the time for appellate review.

13.5.4 APPELLATE REVIEW BOARD

The Board may elect to serve as the appellate review board and hear the appeal acting as a whole, or it may appoint an appellate review board, which shall be composed of not less than three (3) members of the Board, to hear the appeal. Knowledge of the matter involved shall not preclude any person from serving as a member of the appellate review board, so long as that person did not take part in a prior hearing on the same matter. The appellate review board may select an attorney to assist it in the proceeding that will act as an appellate hearing officer and have, as applicable and appropriate, all the authority of and carry out all of the duties assigned to a Hearing Officer as described in this Article XIII. The Hearing Officer shall not be entitled to vote with respect to the appeal. The attorney selected by the appellate review board shall not be the attorney that represented either party at the hearing before the judicial review committee, the attorney who assisted the hearing panel or served as Hearing Officer, or any attorney that would have been ineligible to serve as the Hearing Officer for the hearing. The appellate review board shall have such powers as are necessary to discharge its responsibilities.

13.5.5 APPEAL PROCEDURE

The proceeding by the appellate review board shall be in the nature of an appellate hearing based upon the record of the hearing before the judicial review committee, provided that the appellate review board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the judicial review committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the hearing; or the appellate review board may remand the matter to the judicial review committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal. The appealing party shall submit a written statement that states the specific grounds for appeal. Each party has the right to present a written statement in support of his, her, or its position on appeal. The appellate review hearing officer may establish reasonable time frames for the appealing party to submit a written statement and for the responding party to respond. Each party has the right to personally appear and make oral argument. The appellate review board may then, at a time convenient to itself, deliberate outside the presence of the parties.

13.5.6 DECISION

A. Within thirty (30) days after adjournment of the appellate review proceeding, the appellate review board shall render a final decision in
writing. Final adjournment shall not occur until the appellate review board has completed its deliberations.

B. The appellate review board may affirm, modify, reverse the decision or remand the matter for further review by the judicial review committee or any other body designated by the appellate review board.

C. The appellate review board shall give great weight to the recommendation of the judicial review committee, and shall not act arbitrarily or capriciously. The appellate review board may, however, exercise its independent judgment in determining whether a member was afforded a fair hearing, and whether the decision is reasonable and warranted. The decision shall specify the reasons for the action taken and provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal, if any, and the decision reached, if such findings and conclusions differ from those of the judicial review committee.

D. The appellate review board shall forward copies of the decision to each side involved in the appeal.

E. The appellate review board may remand the matter to the judicial review committee or any other body the appellate review board designates for reconsideration or may refer the matter to the full Board for review. If the matter is remanded for further review and recommendation, the further review shall be completed within thirty (30) days unless the parties agree otherwise or for good cause as determined by the appellate review board.

13.5.7 RIGHT TO ONE HEARING

No member shall be entitled to more than one (1) evidentiary hearing and one (1) appellate review on any matter, which shall have been the subject of adverse action or recommendation.

13.6 EXCEPTIONS TO HEARING RIGHTS

13.6.1 EXCLUSIVE USE DEPARTMENTS

The hearing rights of this Article XIII do not apply to a practitioner whose application for medical staff membership and clinical privileges was denied or whose clinical privileges were terminated on the basis the clinical privileges he or she seeks are granted only pursuant to an exclusive contract or exclusive use policy.

13.6.2 HOSPITAL CONTRACT PRACTITIONERS

The hearing rights of this Article XIII do not apply to practitioners who have contracted with the medical center to provide clinical services. Removal of these practitioners from service at the Medical Center and the termination of their membership on the Medical Staff and clinical privileges shall instead be governed
by the terms of their individual contracts and agreements with the Medical Center. The hearing rights of this Article XIII shall apply if an action is taken which must be reported under state or federal law or the practitioner’s medical staff membership status or clinical privileges which are independent of the practitioner’s contract are removed or suspended for medical disciplinary cause or reason.

13.6.3 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

Notwithstanding anything herein to the contrary, no hearing is required when a member’s license or legal credential to practice has been revoked or suspended as set forth in Section 12.4.1 A. In other cases described in Sections 12.4.1 and 12.4.2, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority or the DEA was unwarranted, but only whether the member may continue to practice in the medical center with those limitations imposed.

13.6.4 DENIAL OF APPLICATIONS FOR FAILURE TO MEET THE MINIMUM QUALIFICATIONS

Notwithstanding anything herein to the contrary, members shall not be entitled to any hearing or appellate review if their membership, privileges, applications, or requests are denied because of their failure to: have a current California license to practice medicine, dentistry, podiatry, or clinical psychology; maintain an unrestricted Drug Enforcement Administration certificate (when it is required); maintain the required professional liability insurance; comply with particular government or other third party payer rules or policies; meet any of the other basic standards specified in Section 4.2; or submit a complete application.
ARTICLE XIV
CONFIDENTIALITY, IMMUNITY AND RELEASES

14.1 AUTHORIZATION AND CONDITIONS

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

A. Authorizes representatives of the Medical Center and the Medical Staff, and their duly authorized representatives, for the purpose of enabling them to discharge their lawful obligations and responsibilities, to access medical staff records, including confidential committee records and credentials files, to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant’s professional ability and qualifications;

B. Authorizes persons and organizations to provide information concerning such practitioner to the Medical Staff;

C. Agrees to be bound by the provisions of this Article XIV and to waive all legal claims against any representative of the Medical Staff or the Medical Center who would be immune from liability under Section 14.3 of this Article XIV; and

D. Acknowledges that the provisions of this Article XIV are express conditions to an application for medical staff membership, the continuation of such membership, and to the exercise of clinical privileges at the Medical Center.

14.2 CONFIDENTIALITY OF INFORMATION

14.2.1 GENERAL

Records and proceedings of all medical staff committees having the responsibility of evaluation and improvement of quality of care rendered in the Medical Center, including, but not limited to, meetings of the medical staff meeting as a committee of the whole, meetings of medical staff councils, meetings of departments and divisions, meetings of committees established under Article XI and the Medical Staff Organization and Functions Manual, and meetings of special or ad hoc committees created by the medical executive committee or by departments and including information regarding any member or applicant to this Medical Staff shall, to the extent permitted by law, be confidential. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the medical staff committee files and shall not become part of any particular patient’s file or of the general hospital records. Dissemination of such information and records shall be made only where expressly required by law or as otherwise provided in these Bylaws.
14.2.2 BREACH OF CONFIDENTIALITY

Inasmuch as effective credentialing, quality improvement, 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, and inasmuch as practitioners and others participate in credentialing, quality improvement, and peer review activities with the reasonable expectations that this confidentiality will be preserved and maintained, any breach of confidentiality of the discussions or deliberations of medical staff departments, divisions, or committees, except in conjunction with another health facility, a professional society, or a licensing authority for peer review activities, is outside appropriate standards of conduct for this Medical Staff, violates these Bylaws, and will be deemed disruptive to the operations of the Medical Center. If it is determined that such a breach has occurred, the medical executive committee may undertake such corrective action, as it deems appropriate.

14.3 IMMUNITY FROM LIABILITY

14.3.1 FOR ACTION TAKEN

Each representative of the Medical Staff and Medical Center and all third parties shall be immune, to the extent permitted by law, from liability to an applicant, member or practitioner 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 or Medical Center.

14.3.2 FOR PROVIDING INFORMATION

Each representative of the Medical Staff and Medical Center and all third parties shall be immune, to the extent permitted by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the Medical Staff, Medical Center, or any other health related organization concerning such person who is, or has been, an applicant to or member of the Medical Staff or who did, or does, exercise clinical privileges or provide services at this Medical Center or by reason of otherwise participating in a medical staff or Medical Center credentialing, quality improvement, or peer review activities.

14.4 ACTIVITIES AND INFORMATION COVERED

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

A. Applications for appointment, reappointment, or specified clinical privileges;
B. Periodic reappraisals for reappointment, privileges, or specified clinical privileges;

C. Corrective action;

D. Hearings and appellate reviews;

E. Quality improvement review, including patient care audits;

F. Peer review, including ongoing and focused professional practice reviews;

G. Utilization reviews;

H. Morbidity and mortality conferences;

I. Other department, division, or committee activities related to monitoring and improving the quality of patient care and appropriate professional conduct; and

J. Queries and reports concerning the National Practitioner Data Bank, peer review organizations, any appropriate licensing authority, and similar queries and reports.

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article XIV may relate to a practitioner’s professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics or other matter that might directly or indirectly affect patient care.

14.5 RELEASES

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

14.6 CUMULATIVE EFFECT

Provisions in these Bylaws and in medical staff application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

14.7 INDEMNIFICATION

The Hospital Authority agrees to indemnify, defend and hold harmless the Medical Staff and its individual members from and against any losses, expenses, judgments, settlements and other amounts actually and reasonably incurred relating to or arising out of 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 if:

(a) the member’s participation is within the course and scope of his or her medical staff duties and responsibilities performed on behalf of the Medical Staff, including peer review and quality assessment activities; and

(b) the member acted in good faith and in a manner such person reasonably believed to be in the best interests of the Medical Center;

The Hospital Authority agrees to pay reasonable defense expenses and to provide legal counsel selected by the Hospital Authority, in its sole discretion, to defend a member in connection with any such claim. Each member agrees to cooperate in all respects with the Hospital Authority in the defense of any such claim. Each member also agrees to repay defense costs and expenses, including attorneys’ fees, incurred in defending against any such claim which may be advanced by the Hospital Authority prior to the final disposition of any proceeding relating to such claim, if it shall be determined ultimately that the member is not entitled to indemnification pursuant to these Bylaws, or any other law or regulation. Said duty of defense and indemnity shall not apply to intentional or willful misconduct, acts taken in bad faith or in pursuit of private economic interests, gross negligence, dereliction or criminal misconduct on the part of the member.
ARTICLE XV
GENERAL PROVISIONS

15.1 RULES AND REGULATIONS

The Medical Staff shall initiate and adopt such rules and regulations as it may deem necessary for the proper conduct of its work and shall periodically review and revise its rules and regulations to comply with current medical staff practice. The Medical Staff Rules and Regulations shall be reviewed by the medical executive committee not less than every two (2) years and revised as appropriate, and as otherwise necessary to comply with applicable law and/or accreditation standards. Neither the Medical Staff nor the Board may unilaterally amend the Medical Staff Rules and Regulations. New Medical Staff Rules and Regulations or changes to the Medical Staff Rules and Regulations (“Proposed Rules”) may emanate from any responsible committee, department, medical staff officer, or by petition signed by at least twenty-five percent (25%) of the members of the Medical Staff eligible to vote. Additionally, Medical Center administration may develop and recommend Proposed Rules, and in any case shall be consulted as to the impact of any Proposed Rules on Medical Center operations and the feasibility of implementation of such Proposed Rules. Proposed Rules shall be submitted to the Medical Executive Committee for review and action, as follows:

A. Except as provided at Section 15.1.G below, with respect to circumstances requiring urgent action, the medical executive committee shall not act on the Proposed Rule until the Medical Staff has had a reasonable opportunity to review and comment on the Proposed Rule. This review and comment opportunity may be accomplished by providing written notice by mail as contemplated by these Bylaws to each medical staff member eligible to vote at least thirty (30) days prior to the scheduled medical executive committee meeting, together with instructions how interested members may communicate comments to the medical executive committee. A comment period of at least fifteen (15) days shall be afforded, and all comments shall be summarized and provided to the medical executive committee prior to medical executive committee action on the Proposed Rule.

B. Medical executive committee approval is required, unless the Proposed Rule is one generated by petition of at least twenty-five percent (25%) of the members of the Medical Staff eligible to vote. In this latter circumstance, if the medical executive committee fails to approve the Proposed Rule, it shall notify the Medical Staff. In such circumstances, the medical executive committee and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Section 15.17.

C. If conflict management is not invoked within thirty (30) days it shall be deemed waived. In this circumstance, the Medical Staff’s Proposed Rule shall be submitted for vote by the Medical Staff, and if approved by the Medical Staff pursuant to Section 15.1.E, the Proposed Rule shall be forwarded to the Board for action. The medical executive committee may
forward comments to the Board regarding the reasons it declined to approve the Proposed Rule.

D. If conflict management is invoked, the Proposed Rule shall not be voted upon or forwarded to the Board until the conflict management process has been completed, and the results of the conflict management process shall be communicated to the Board.

E. With respect to Proposed Rules generated by petition of the Medical Staff, approval of the Medical Staff requires the affirmative vote of a majority of the Medical Staff members voting on the matter by mailed secret ballot, provided at least fourteen (14) days’ advance written notice, accompanied by the Proposed Rule, has been given, and at least fifty percent (50%) of the members of the Medical Staff eligible to vote have cast votes.

F. Following approval by the medical executive committee or favorable vote of the Medical Staff as described above, a Proposed Rule shall be forwarded to the Board for approval, which approval shall not be withheld unreasonably. The Proposed Rule shall become effective immediately following approval by the Board.

G. Where urgent action is required to comply with law or regulation, the medical executive committee is authorized to provisionally adopt a Proposed Rule and forward it to the Board for approval and immediate implementation, subject to the following. If the Medical Staff did not receive prior notice of the Proposed Rule (as described in this Section 15.1) the Medical Staff shall be notified of the provisionally-adopted and -approved Proposed Rule, and may, by petition signed by at least twenty-five percent (25%) of the members of the Medical Staff eligible to vote require the Proposed Rule to be submitted for possible recall; provided, however, the approved Medical Staff Rule and Regulation shall remain effective until such time as a superseding Medical Staff Rule and Regulation meeting the requirements of the law or regulation that precipitated the initial urgency has been approved pursuant to any applicable provision of this Section 15.1.

15.2 MEDICAL STAFF ORGANIZATION AND FUNCTIONS MANUAL

The Medical Staff shall initiate and adopt an Organization and Functions Manual, which describes the various medical staff committees and functions and shall periodically review and revise such manual to comply with current medical staff practice. Following adoption by the Medical Staff such Organization and Functions Manual shall become effective upon approval by the Board, which approval shall not be withheld unreasonably. The Organization and Functions Manual shall be reviewed by the medical executive committee not less than every two (2) years and revised as appropriate, and as otherwise necessary to comply with applicable law and/or accreditation standards. The Organization and Functions Manual shall be adopted and amended in the same manner as Medical Staff
Rules and Regulations and shall for all purposes under these Bylaws be treated and have the same status as Medical Staff Rules and Regulations. Applicants and members of the Medical Staff shall be governed by such manual, as is properly initiated and adopted. If there is a conflict between these Bylaws and the Medical Staff Organization and Functions Manual, these Bylaws shall take priority. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Organization and Functions Manual. Neither the Medical Staff nor the Board may unilaterally amend the Medical Staff Organization and Functions Manual.

15.3 MEDICAL STAFF POLICIES

A. Medical Staff policies shall be developed as necessary to implement more specifically the general principles found within these Bylaws and the Medical Staff Rules and Regulations. The policies of the Medical Staff shall be reviewed by the medical executive committee not less than every two (2) years and revised as appropriate, and as otherwise necessary to comply with applicable law and/or accreditation standards. The policies may be adopted, amended or repealed by majority vote of the medical executive committee and approval by the Board. Such policies shall not be inconsistent with the Medical Staff or Medical Center bylaws, rules, regulations or other policies, and upon adoption shall have the force and effect of these Bylaws.

B. A new or revised Medical Staff policy (a “Proposed Policy”) may emanate from any responsible committee, department, medical staff officer, or by petition signed by at least twenty-five percent (25%) of the members of the Medical Staff eligible to vote. Medical Center administration may also develop and recommend Proposed Policies, and in any case shall be consulted as to the impact of the Proposed Policies on Medical Center operations and the feasibility of the implementation of such Proposed Policies. Medical Executive Committee approval is required, unless the Proposed Policy is one generated by petition of at least twenty-five percent (25%) of the members of the Medical Staff eligible to vote. In this latter circumstance, if the medical executive committee fails to approve the Proposed Policy, it shall notify the Medical Staff. The medical executive committee and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Section 15.17.

C. If conflict management is not invoked within thirty (30) days it shall be deemed waived. In this circumstance, the Medical Staff’s Proposed Policy shall be submitted for vote, and if approved by the Medical Staff pursuant to Section 15.3.E, the Proposed Policy shall be forwarded to the Board for action. The medical executive committee may forward comments to the Board regarding the reasons it declined to approve the Proposed Policy.

D. If conflict management is invoked, the Proposed Policy shall not be voted upon or forwarded to the Board until the conflict management process has
been completed, and the results of the conflict management process shall be communicated to the Medical Staff and the Board.

E. Approval of the Medical Staff shall require the affirmative vote of a majority of the Medical Staff members voting on the matter by mailed secret ballot, provided at least fourteen (14) days’ advance written notice, accompanied by the proposed policy, has been given and votes have been cast by at least fifty percent (50%) of the members of the Medical Staff eligible to vote. Following approval by the medical executive committee or the voting Medical Staff as described above, a Proposed Policy shall be forwarded to the Board for approval, which approval shall not be withheld unreasonably. The policy shall become effective immediately following approval by the Board.

F. If prior notice was not provided to the Medical Staff, the Medical Staff shall be notified of a policy approved by the medical executive committee, and may, by petition signed by at least twenty-five percent (25%) of the voting members of the Medical Staff require the policy to be submitted for possible recall; provided, however, the approved policy shall remain effective until such time as it is repealed or amended pursuant to any applicable provision of this Section 15.3.

15.4 DUES OR ASSESSMENTS

The medical executive committee shall have the power to establish (a) annual dues or assessments, if any, for each category of medical staff membership, and (b) application fees for appointment and re-appointment to the Medical Staff, and to determine the manner of expenditure of such funds received. The medical executive committee shall have the authority to waive dues if circumstances warrant. Medical staff dues shall be used as appropriate for the purposes of the Medical Staff and only in a manner that does not jeopardize the licensure, Medicare and/or Medi-Cal provider status, accreditation, certification or tax exempt status of the Medical Center.

15.5 CONSTRUCTION OF TERMS AND HEADINGS

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

15.6 AUTHORITY TO ACT

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 executive committee may deem appropriate.
15.7 NOTICES

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

Name and proper title of addressee, if known or applicable
Name of department, division, or committee
c/o President of Staff
Kern Medical Center
1700 Mount Vernon Avenue
Bakersfield, California 93306

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

15.8 DISCLOSURE OF INTEREST

All nominees for election or appointment to medical staff offices, department chair positions, or to the medical executive committee shall, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the medical executive committee (a) 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, and (b) any potential and actual conflicts of interest required to be disclosed by the Hospital Authority policy on conflicts or the Hospital Authority Conflict of Interest Code. The medical executive committee shall evaluate the significance of such disclosures and discuss any conflicts with the nominee. If a nominee with a conflict remains on the ballot, the nature of his or her conflict shall be disclosed in writing and circulated with the ballot.

15.9 NOMINATION OF MEDICAL STAFF REPRESENTATIVES

Candidates for positions as medical staff representatives to local, state and national hospital medical staff sections should be filled by such selection process as the Medical Staff may determine. A nominating committee appointed by the medical executive committee shall make nominations for such positions.
15.10 MEDICAL STAFF CREDENTIALS FILES

15.10.1 INSERTION OF ADVERSE INFORMATION

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

A. Any person may provide information to the Medical Staff about the conduct, performance or competence of its members.

B. When a request is made for insertion of adverse information into the member’s credentials file, the respective department chair and President of Staff shall review such a request.

C. After such a review a decision will be made by the respective department chair and President of Staff to:

1. Insert the information (unless directed by the medical executive committee not to do so);

2. Notify the member of the adverse information by a written summary and offer the opportunity to rebut this assertion before it is entered into the member’s file; or

3. Insert the information along with a notation that a request has been made to the medical executive committee for an investigation as outlined in Section 12.2.3 of these Bylaws.

D. This decision shall be reported to the medical executive committee. The medical executive committee, when so informed, may either ratify or initiate contrary actions to this decision by a majority vote.

15.10.2 REVIEW OF ADVERSE INFORMATION AT THE TIME OF REAPPRAISAL AND RENEWAL OF MEMBERSHIP

The following applies to the review of adverse information in the member’s credentials file at the time of reappraisal and renewal of membership:

A. Prior to recommendation on renewal of membership, the credentials committee, as part of its reappraisal function, shall review any adverse information in the credentials file pertaining to a member.

B. Following this review, the credentials committee shall determine whether documentation in the file warrants further action.

C. With respect to such adverse information, if it does not appear that an investigation and/or adverse action at the time of membership renewal is
warranted, the credentials committee shall so inform the medical executive committee.

D. If an investigation or adverse action at the time of membership renewal is warranted, the credentials committee shall so inform the medical executive committee.

E. No later than sixty (60) days following final action on the request for renewal of membership, the medical executive committee shall:

   1. Initiate a request for corrective action, based on such adverse information and on the credentials committee’s recommendation relating thereto; or

   2. Cause the substance of such adverse information to be summarized and disclosed to the member.

F. The member shall have the right to respond thereto in writing, and the medical executive committee may elect to remove such adverse information on the basis of such response or otherwise on its own initiative.

15.11 CONFIDENTIALITY

The following applies to records of the Medical Staff and its department and committees responsible for the evaluation and improvement of patient care:

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

B. Access to such records shall be limited to (1) the Chief Executive Officer, the Board, and their duly authorized representatives and designees, and (2) department chairs, division chiefs, duly appointed officers and committees of the Medical Staff, and their duly authorized representatives and designees for the sole purpose of discharging medical staff responsibilities and subject to the requirement that confidentiality be maintained.

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

D. Information contained in the credentials file of any member may be disclosed with the member’s consent, to any medical staff or professional licensing board, or as required by law. However, any disclosure for use of the information outside of the Medical Staff at the Medical Center shall require the authorization of the President of Staff and the concerned department chair or their designees, with notice to the member.
E. A medical staff member shall be granted access to his or her credentials file, subject to the following provisions:

1. Timely notice of such shall be made by the member to the President of Staff or designee;

2. The member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information, including peer review committee findings, letters of reference, proctoring reports, complaints, etc., shall be provided to the member, in writing, by the designated officer of the Medical Staff, within a reasonable period of time, as determined by the Medical Staff. Such summary shall disclose the substance, but not the source, of the information summarized; and

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

F. In the event a notice of action or proposed action is filed against a member, access to that member’s credentials file shall be governed by Section 13.4.2.

15.12 LEGAL COUNSEL

The Medical Staff may, at its expense, retain and be represented by independent legal counsel.

15.13 AUTHORITY TO ACT

Any member who acts in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the medical executive committee may deem appropriate.

15.14 DISPUTES WITH THE BOARD

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

A. Invoking the Dispute Resolution Process

1. The medical executive committee may invoke formal dispute resolution, upon its own initiative, or upon written request of twenty-five percent (25%) of the members of the Active Staff.

2. In the event the medical executive committee declines to invoke formal dispute resolution upon the written request of twenty-five percent (25%) of the members of the Active Staff, such process
shall be invoked upon written petition of fifty percent (50%) of the members of the Active Staff.

B. Dispute Resolution Forum

1. Ordinarily, the initial forum for dispute resolution shall be the joint conference committee, which shall meet and confer as further described in Section 11.3.2.

2. However, upon request of at least 2/3 of the members of the medical executive committee, and with the consent of the two (2) Board members of the joint conference committee, the meet and confer will be conducted by a meeting of the full medical executive committee and the two (2) Board members assigned to the joint conference committee. A neutral mediator acceptable to (a) the two (2) Board members serving on the joint conference committee and (b) the medical executive committee may be engaged to further assist in dispute resolution.

C. If the parties are unable to resolve the dispute, the Board shall make its final determination giving great weight to the actions and recommendations of the medical executive committee. Further, the Board determination shall not be arbitrary and capricious, and shall be in keeping with its legal responsibilities to act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the Medical Center.

15.15 NO RETALIATION

Neither the Medical Staff, its members, committees or department chairs, the Board, nor any other employee or agent of the Medical Center or Medical Staff, shall discriminate or retaliate, in any manner, against any patient, Medical Center employee, member of the Medical Staff, or any other health care worker of the Medical Center because that person has done either of the following:

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

B. Has initiated, participated, or cooperated in an investigation or administrative proceeding related to, the quality of care, services, or conditions at the Medical Center that is carried out by an entity or agency responsible for accrediting or evaluating the Medical Center or its Medical Staff, or governmental entity.
15.16 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

The Board may determine, as a matter of policy and in accordance with state and federal law, that certain hospital clinical facilities may be used only on an exclusive basis in accordance with written contracts between the hospital and qualified professionals, or in a limited fashion pursuant to a closed or limited staff policy. At the request of the Board, the medical executive committee shall review and make recommendations to the Board regarding quality of care issues related to such exclusive arrangements in the following situations:

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

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

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

The medical executive committee may also provide Medical Center administration and the Board with its recommendations regarding such matters on its own initiative.

15.17 CONFLICT RESOLUTION PROCESS FOR DISPUTES BETWEEN THE MEDICAL STAFF AND THE MEDICAL EXECUTIVE COMMITTEE

15.17.1 REQUIREMENTS FOR CONFLICT RESOLUTION PROCESS

In the event that at least twenty-five percent (25%) of the Active Staff who are in good standing and entitled to vote sign a petition or otherwise evidence disagreement with any action taken by the medical executive committee, including, but not limited to, any proposed Medical Staff Bylaw, Medical Staff Rule and Regulation or Medical Staff policy, such members may petition that the conflict resolution process under this Section 15.17 be followed. The conflict resolution process under this Section 15.17 shall not apply to any individual peer review action or hearing concerning an individual member of the Medical Staff or any other individual authorized to exercise clinical or practice privileges at the Medical Center. The petition shall clearly state the basis of the disagreement and may include any other information by way of additional explanation to medical staff members. Each signatory must acknowledge that he/she has read the petition and all attachments, if any, in order for his/her signature to be considered valid.

15.17.2 PROCESS

Once the conflict resolution threshold has been achieved, the petition and any attachments and a list of petitioners shall be forwarded to the medical executive committee. Within thirty (30) days of the medical executive committee’s receipt of the petition, a meeting between up to five (5) representatives of the medical executive committee, appointed by the President of Staff, and up to five (5) of the
petitioners, who shall be designated on the petition, shall be scheduled. The meeting(s) shall include an equal number of medical executive committee members and petitioners. The parties shall act in good faith and shall take reasonable steps to resolve the conflict in question in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the medical executive committee, and the safety and quality of patient care at the Medical Center.

15.17.3 RESOLUTION OF CONFLICT

If the medical executive committee and the petitioners are able to resolve the conflict, the resolution shall be submitted to the Medical Staff. If the Medical Staff approves the proposed resolution by the affirmative vote of the majority of the votes cast by medical staff members eligible to vote on the matter, with such vote taken in the manner authorized by these Bylaws, then the matter shall be forwarded to the Board for its review and consideration. Thirty (30) days written notice accompanied by a summary of the proposed resolution(s) shall be given prior to the vote.

15.17.4 FAILURE TO REACH RESOLUTION

Should the medical executive committee and the petitioners fail to reach resolution, or if the medical staff members do not approve any proposed solution agreed to by the petitioners and the medical executive committee, the petition and all accompanying materials shall be forwarded to the Board for its review and consideration. The decision of the Board shall be final and shall not serve as a basis for conflict resolution under these Bylaws.

15.17.5 FINAL DISPOSITION

If the Medical Staff accepts the conflict resolution as proposed by petitioners and the medical executive committee, the resolution, the initial petition and all accompanying materials shall be forwarded to the Board for its review and consideration. If approved by the Board, the decision shall be final. If not approved by the Board, the medical executive committee and/or the petitioners shall each have the option of requesting that the conflict resolution process under these Bylaws be initiated by requesting a meeting of the joint conference committee as constituted pursuant to Section 11.3 of these Bylaws. For purposes of implementing a conflict resolution process as contemplated by this Section 15.17, the joint conference committee shall meet on the call of the Board, the medical executive committee, or the petitioners’ signed petition requesting implementation of the conflict resolution process if the petition is signed by at least twenty-five percent (25%) of the Active Staff who are in good standing and entitled to vote. Other than the identity of the parties who are entitled to call a meeting of the joint conference committee, the joint conference committee shall otherwise operate in all respects as contemplated by Section 11.3 of these Bylaws for purposes of the conflict resolution process contemplated by this Section 15.17.
15.17.6 COMMUNICATIONS

Nothing under this Article XV precludes an individual medical staff member from communicating with the Board on any Medical Staff Rule and Regulation or Medical Staff policy already adopted by the Medical Staff or the medical executive committee. Such communication shall be forwarded to the Board through the Chief Executive Officer (or his/her designee) and to the medical executive committee through the President of Staff. The chair of the Board shall determine the manner and method of responding to the Medical Staff.
ARTICLE XVI
ADOPTION AND AMENDMENT OF BYLAWS

16.1 PROCEDURE

The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt and recommend Medical Staff Bylaws and amendments. Such responsibility and authority shall be exercised in good faith and in a reasonable and timely manner, reflecting the interests of providing patient care of the generally recognized quality and efficiency, and maintaining a harmony of purpose and effort with the Board. The Medical Staff Bylaws shall be reviewed by the medical executive committee not less than every two (2) years and revised as appropriate, and as otherwise necessary to comply with applicable law and/or accreditation standards. Proposals to adopt, amend or repeal these Bylaws may be initiated by and in accordance with the following methods and procedures:

A. The medical executive committee, with the recommendation of the bylaws committee, or on its own motion, may recommend adoption, amendment or repeal of the Bylaws to the voting members of the Medical Staff as provided in this Article XVI.

B. The members of the Active Staff, by a written petition signed by at least twenty-five percent (25%) of the members of the Medical Staff eligible to vote, may petition the medical executive committee to initiate a proposal to adopt, amend or repeal these Bylaws. Such petition shall identify the exact language to be added, changed or deleted. If the medical executive committee agrees with the proposed change, it may recommend the change as provided in Section 16.1 A above. If the medical executive committee does not agree with the proposed change, it shall notify the Medical Staff. The medical executive committee and Medical Staff each have the option of invoking and waiving the conflict resolution provisions of Section 15.17.

C. If conflict resolution is not invoked within thirty (30) days, it shall be deemed waived. In this circumstance, the Medical Staff’s proposed Bylaws amendment shall be submitted for vote, and if approved by the Medical Staff pursuant to Section 16.2, the proposed Bylaws amendment shall be forwarded to the Board for action. The medical executive committee may forward comments to the Board regarding the reasons it declined to approve the proposed Bylaws amendment.

D. If conflict resolution is invoked, the proposed Bylaws amendment shall not be voted upon or forwarded to the Board until the conflict resolution process has been completed, and the result of the conflict resolution process shall then be communicated to the Medical Staff and the Board.

E. Medical Center administration may develop and recommend revisions to the Bylaws, which shall be submitted to the medical executive committee
for review, consideration, and possible action as contemplated by Section 16.1 (A) of these Bylaws.

F. Medical Center administration shall be consulted by the medical executive committee on the impact of any proposed Bylaws and/or amendments to the Bylaws on Medical Center operations and the ease and feasibility of implementation. Proposed Bylaws and amendments to the Bylaws shall be submitted to the Board for comments at least thirty (30) days before they are distributed to the Medical Staff for a vote. The Board has the right to require that its comments regarding the proposed Bylaws and amendments be circulated with the proposed Bylaws and amendments at the same time that they are distributed to the Medical Staff for a vote.

16.2 ACTION BY THE ACTIVE STAFF

These Bylaws may be amended at (1) any regular meeting of the Medical Staff or (2) any special meeting of the Medical Staff called for such purpose, provided written notice of such proposed amendment is given to each member of the Medical Staff eligible to vote at least fifteen (15) calendar days prior to such meeting, accompanied by a ballot that would allow the recipient to vote on the proposed amendment in lieu of attending such meeting. To be counted for any purpose, such ballot must be returned to the medical staff office by that date which is five (5) business days after the date the meeting of the Medical Staff is held. An amendment to these Bylaws shall require for adoption: (1) voting by no less than fifty percent (50%) of the members of the Medical Staff eligible to vote, aggregating for this purpose the number of votes cast at such meeting and the number of votes cast by ballot as provided above (the “Aggregated Votes”); and (2) an affirmative vote of a majority of the Aggregated Votes. An amendment to these Bylaws may be adopted at a regular meeting of the Medical Staff or a special meeting of the Medical Staff called for that purpose by aggregating the votes cast at such meeting and the number of votes cast by ballot as provided above even if a quorum was not present at the meeting where votes were cast. In lieu of (1) any regular meeting of the Medical Staff or (2) any special meeting of the Medical Staff called for purposes of amending the Bylaws, these Bylaws may also be amended by vote of the Medical Staff, without a meeting, provided written notice of the proposed amendment and the date the votes are to be tabulated is given to each member of the Medical Staff eligible to vote at least thirty (30) days prior to the date the votes are to be tabulated, accompanied by a ballot that will allow the recipient to vote on the proposed amendment. For purposes of this paragraph, notice will be deemed to be given as of date the proposed amendment is mailed to the members of the Medical Staff. To be counted for any purpose, a ballot must be returned to the medical staff office no later than one (1) business day prior to the date designated in the written notice as the date the votes are to be tabulated. All votes by the Medical Staff to amend the Bylaws shall be by secret ballot. Notwithstanding anything herein to the contrary, an amendment to the Bylaws adopted by the Medical Staff as contemplated by this Section 16.2 shall not become effective until approved by the Board.
16.3 APPROVAL

Upon approval by the Medical Staff as provided above, the proposed amendment to the Bylaws shall be submitted to the Board for approval. The Board shall give great weight to the Medical Staff’s recommendation that the proposed amendment be approved. The proposed amendment shall become effective immediately following approval by the Board. The Board may not unreasonably withhold its approval from the Medical Staff’s recommended amendment to the Bylaws. If the Board votes to disapprove the entire or any part of the recommended amendment to the Bylaws, the Board chair shall give the President of Staff written notice of the reasons for non-approval within ten (10) business days from the Board’s action. At the request of the medical executive committee, the Board’s disapproval shall be submitted to the conflict resolution process as established by these Bylaws.

16.4 TECHNICAL AND EDITORIAL CORRECTIONS

The medical executive committee shall have the power to approve technical corrections, such as reorganization or renumbering of the bylaws, or to correct punctuation, spelling or other errors of grammar expression or inaccurate cross-references. No substantive amendments are permitted pursuant to this section. Corrections may be effected by motion and acted upon in the same manner as any other motion before the medical executive committee. After approval, such corrections shall be communicated in writing to the Medical Staff and to the Board. Such corrections are effective upon adoption by the medical executive committee; provided, however, they may be rescinded by vote of the Medical Staff or the Board within one hundred twenty (120) days of the date of adoption by the medical executive committee. (For purposes of this section, “vote of the Medical Staff” shall mean a majority of the votes cast, provided at least twenty-five percent (25%) of the voting members of the Medical Staff cast ballots.)

16.5 EXCLUSIVITY AND CONFLICTS

The Medical Staff Bylaws and the Hospital Authority Bylaws for Governance shall be consistent. Neither the Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws. The mechanisms described herein shall be the sole methods for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws. To the extent that these Bylaws conflict with the Medical Staff Rules and Regulations and/or any policies of the Medical Staff, these Bylaws shall prevail. To the extent that the Medical Staff Rules and Regulations conflict with any policies of the Medical Staff, the Medical Staff Rules and Regulations shall prevail.

16.6 CONSTRUCTION OF TERMS AND HEADINGS

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

ADOPTED by the Medical Staff of Kern Medical Center on

APR 20 2016
Date

[Signature]
President of Staff

APPROVED by the Hospital Authority Board of Governors on

APR 20 2016
Date

[Signature]
Chairman, Board of Governors