FORM APPROVED COUNTY COUNSEL
BY: ANITA C. WILLIS DATE 4-13-15

Departmental Concurrence

SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

3.12A

FROM: Riverside County Regional Medical Center (RCRMC)

SUBMITTAL DATE:
April 9, 2015

SUBJECT: Medical Staff Bylaws Revision

RECOMMENDED MOTION: That the Board of Supervisors:

1. Approve the attached Revision to the RCRMC Medical Staff Bylaws authorizing the Hospital Director to make medical staff appointments subject to ratification by the Board of Supervisors; and

2. Authorize the Hospital Director to make medical Staff appointments upon favorable recommendation by the RCRMC Medical Executive Committee (MEC) subject to ratification by the Board of Supervisors.

BACKGROUND:
Summary
The proposed amendment to the Medical Staff Bylaws and the request to authorize the Hospital Director to make appointments upon favorable recommendation of the MEC subject to ratification by the Board of Supervisors arises out of the need to reduce delays in retaining medical staff.

Jennifer Cruikshank, COO for
Zareh Sarrafian, Hospital Director
Jennifer Cruikshank, Chief Operation Officer

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost:	POLICY/CONSENT (per Exec. Office)
COST	$ 0	$	$ 0	$ 0	Consent ☐ Policy ☒
NET COUNTY COST	$ 0	$ 0	$ 0	$ 0	

SOURCE OF FUNDS:

Budget Adjustment: No
For Fiscal Year: FY 14/15

C.E.O. RECOMMENDATION: APPROVE
BY: Debra Cournoyer
Debra Cournoyer

County Executive Office Signature

MINUTES OF THE BOARD OF SUPERVISORS

☐ Positions Added ☐ Change Order
☐ A-30 ☐ 4/5 Vote

Prev. Agn. Ref.: | **District:** 5 | **Agenda Number:** 3-29

BACKGROUND:

Summary (continued)

Delays in processing medical staff appointments/re-credentialing have on occasion occurred due to the BOS agenda timing, particularly during times where there are frequent "dark" days when the Board does not meet. This particularly occurs during the summer months. The delays could have an impact on meeting patient needs within the community if the initial appointment and re-credentialing of physicians and other medical staff does not occur on a timely basis. The revision, as set forth primarily in Section 6.3-7 (b) of the Bylaws would require the appointment to be ratified by the Board of Supervisors within 45 days or at the next Board meeting, whichever occurs first. Medical appointments that are not ratified by the Board shall be terminated pursuant to the recommended revision to the Bylaws.

Impact on Citizens and Businesses

The Board of Supervisors' approval of medical staff appointments is required pursuant to the RCRMC Medical Staff Bylaws and pursuant to state and/or federal guidelines regarding credentialing and provision of hospital privileges. This process will continue to ensure that the RCRMC healthcare practitioners meet all necessary credentialing requirements, while continuing to provide the highest quality of healthcare to the community.

RIVERSIDE COUNTY
REGIONAL MEDICAL CENTER

MEDICAL STAFF BYLAWS

PREAMBLE

WHEREAS, Riverside County Regional Medical Center is a public general acute hospital organized under the laws of the State of California; and

WHEREAS, its purpose is to serve as a general acute hospital providing patient care, education, and research; and

WHEREAS, it is recognized that the governing board has the ultimate authority and responsibility for all aspects of the hospital operation, including the professional component and, therefore, the medical staff is accountable to the governing board for the proper discharge of its responsibilities, and all medical staff activities and actions are subject to review and approval by the governing board; and

WHEREAS, it is recognized that the medical staff is delegated responsibility by the governing board for the quality of medical care at the hospital and must accept and discharge this responsibility subject to the governing board's ultimate authority; and

WHEREAS, it is recognized that the cooperative efforts of the medical staff, the hospital administration, and the governing board are necessary to fulfill the foregoing responsibilities of the medical staff and the hospital's obligations to its patients; and

WHEREAS, only duly qualified physicians, dentists, podiatrists, and clinical psychologists are eligible for medical staff membership, privileges and prerogatives; and

WHEREAS, some duly qualified allied health professionals may be eligible to participate as independent practitioners in the provision of certain patient care services in the hospital setting;

THEREFORE, the physicians, dentists, podiatrists, and clinical psychologists practicing at this hospital hereby organize themselves into a medical staff in conformity with these bylaws.

DEFINITIONS:

1. **ALLIED HEALTH PROFESSIONAL** or **AHP** means Physician Assistants, Nurse Practitioners, Nurse Certified Midwife and Audiologist who exercises judgment within the areas of professional competence and the limits established by the governing board, the medical staff and the applicable State Practice Acts; who is qualified to render direct or indirect medical, dental, podiatric or clinical psychological care under the supervision or direction of a medical staff member possessing privileges to provide such care in the hospital; and who may be eligible to exercise practice privileges and prerogatives in conformity with the rules adopted by the governing board, if any, these bylaws, and the medical staff rules and regulations. AHPs are not eligible for medical staff membership.

2. **ATTENDING PHYSICIAN*** is the medical staff physician responsible for rendering, coordinating and directing care and services provided to a patient while hospitalized. Expertise and training relative to the principal diagnosis precipitating hospitalization generally determines initial pairing of patients to attending physicians.

   A patient may have more than one attending physician over the course of a hospitalization, but should have only one attending physician at a time. One physician must be in charge. Transfer of responsibility from one attending physician to another must be clearly specified in the medical record, whether it will be for weekend or holiday coverage within a department, or whether it be a transfer from one medical service to another.

3. **CONSULTING PHYSICIAN**** is a medical staff member who responds to the request of the attending physician (or designee). The consulting physician provides specific consultation or service to a patient at the request of the attending physician (or designee). Consultation is provided within the scope of medical staff privileges and expertise.

   The attending physician defines the clinical question or service, and specifies the level of consultation sought: a one-visit opinion, a specific service or intervention, transfer of care (making the consultant the attending physician), or **some other defined arrangement**, as mutually agreed. Consultation may be sought for specific or general expertise or skill, going from generalists to subspecialists or the other way around, depending on patient care needs.

   Physician consultants respect the relationship between the patient and the attending physician, promptly and effectively communicating recommendations to the attending physician, and should obtain concurrence of the attending physician for major procedures or involvement of additional consultants. Consultants who need temporary charge of the patient's care should obtain the attending physician's cooperation and assent.

   A complex clinical situation may call for multiple consultations. When the attending physician disagrees with the consultant's recommendations, another consultation may be required. To assure a coordinated effort in the best interest of the patient, the attending physician remains in charge of overall care, communicating with the patient and coordinating care on the basis of information derived from consultations.

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* Near synonyms: "Principal physician," "primary physician" (not to be confused with primary care physician), "physician of record."
Principal physician generally has connotations of a subspecialist who also provides primary care for a patient. Physician of record is a term with retrospective connotations and of specific context. Who was the physician of record? Who was the physician of record for the liver biopsy? Primary physician comes closest to the definition used here, but has the potential of confusion with the term primary care physician.

** As used here, "Consulting Physician" refers to a specific role relative to patient care distinct from the medical staff membership category of "Consulting Staff."

4. **CHIEF OF MEDICAL STAFF or CHIEF OF STAFF** means the chief administrative officer of the medical staff.

5. **CLINICAL PRIVILEGES** means the permission granted to a medical staff and allied health professionals to render specific diagnostic, therapeutic, medical, dental, podiatric, clinical psychological or surgical services.

6. **COMPLETE APPLICATION** means the applicant has filled out the application form in full, answered all questions, signed and dated all forms that require signature and has paid the required fees; items on the application have been verified as specified in the Credentials Policies and Procedures Manual (not verified by documents provided by the applicant); the applicant has provided answers to all questions which have arisen during the application verification process; and the relevant department chair, the Credentials Committee and the Medical Executive Committee have all the information they need to make a decision.

7. **EX-OFFICIO MEMBER** means an officer or other individual as designated by these bylaws, who maybe a committee member by virtue of elected or appointed position. An ex-officio member may attend meetings with power to vote unless otherwise stated in these bylaws or in the Medical Staff Committee and Functions Manual.

8. **GOVERNING BOARD or BOARD** means the Riverside County Board of Supervisors.

9. **HOSPITAL or RCRMC** means Riverside County Regional Medical Center.

10. **HOSPITAL DIRECTOR or ADMINISTRATOR** means the person appointed by the County CEO to act on its behalf in the overall management of the hospital, or the hospital director's authorized representative.

11. **IN GOOD STANDING** means a practitioner is currently not under suspension or serving with any limitations of voting or other prerogatives imposed by operation of the bylaws, rules and regulations or policies of the medical staff.

12. **INVESTIGATION** means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a member of the medical staff, and does not include activity of the Physician Well-Being Committee.

13. **MEDICAL DIRECTOR** means the medical administrative officer of the hospital.

14. **MEDICAL EXECUTIVE COMMITTEE or MEC** means the Medical Executive Committee of the medical staff.

15. **MEDICAL STAFF or STAFF** means the formal organization of all licensed physicians, dentists, podiatrists, and clinical psychologists who are privileged to attend patients at the hospital.

16. **MEDICAL STAFF YEAR** means the period from July I to June 30.

17. **MEDICO-ADMINISTRATIVE OFFICER** means a practitioner, employed by or otherwise serving the hospital on a full- or part-time basis, whose duties include certain responsibilities which are both administrative and clinical in nature. Clinical responsibilities, as used herein, are those responsibilities which require a practitioner

to exercise clinical judgment with respect to patient care and it includes the supervision of professional activities of practitioners under the medico-administrative officer's direction.

18. **PHYSICIAN means** an individual with a M.D. or D.O. degree or the equivalent degree (i.e., foreign) as recognized by the Medical Board of California (MBC) or the Board of Osteopathic Examiners (BOE), who is licensed by either the MBC or the BOE.

19. **PRACTITIONER** means physician, dentist, podiatrist, or clinical psychologist or allied health professional who exercises clinical privileges at the hospital.

20. **PREROGATIVE** means a participatory right granted, by virtue of staff category or otherwise, to a medical staff member, which is exercisable subject to, and in accordance with, the conditions imposed by these bylaws and by other hospital and medical staff rules, regulations, or policies.

ARTICLE I

NAME

The name of this organization is the medical staff of Riverside County Regional Medical Center.

ARTICLE II

PURPOSES

The purposes of this organization are:

1. The purpose of this medical staff is to organize the activities of physicians and other clinical practitioners who practice at Riverside County Regional Medical Center. In order to carry out, in conformity with these bylaws, the functions delegated to the medical staff by the hospital County Board of Supervisors

2. To initiate and maintain rules and regulations for the medical staff to carry out its responsibilities to be self-governing with respect to the professional work performed in the hospital.

3. To provide means whereby issues concerning the medical staff and the hospital may be discussed by the medical staff with the governing board and the hospital director.

4. To be responsible, in cooperation with affiliated institutions, to carry out the education and training of the house staff as prescribed by the Council on Medical Education and Hospitals of the American Medical Association.

5. To carry out the education and training of other allied hospital personnel.

ARTICLE III

MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

Medical Staff Membership shall be extended only to professionally competent physicians, dentists, podiatrists or clinical psychologists who continuously meet the qualifications, standards and requirements set forth in these bylaws. Appointment to and membership in the medical staff shall confer on the member only such privileges and prerogatives as have been granted by the governing board in accordance with these bylaws. No practitioner shall admit or provide services to patients at the hospital unless medical staff privileges have been granted in accordance with the procedures set forth in these bylaws and the Credentials Policies and Procedures Manual.

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2-1 GENERAL QUALIFICATIONS

Practitioners shall be qualified for medical staff membership only if they:

(a) document their licensure, experience, background, training, demonstrated ability, and judgment to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency established by the hospital, and that they are qualified to exercise clinical privileges at the hospital;

(b) are determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective professions, including the principles of the California Medical Association and the Principles of Ethics of the American Medical Association or the American Dental Association, to work cooperatively with others in the hospital setting so as not to adversely affect patient care or hospital operations, to be willing to participate in and properly discharge medical staff responsibilities, and to be willing to commit to and regularly assist the hospital in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials;

(c) are located closely enough to the hospital to provide continuous care to their patients or provide alternate coverage; and

(d) document physical and mental status (subject to any necessary reasonable accommodation) to demonstrate to the satisfaction of the medical staff that s/he is professionally and ethically competent so that patients can reasonably expect to receive the generally recognized professional level of quality of care for this community.

3.2-2 PARTICULAR QUALIFICATIONS

(a) **Physicians.** An applicant for physician membership in the medical staff, except for honorary staff, must hold a M.D. or D.O. degree or their equivalent and a valid, unrevoked and unsuspended certificate to practice medicine issued by the Medical Board of California or the Osteopathic Medical Board of California. For the purpose of this section, "or the equivalent" shall mean any degree (i.e., foreign) recognized by the Medical Board of California or the Osteopathic Medical Board of California.

(b) **Dentists.** An applicant for dental membership in the medical staff, except for honorary staff, must hold a D.D.S. or equivalent degree issued by a dental school and a valid, unrevoked and unsuspended certificate to practice dentistry issued by the California Board of Dental Examiners.

(c) **Podiatrists.** An applicant for podiatric membership in the medical staff, except for honorary staff, must hold a D.P.M. degree and a valid, unrevoked, and unsuspended certificate to practice podiatry issued by the Medical Board of California.

(d) **Clinical Psychologist.** An applicant for clinical psychologist membership, except for the honorary staff, must hold a clinical psychologist degree, have

not less than two (2) years clinical experience in a multi-disciplinary facility licensed or operated by this or another state or by the United States to provide healthcare or be listed in the latest edition of the National Register of Health Service Provider in Psychology, and hold a valid, unrevoked, and unsuspended license to practice clinical psychology issued by the Board of Psychology.

3.2-3 PROFESSIONAL LIABILITY INSURANCE

A member granted clinical or practice privileges in the hospital shall maintain in force professional liability insurance in not less than the minimum amounts, if any, as from time to time may be determined by the governing board, or shall provide other proof of financial responsibility in such manner as the governing board may from time to time establish.

3.3 EFFECT OF OTHER AFFILIATIONS

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

3.4 NONDISCRIMINATION

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, sexual orientation, or on the basis of any other criterion, unrelated to the delivery of quality patient care in the hospital setting, to professional qualifications, the hospital's purposes, needs and capabilities, or community needs.

3.5 MEDICO-ADMINISTRATIVE OFFICERS

A practitioner who is engaged in a medico-administrative position must be a medical staff member, achieving this status by the procedure provided in Article VI and VII. The medical staff membership and clinical privileges of any medico-administrative officer shall also be subject to the terms and conditions of the practitioner's contract or agreement with the hospital. The contract or agreement shall govern over these medical staff bylaws as to all matters covered by said contract or agreement, and shall be consistent with these bylaws.

3.6 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Members of the medical staff shall:

(a) Provide patients with care at the generally recognized professional level of quality and efficiency established by the hospital's medical staff.

(b) Retain responsibility within the area of professional competence for the continuous care and supervision of patients at the hospital for whom providing services, or arrange for a suitable alternative physician, who is on the medical staff with equivalent clinical privileges, to assure such care and supervision.

(c) Abide by the medical staff bylaws and rules and regulations and by all other lawful standards, policies, and rules of the hospital and shall conform to current JC, HIPAA, CMS and state mandated standards.

(d) Comply with all requirements set forth in the medical staff bylaws and rules and regulations, including, but not limited to, those requiring maintenance of professional liability insurance (Section 15.3), payment of medical staff dues (Section 15.4), acceptance of principles (Section 15.7), and refraining from division of fees (Section 15.8).

(d) Discharge such personal, medical staff, department, committee and hospital functions, including, but not limited to, peer review, patient care audit, utilization review, quality assessment, emergency service and back-up functions, for which the member is responsible by virtue of staff category assignment, appointment, election, utilization of allied health professionals or exercise of privileges, prerogatives or other rights in the hospital.

(f) Prepare and complete in a timely fashion the medical and other required records for all patients the staff member admits or in any way provides care to at the hospital.

(g) Perform a medical history and physical examination not more than 14 days prior to a patient's admission or 24 hours after admission by a doctor of medicine, osteopathy or surgeon who has been granted privileges by the medical staff in accordance with state law. The documentation of the medical history, physical examination, and required updates, must be in the chart within 24 hours after the patient's admission.

An updated examination of the patient, including any changes in the patient's condition, be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 14 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician (as defined in section 1861(r) of the Act),or other qualified licensed individual in accordance with State law and hospital policy.

(h) Aid in any educational programs for medical staff members, medical students, interns, resident physicians, resident dentists, nurses, and other

personnel when so assigned. A medical staff member who chooses not to participate in the teaching programs is not subject to denial or limitation of privileges for this reason alone.

(i) Agree to provide continuous quality care for patients.

(j) Assist the hospital in fulfilling its uncompensated or partially compensated patient care obligations within the areas of the staff member's professional competence and credentials.

(k) Pledge not to receive or pay to another physician or dentist, either directly or indirectly, any part of a fee received for professional services.

(l) Pledge to maintain an ethical practice, including refrain from illegal inducements for patient referral, and refrain from failing to disclose to patients when another surgeon will be performing the surgery.

(m) Refrain from any unlawful harassment or discrimination against any person (including any patient, hospital employee, hospital independent contractor, medical staff member, volunteer, visitor, etc.) based upon the person's age, sex, religion, race, creed, color, national origin, or health status as further described in Section 3.10, or ability to pay or source of payment.

(n) Refrain from delegating patient care responsibility, including diagnosis or care of hospitalized or outpatient patients to a practitioner or allied health professional that is not qualified to undertake this responsibility or who is not adequately supervised.

(o) Coordinate individual patient care, treatment, and service with other practitioners and hospital personnel, including, but not limited to, seeking consultation whenever warranted by the patient's condition or when required by the rules or policies and procedures of the medical staff or applicable department.

(p) Recognize the importance of confidentially communicating concerns to appropriate department officers and/or medical staff officers when s/he obtains credible information including that a fellow medical staff member may have engaged in unprofessional or unethical conduct, or may have a health condition which 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 manner.

(q) Participate in the medical staff focused professional practice evaluation and ongoing professional practice evaluation in accordance with the bylaws, rules and policies and procedures of the medical staff.

(r) Immediately notify the Medical Staff Services Office by telephone and furnish in writing within two (2) business days upon notification of any action taken regarding the member's license, DEA registration, privileges at other facilities, changes in liability insurance coverage, any report filed with the National Practitioner Data Bank, or any other action that could affect his/her medical staff standing and/or clinical privileges at the hospital.

(s) Adhere to the medical staff organization's Standards of Conduct (as further

described in Section 3.11), so as not to adversely affect patient care or hospital operations.

3.7 DURATION OF APPOINTMENT

Initial appointment to the medical staff shall not exceed a period of two (2) years. Reappointment shall be for a period of not more than two (2) years.

3.8 PROCTORING REQUIREMENTS

3.8-1 FOR INITIAL APPOINTMENT

Except as otherwise determined by the Medical Executive Committee, all initial appointees to the medical staff that have been granted clinical privileges and all members granted additional clinical privileges, shall be subject to a period of proctoring. Proctoring can be prospective, concurrent and retrospective review. An initial appointee shall be assigned to a department where the appointee's performance shall be proctored by the chair of the department or the department designee, during the term of proctoring required by that department, as established pursuant to Section 3.8-3, to determine the initial appointee's eligibility for continued medical staff membership in the category to which appointed and to exercise the clinical privileges initially granted in that department. Proctoring arrangement shall be the responsibility of the appointee. The exercise of clinical privileges in any other department shall also be subject to prospective, concurrent and retrospective proctoring. The appointee shall remain subject to proctoring until the Credentials Committee has been furnished with:

(a) A report signed by the chair, or designee, of the department to which the appointee is assigned describing the types and number of cases observed, an evaluation of the appointee's performance, and a statement that the appointee appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the category to which appointed. The proctoring will include prospective, concurrent and retrospective chart review.

(b) A report signed by the chair, or designee, of the other department in which the appointee will exercise clinical privileges, describing the types and number of cases observed, an evaluation of the appointee's performance, and a statement that the appointee has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted.

3.8-2 FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES

When recommended by the Credentials and the Medical Executive Committees, and approved by the governing board, medical staff members who are granted additional privileges shall complete a period of proctoring with the procedures outlined in Section 3.8-1 for initial appointees.

3.8-3 TERM OF PROCTORING PERIOD

Each department may establish, in its rules and regulations, a term of proctoring and the number of cases, and/or specific number of cases applicable to particular

clinical privileges whenever such requirements are appropriate in view of the clinical privileges which are involved. Proctoring will begin when privileges are initially granted, whether at the time of initial appointment or the granting of temporary privileges. The term of proctoring may be extended not more than six (6) months, for a total proctoring period of not more than twelve (12) months. If an initial appointee fails within that period to complete the minimum number of cases and/or furnish the certificates required in Section 3.8-1, the appointee's medical staff membership or particular clinical privilege, as applicable, shall be automatically terminated. If a medical staff member requesting modification fails within that period to complete the minimum number of cases and/or furnish the certifications required in Section 3.8-1, the change in medical staff category or department assignment or the additional privileges, as applicable, shall be automatically terminated. The Medical Executive Committee chair shall give the initial appointee, or medical staff member so affected, written notice that medical staff membership and/or clinical privileges have been automatically terminated because of failure to satisfactorily complete the proctoring requirements.

3.9 LEAVE OF ABSENCE

3.9-I LEAVE STATUS

A leave of absence may be considered upon the written request of a medical staff member. A leave of absence may be granted for not more than two (2) years. On no condition will a leave of absence be granted beyond two years. The Credentials Committee will review the request for a leave of absence and the action by Credentials, upon ratification by the Medical Executive Committee, will be transmitted to the hospital director for notation in the practitioner's file. The practitioner must give a date of expected return in order that the leave of absence is kept current. During the period of the leave, the practitioner's clinical privileges, prerogatives, responsibilities shall be suspended.

3.9-2 REASONS FOR GRANTING LEAVE

The following reasons for granting a leave of absence shall be considered by the Credentials Committee.

(a) Illness
(b) Military service
(c) Temporary medical training or education
(d) Sabbatical leave
(e) Outside high achievement of exceptional merit
(f) Other special conditions as approved by the Credentials Committee

3.9-3 TERMINATION OF LEAVE

At least thirty (30) days prior to the termination of the leave, or at any earlier time, the medical staff member may request reinstatement of privileges and prerogatives by submitting a written notice to that effect to the hospital director and to the Credentials Committee. If so requested by the Medical Executive Committee or the hospital director, the staff member shall submit a written summary of relevant activities during the leave. The Medical Executive Committee shall recommend whether to approve the member's request for reinstatement of privileges and prerogatives; thereafter, the procedure set forth in Sections 6.3-7 through 6.3-11 shall be followed.

Failure, without good cause, to request reinstatement or to provide a requested summary of activities shall be deemed to be a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives.

3.10 HARASSMENT PROHIBITED

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

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

Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

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

3.11 STANDARDS OF CONDUCT

Members of the medical staff and allied health professionals are expected to adhere to the Medical Staff Standards of Conduct, including but not limited to the following:

3.11-1 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 of the medical staff and the hospital may be found to be disruptive behavior. It is specifically recognized that patient care and hospital operations can be adversely affected whenever any of the foregoing occurs with respect to interaction at any level of the hospital, in that all personnel play an important part in the ultimate mission of delivering quality patient care.

(b) In assessing whether particular circumstances in fact are affecting quality patient care or hospital 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 payors) as necessary to effect payment for care, and general patient satisfaction with the services rendered and the individuals involved in rendering those services.

3.11-2 CONDUCT GUIDELINES

(a) Upon receiving medical staff membership and/or privileges at the hospital, the member enters 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, hospital staff, visitors, and others in and affiliated with the hospital.

(c) Interactions 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 hospital.

(d) Complaints and disagreements shall be aired constructively, in a non-demeaning manner, and through official channels.

(e) Cooperation and adherence to the rules of the hospital and the medical staff is required.

(f) Members of the medical staff shall not engage in conduct that is offensive or disruptive, whether it is written, oral, or behavioral.

3.11-3 ADOPTION OF RULES

The Medical Executive Committee may promulgate rules further illustrating and implementing the purposes of this section, including but not limited to procedures for investigating and addressing incidents of perceived misconduct, and progressive remedial measurers, including, when necessary, disciplinary action.

3.12 ORGANIZED HEALTH CARE ARRANGEMENT

Under the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA), the medical staff and the hospital are in an Organized Health Care Arrangement (OHCA). The OHCA is a clinically integrated care setting in which individuals receive health care from more than one provider and the providers hold themselves out to the public as participating in a joint arrangement. The medical staff is in an OHCA with the hospital for care provided at hospital locations. This joint arrangement is disclosed to the patients in the Notice of Privacy Practices given to patients when they access care at any hospital and county affiliated facility. Members of the medical staff shall use patient medical and demographic information only as described in the Notice of Privacy Practices.

ARTICLE IV

CATEGORIES OF MEMBERSHIP

4.1 CATEGORIES

The categories of the medical staff shall include the following: active, provisional, courtesy, consulting, honorary, and adjunct.

4.2 ACTIVE STAFF

4.2-1 QUALIFICATIONS

The active staff shall consist of practitioners who:

(a) Meet the qualifications set forth in Section 3.2.

(b) Regularly admit patients to or otherwise regularly provide professional services for patients at the hospital or regularly participate in medical staff functions.

(c) Have satisfactorily completed appointment in the provisional category.

4.2-2 PREROGATIVES

The prerogatives of active medical staff members shall be to:

(a) Exercise such clinical privileges as are granted to them pursuant to Article VII.

(b) Hold office in the medical staff and in the department and committees of which they are a member, and serve on committees, unless otherwise provided in the medical staff bylaws and/or the Medical Staff Committees and Functions Manual.

(c) Vote for medical staff officers, on bylaws' amendments, and on all matters presented at general and special meetings of the medical staff and of the department and committee of which they are members, unless otherwise provided in the medical staff bylaws and/or the Medical Staff Committees and Functions Manual.

(d) Participate in educational programs and departmental functions at the hospital. Minimum standards of active participation in the teaching program shall be established by the chair or designee, of each department in consultation with the medical director. Active staff members shall participate in educational programs as requested by the medical director.

(e) Treat and service patients, in both inpatient and outpatient services, as assigned by their department chair and in accordance with privileges granted.

4.2-3 RESPONSIBILITIES

Active staff members shall:

(a) Meet the basic responsibilities set forth in Section 3.6.

(b) Actively participate in and regularly assist the hospital in fulfilling its obligations related to patient care within areas of professional competence, including but not limited to emergency service and back-up function, patient care audit, peer review, utilization review, quality evaluation and related monitoring activities required of and by the medical staff in supervising and proctoring initial appointees and AHPs, and in discharging such other functions as may be required from time to time.

4.3 PROVISIONAL STAFF

4.3-1 QUALIFICATIONS

The provisional staff shall consist of practitioners who meet the qualifications for membership set forth in Section 3.2, except that they have not yet satisfactorily completed the proctoring requirements specified in Section 3.8; have been medical staff members for less than one year; and/or have not fulfilled such other requirements as may be set forth in these bylaws, the medical staff and department rules and regulations, or hospital policies.

4.3-2 PREROGATIVES

The prerogatives of provisional staff members shall be to:

(a) Exercise such clinical privileges as are granted to them pursuant to Article VII.

(b) Serve on committees, unless provided otherwise in these bylaws and/or in the Medical Staff Committees and Functions Manual. Provisional members may not hold office in the medical staff or in the department and committee of which they are members, unless otherwise provided in these bylaws.

(c) Vote on all matters presented at committee meetings of which they are members. Provisional members may not vote for medical staff officers, on bylaws' amendments, or on any matters presented at general and special meetings of the medical staff and of the department of which they are members, unless otherwise provided in these bylaws and/or in the Medical Staff Committees and Functions Manual.

4.3-3 RESPONSIBILITIES

Provisional staff members shall be required to discharge the responsibilities which are specified in Section 4.2-3 for active staff members. Failure to fulfill those responsibilities shall be grounds for denial of advancement to active, courtesy, or consulting staff status and termination of provisional staff status.

4.3-4 OBSERVATION OF PROVISIONAL STAFF MEMBER

The provisional staff member shall undergo a period of observation by designated monitors as described in Section 3.8. The purpose of observation shall be to evaluate the member's:

(a) Proficiency in the exercise of clinical privileges initially granted, and

(b) Overall eligibility for continued staff membership and advancement within staff categories.

Observation of a provisional staff member shall follow whatever frequency and format the department deems appropriate in order to adequately evaluate the provisional staff member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records shall be maintained. The results of the observation shall be communicated by the department chair to the Credentials Committee.

4.3-5 ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS

(a) If the provisional staff member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued medical staff membership, the member shall be eligible for placement in the active, courtesy or consulting staff as appropriate, upon the recommendation of the Credentials Committee and the Medical Executive Committee.

(b) In all other cases, the appropriate department chair shall advise the Credentials Committee, who shall make its recommendation to the Medical Executive Committee regarding a modification of clinical privileges, a modification of staff category, or termination of medical staff membership.

4.4 COURTESY

4.4-1 QUALIFICATIONS

The courtesy staff shall consist of practitioners who:

(a) Meet the qualifications set forth in Section 3.2.

(b) Are involved in sufficient patient care activities at the hospital so that the medical staff will be able to evaluate the staff member's current clinical competency on an ongoing basis. Courtesy staff members who provide services for more than five (5) patients during each medical staff year will be given the opportunity to be appointed to the active staff category.

(c) Have satisfactorily completed appointment in the provisional category.

4.4-2 PREROGATIVES

The prerogatives of courtesy staff members shall be to:

(a) Admit or provide professional services for not more than five (5) patients at the hospital during each medical staff year. Members whose activity will exceed this limit must apply and qualify for active or consulting staff status.

(b) Attend meetings of the medical staff and the department of which they are members. Courtesy staff members may not hold office in the medical staff or in the department of which they are members. Courtesy staff members may serve on committees.

(c) Courtesy staff members may not vote on any medical staff matter.

4.4-3 RESPONSIBILITIES

Courtesy staff members shall meet the basic responsibilities set forth in Section 3.6.

4.5 CONSULTING STAFF

4.5-1 QUALIFICATIONS

The consulting staff shall consist of practitioners who:

(a) Meet the qualifications set forth in Section 3.2, except that this requirement shall not preclude an otherwise qualified out-of-state practitioner from appointment within the limitations of California Business and Professions Code 2060.

(b) Possess clinical expertise and reports to the hospital when so scheduled or when called by a member of the medical staff to render a clinical opinion within their competence.

(c) Have satisfactorily completed appointment in the provisional category.

(d) Are of recognized outstanding professional ability.

4.5-2 PREROGATIVES

The prerogatives of consulting staff members shall be to:

(a) Exercise such clinical privileges as are granted to them pursuant to Article VII, Clinical Privileges, except to an out-of-state practitioner for whom the granting of privileges under Article VII shall be subject to the limitations of California Business and Professions Code 2060.

(b) Attend meetings of the medical staff and the department of which they are members. Consulting staff members may not hold office in the medical staff or in the department of which they are members. Consulting staff members may serve on committees.

(c) Teach in the medical education programs as requested by the chair of various departments.

(e) Consulting staff members may not vote on any medical staff matter.

4.5-3 RESPONSIBILITIES

Consulting staff members shall meet the basic responsibilities set forth in Section 3.6.

4.6 HONORARY STAFF

4.6.1 QUALIFICATIONS

The honorary staff shall consist of practitioners who do not actively practice at the hospital but are deemed deserving of membership by virtue of their outstanding reputation,

noteworthy contributions to the health or medical sciences, or their previous long-standing service to the hospital, and who continue to exemplify high standards of professional and ethical conduct.

4.6-2 PREROGATIVES

Honorary staff members are not eligible to admit patients to the hospital or to exercise clinical privileges in the hospital. They may, however, attend staff and department meetings and any staff or hospital educational meetings. Honorary staff members may not vote on any medical staff matter, hold office in the medical staff or in the department of which they are a member, or serve on committees.

4.6-3 RESPONSIBILITIES

Honorary staff members shall meet the basis responsibilities specified in Section 3.6, Paragraphs (c), (k), (m), (p), (r), and (s).

4.7 ADJUNCT STAFF

4.7-1 QUALIFICATIONS

The adjunct staff shall consist of practitioners who do not have clinical privileges.

4.7-2 PREROGATIVES

Adjunct staff members may observe the care and treatment of their patients that are cared for at this hospital. Adjunct staff members shall not be assigned to a specific department; therefore, they shall not be expected to attend departmental meetings. They shall not have the right to vote or to serve on committees. Adjunct staff members shall not require proctoring.

4.7-3 RESPONSIBILITIES

Adjunct staff members shall meet the basis responsibilities specified in Section 3.6, Paragraphs (c), (k), (m), (p), (r), (s), and including any others which would be relevant to their staff category.

4.8 PER DIEM RESIDENT

4.8.-1 QUALIFICATION

Per diem/moonlighting resident medical staff membership shall be held by post-doctoral residents who have successfully completed at least **(2) two out of (3) three years** of an accredited residency program approved by the Accreditation Council on Graduate Education (ACGME) or the American Osteopathic Association (AOA) who are not eligible for another staff category and who are either licensed or registered with the appropriate State of California licensing board. All per diem/moonlighting resident medical staff members must have a license to practice medicine within the State of California.

4.8-2 PREROGATIVES

Post-doctoral trainees who are enrolled in accredited residency training programs and who meet the above qualifications shall be appointed to the per diem resident

medical staff. Members of the per diem resident/moonlighting medical staff are not eligible to hold office within the medical staff, but may participate in the activities of the medical staff through membership on medical staff committees.

All medical care provided by per diem resident medical staff is under the supervision of the department chair and/or his designee(s). Care should be in accordance with the provision of a program approved by and in conformity with the Accreditation Council on Graduate Medical Education of the American Medical Association, the American Osteopathic Association, or the American Dental Association's Commission Dental Accreditation.

Appointment to the per diem resident medical staff shall be for (1) one year and may be renewed annually. Per diem resident medical staff membership may not be considered as the observational period required to be completed by provisional staff. Per diem resident medical staff membership terminates with termination from the training program. Upon completion of the training program, per diem resident medical staff may apply for regular medical staff membership.

4.9 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these bylaws, by the medical staff rules and regulations, or by other policies of the hospital.

The prerogatives of dental and podiatric members of the medical staff shall be limited to those for which they can demonstrate the possession of the requisite licensure, education, training, and experience.

EXCEPTIONS TO PREROGATIVES

Regardless of the category of their membership in the medical staff, unless otherwise required by law, dentist and podiatrist members:

(a) May not hold office in the medical staff. A dentist or podiatrist and clinical psychologist.

(b) May only admit and treat a patient by co-admitting the patient with a physician member of the medical staff who has privileges to admit patients and who assumes, as required by Section 7.3 (Special Conditions Applicable to Dental and Podiatric Privileges) hereof, responsibility for the care of the patient's medical problems.

ARTICLE V
ALLIED HEALTH PROFESSIONALS

5.1 QUALIFICATIONS

Allied Health Professionals (AHPs) holding a license, certificate or such other legal credentials, if any, as required by California law, which authorize the AHPs to provide certain professional services, are not eligible for medical staff membership. Such AHPs are eligible for practice privileges at this hospital only if they:

(a) Hold a license, certificate or other legal credential in a category of AHPs which the Medical Executive Committee has identified as eligible to apply for practice privileges;

(b) document their experience, background, training, demonstrated ability, judgment, and physical and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency established by the hospital, and that they are qualified to exercise practice privileges at the hospital; and

(c) are determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective professions; to work cooperatively with others in the hospital setting; and to be willing to commit to and regularly assist the hospital in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials.

5.2 DELINEATION OF CATEGORIES OF AHP's ELIGIBLE TO APPLY FOR PRACTICE PRIVILEGES

For each eligible AHP category, the Medical Executive Committee shall identify the mode of practice in the hospital setting and the practice privileges and prerogatives that may be granted to qualified AHPs in that category. The Medical Executive Committee shall also identify the terms and conditions which may be granted and apply to AHPs in each category. The delineation of categories of AHPs eligible to apply for practice privileges and the corresponding practice privileges, prerogatives, terms, and conditions for each such AHP category, when approved by the Medical Executive Committee, shall be set forth by the department in which they serve.

5.3 PROCEDURE FOR GRANTING PRACTICE PRIVILEGES

AHPs must apply and qualify for practice privileges. Applications for initial granting of practice privileges, and biennial renewal thereof, shall be submitted by the Interdisciplinary Practice Committee to the Credentials Committee.

AHPs who do not have licensure or certification in an AHP category identified as eligible for practice privileges in the manner required by Section 5.2 above cannot apply for practice privileges, but may submit a written request to the Interdisciplinary Practice Committee, asking that the Medical Executive Committee consider identifying the appropriate category of AHPs as eligible to apply for practice privileges. AHPs shall be assigned to the clinical department appropriate to their occupational or professional training and, unless otherwise specified in the rules and regulations, shall be subject to terms and conditions paralleling those specified in Article VIII (Corrective Action), as they may be applied to AHPs and appropriately tailored to the particular AHP's profession.

5.4 PREROGATIVES

The prerogatives which may be extended to AHPs shall be defined in the medical staff rules or regulations or hospital policies. Such prerogatives may include:

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

(c) Service on medical staff, department, and hospital committees.

(c) Attendance at meetings of the department to which assigned, as permitted by the department rules and regulations, and attendance at hospital education programs in their field of practice.

5.5 RESPONSIBILITIES

Allied Health Professionals shall:

(a) Meet those responsibilities required by the medical staff rules and regulations, and if not so specified, meet those responsibilities specified in Section 3.6 (Basic Responsibilities of Medical Staff Membership) and 3.8 (Proctoring Requirements) as are generally applicable to the more limited practice of AHPs.

(b) Retain appropriate responsibility within their area of professional competence for the care and supervision of patients at the hospital for whom they are providing services.

(d) Participate, as appropriate, in patient care audit and other quality review, evaluation, and monitoring activities required of AHPs, in supervising initial appointees of their same occupation or profession or of a lessor included occupation or profession, and in discharging such other functions as may be required from time to time.

5.6 REAPPLICATION

An allied health professional must reapply every two years for a renewal service authorization in accordance with Section 5.3 Procedure for Granting Practice Privileges.

ARTICLE VI
PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT
(Including Telemedicine Services)

6.1 GENERAL PROCEDURE

The medical staff through its designated departments, committees, and officers shall consider each application for appointment or reappointment to the staff and for clinical privileges and each request for modification of staff membership status or clinical privileges, utilizing the resources of the hospital director and its staff to evaluate and validate the contents of the application, before adopting and transmitting its recommendation to the governing board.

The medical staff shall also perform the same function in connection with any individual who has applied only for temporary privileges or who otherwise seeks to exercise privileges or to provide specified services in any hospital department or service.

6.2 APPLICATION FOR APPOINTMENT

6.2-1 CONTENT

All applications for appointment to the medical staff shall be in writing, submitted on a form prescribed by the Medical Executive Committee, with all provisions completed (or an

explanation why answers are unavailable), and signed by the applicant. The applicant shall be given a copy of these bylaws, the medical staff rules and regulations, and the hospital bylaws.

The application form shall require detailed information including, but not limited to:

(a) The applicant's professional qualifications and competency, including, but not limited to, professional training and experience, current California licensure, current DEA registration if applicable, and continuing medical education information related to the clinical privileges to be exercised by the applicant.

(b) The names of at least three (3) persons who hold the same professional license, whenever possible, as the applicant, including, whenever possible, at least two (2) staff members who can provide adequate references based on their current knowledge of the applicant's professional qualifications, professional competency, and ethical character. The medical staff may request directed references.

(e) Information as to whether any action, including any investigation, has ever been undertaken, whether it is still pending or completed, which involves denial, revocation, suspension, reduction, limitation, probation, nonrenewal, voluntary or involuntary relinquishment by resignation or expiration (including relinquishment that was requested or bargained for) of the applicant's membership status and/or clinical privileges and/or prerogatives at any other hospital or institution; membership or fellowship in any local, state, regional, national, or international professional organization; license to practice any profession in any jurisdiction; Drug Enforcement Administration or other controlled substances registration; specialty board certification; and/or professional school faculty position or membership.

(e) Information pertaining to the applicant's professional liability insurance coverage, any professional liability claims, complaints, or causes of action that have been lodged against the applicant and the status or outcome of such matters.

(f) Information as to any pending administrative agency or court cases, or administrative agency decisions or court judgments in which the applicant is alleged to have violated, or was found guilty of violating, any criminal law (excluding minor traffic violations) or is alleged to be liable, or was found liable, for any injury caused by the applicant's negligent or willful act or omission in rendering services.

(f) Information as to details of any prior or pending or current exclusion from a federal health care program, government agency or third party payor proceeding or litigation challenging or sanctioning applicant's patient admission, treatment, discharge, charging, collection, or utilization practices, including but not limited to Medicare and Medi-Cal fraud and abuse proceedings and convictions.

(g) Information pertaining to the applicant's physical and mental condition, and the applicant agrees to submit any additional documentation if requested.

(h) Certification of the applicant's agreement to terms and conditions set forth in Section 6.2-2 regarding the effects of the application.

(i) An acknowledgment that the applicant has received (or has been given access to) and read the medical staff bylaws and rules and regulations, has received an explanation of the requirements set forth therein and of the appointment process, and that the applicant agrees to be bound by the terms thereof, as they may be amended from time to time, if granted membership or clinical privileges, and to be bound by the terms thereof, without regard to whether or not the applicant is granted membership and/or clinical privileges in all matters relating to consideration of the application.

(j) An acknowledgment of the applicant's responsibility to inform the Medical Staff Services Office of any change in the information provided through the application form during the application period or at any subsequent time.

The applicant shall also identify the staff category, clinical department, and clinical privileges for which the applicant wishes to be considered. The applicant shall pay a nonrefundable application fee, payable in advance, in the amount established by the Medical Executive Committee pursuant to Section 15.4. The option to waive an applicant's initial processing fee may be considered by the Credentials Committee if requested in writing by the relevant department chair.

6.2-2 EFFECTS OF APPLICATION

By applying for appointment to the medical staff, reappointment, advancement or transfer, the applicant thereby signifies willingness to appear for interviews in regard to the application; authorizes the hospital's medical staff or its designee to consult with members of medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on the applicant's competence, character and ethical qualifications, and authorizes such persons to provide all such information; consents to the hospital's inspection of all records and documents that may be material to an evaluation of professional qualifications, personality, ability to cooperate with others, moral and ethical qualifications for membership, and physical, mental, and professional competence to carry out the clinical privileges the applicant requests and directs individuals who have custody of such records and documents to permit inspection and/or copying; certifies to report in writing any changes in the information submitted on the application form, which may subsequently occur, to the Credentials Committee and the hospital director; and releases from any and all liability, all individuals and organizations providing information to the hospital concerning the applicant and all hospital representatives for their acts performed in connection with evaluating the applicant and his/her credentials; agrees that the hospital and medical staff may share information with a representative or agent from affiliated health care entities and providers, including information obtained from other sources, and release each person and each entity who received the information and each person and each entity who disclosed the information from any and all liability, including any claims of violations of any federal or state law, including the laws forbidding restraints of trade, that might arise from the sharing of the information and likewise agrees that the hospital and its affiliated health care entities may act upon such information.

6.2-3 PHYSICAL AND MENTAL CAPABILITIES

(a) Obtaining Information:

i. When the Medical Staff Services Office verifies information and obtains references, it shall ask for any information concerning physical or mental disabilities to be reported. This information will also be referred to the department chair.

ii. The medical director, on behalf of the Physician Well-Being Committee, and with the assistance of the Physician Well-Being Committee shall be responsible for investigating any practitioner who has or may have a physical or mental disability that might affect the practitioner's ability to exercise the requested privileges in a manner that meets the hospital and medical staff's quality of care standards. This may include one or all of the following:

(1) **Medical Examination:** To ascertain whether the practitioner has a physical or mental disability that might interfere with the practitioner's ability to provide care which meets the hospital and medical staff's quality of care standards.

(2) **Interview:** To ascertain the condition of the practitioner and to assess if and how reasonable accommodations can be made.

iii. Practitioners who feel limited or challenged in any way by a qualified mental or physical disability in exercising their clinical privileges and in meeting quality of care standards should make such limitation immediately known to the medical director. Any such disclosure will be treated with the high degree of confidentiality that attaches to the medical staff's peer review activities.

(b) Review and Reasonable Accommodations:

i. Practitioners who disclose or manifest a qualified physical or mental disability will have their application processed in the usual manner without reference to the condition.

ii. The medical director shall not disclose any information regarding any practitioner's qualified physical or mental disability until the Credentials Committee (or, in the case of temporary privileges, the medical staff representatives who review temporary privileges requests and the hospital director) has determined that the practitioner is otherwise qualified for membership and/or to exercise the privileges requested. Once the determination is made that the practitioner is otherwise qualified, the medical director and the Physician Well-Being Committee may disclose information they have regarding any physical or mental disabilities and the effect of those on practitioner's application for membership and privileges. The medical director and the Physician Well-Being Committee and any other appropriate committees may meet with the practitioner to discuss if and how reasonable accommodations can be made.

iii. As required by law, the medical staff and hospital will attempt to provide reasonable accommodations to a practitioner with known physical or mental disabilities, if the practitioner is otherwise qualified and can perform the essential functions of the staff appointment and privileges in a manner which meets the hospital and medical staff quality of care standards. If reasonable accommodations are not possible under the standards set forth herein, it may be necessary to withdraw or modify a practitioner's privileges and the practitioner shall have the hearing and appellate review rights described in the bylaws rules.

6.3 PROCESSING THE APPLICATION

6.3-1 APPLICANT'S BURDEN

In connection with all applications for appointment and reappointment, the applicant shall have the burden of producing accurate and adequate information for a proper evaluation of the applicant's experience, background, training, demonstrated ability, physical and mental health status, and all other qualifications specified in the medical staff bylaws and rules and regulations, and of the applicant's compliance with standards and criteria set forth in the medical staff bylaws and rules and regulations, and for resolving any doubts about these matters. The applicant's failure to sustain this burden shall be grounds for denial of the application. The provision of information containing significant misrepresentations or omissions and/or a failure to sustain the burden of producing adequate information shall also be grounds for denial of the application.

6.3-2 VERIFICATION OF INFORMATION

The applicant shall deliver an application form in full to the Medical Staff Services Office which shall, in a timely fashion, seek to collect or verify the references, licensure, and other qualification evidence submitted. The Medical Staff Services Office shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information. An applicant whose application is not completed within six (6) months after being received by the Medical Staff Services Office shall be automatically removed from consideration for staff membership and/or clinical privileges. Such an applicant's application may, thereafter, be reconsidered only if all information therein which may change over time, including, but not limited to, hospital reports and personal references, have been resubmitted.

6.3-3 DEPARTMENT AND CREDENTIALS COMMITTEE ACTION

Under the direction of the Credentials Committee, the department chair and/or appropriate subject matter experts, as deemed necessary by the Credentials Committee, shall review the application and supporting documentation according to established medical staff criteria regarding clinical privileges, professional conduct and competence, and may conduct a personal interview with the applicant. The department chair subject matter expert shall forward a written evaluation to the Credentials Committee. The department chair subject matter expert may also suggest that the Credentials Committee defer action. The Credentials Committee, or in cases eligible for expedited process the duly appointed designee, shall transmit to the Medical Executive Committee its report and recommendation, prepared in accordance with Section 6.3-6.

6.3-4 MEDICAL EXECUTIVE COMMITTEE (MEC) ACTION

At its next regular meeting, after receipt of the Credentials Committee report and recommendation, the Medical Executive Committee shall consider the Credentials Committee report. The Medical Executive Committee may ask the applicant to appear for an interview and/or request further documentation. The Medical Executive Committee shall then immediately forward to the hospital director for prompt transmittal to the governing board, its recommendation. The recommendation shall be prepared in accordance with Section 6.3-6. The MEC may also defer action on the application pursuant to Section 6.3-7. (a).

6.3-5 APPOINTMENT REPORTS

The department chair, Credentials Committee, and Medical Executive Committee reports and recommendations shall be transmitted in the form prescribed by the Medical Executive Committee. The report and recommendation shall specify whether medical staff appointment is recommended, and, if so, the membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The reason for the recommendation shall be stated, and supported by reference to the completed application and all other documentation which was considered, all of which shall be transmitted with the report.

6.3-6 BASIS FOR APPOINTMENT

The recommendation concerning an applicant for medical staff membership and clinical privileges shall be based upon whether the applicant meets the qualifications specified in Section 3.2; can carry out the responsibilities specified in Section 3.6; and meets all of the standards and requirements set forth in all sections of these bylaws and in the medical staff rules and regulations. Specifically, a recommendation shall also be based upon the practitioner's compliance with legal requirements applicable to the practice of the applicant's profession and other hospitals' medical staff bylaws, rules and regulations, and policies, rendition of services to patients, any physical or mental impairment which might interfere with the ability to practice medicine with reasonable skill and safety, and provision of accurate and adequate information to allow the medical staff to evaluate the applicant's competency and qualifications.

6.3-7 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

(a) **Interviews, Further Documentation, Deferral:** Action by the MEC to interview the applicant, seek further documentation, or defer the application for further consideration must be followed up within seventy (70) days with a subsequent recommendation for appointment with specified clinical privileges, or for denial of the request for medical staff membership.

(b) **Favorable Recommendation:** When the MEC's recommendation is favorable to the applicant, the hospital director shall forward the recommendation to the governing board within 45 days or at the next available Governing Board meeting, whichever occurs first. The Hospital Director is authorized by the Governing Board to make an appointment subject to final action by the Governing Board ratifying the appointment. In the event that the Governing Board does not ratify the Hospital Director's action, that appointment shall be terminated and the Hospital shall notify the applicant and follow the procedure set forth in Section 6.3-8 (a) below.

(c) **Adverse Recommendation:** When the MEC's recommendation is adverse to the applicant, the chief of medical staff shall give the applicant written notice of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 9.3-2; and the applicant shall be entitled to the procedural rights as provided in Article IX. For the purposes of this Section 6.3-8 (c), an "adverse recommendation" by the MEC is as defined in Section 9.2.

6.3-8 ACTION BY THE GOVERNING BOARD

(a) **On Favorable Medical Executive Committee Recommendation**: The governing board shall, in whole or in part, adopt or reject a Medical Executive

Committee recommendation which is favorable to the applicant or refer the recommendation back to the Medical Executive Committee for further interviews, documentation, or consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. If the recommendation of the governing board is one of those set forth in Section 9.2, the hospital director shall give the applicant written notice of the tentative adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 9.3-2; and the applicant shall be entitled to the procedural rights as provided in Article IX before any final adverse action is taken.

(b) **Without Benefit of Medical Executive Committee Recommendation:** If the governing board does not receive a Medical Executive Committee recommendation within the time period specified in Section 6.3-12, it may, after notifying the Medical Executive Committee, take action on its own initiative. If such recommendation is favorable, it shall become effective as the final decision of the governing board. If the recommendation is one of those set forth in Section 9.2, the hospital director shall give the applicant written notice of the tentative adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 9.3-2; and the applicant shall be entitled to the procedural rights as provided in Article IX before any final adverse action is taken.

(c) **After Procedural Rights:** In the case of an adverse Medical Executive Committee recommendation pursuant to Section 6.3-7 (c) or an adverse governing board recommendation pursuant to Section 6.3-8 (a) or (b), the governing board shall take final action in the matter only after the applicant has exhausted or has waived procedural rights as required in Article IX. Action thus taken shall be the conclusive decision of the governing board, except that the governing board may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons thereof, shall set a time limit within which a subsequent recommendation to the governing board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the governing board shall make a final decision.

6.3-9 NOTICE OF FINAL DECISION

Notice of the final decision shall be given, through the hospital director, to the Medical Executive Committee, the Credentials Committee, the chair of each department concerned, and the applicant. A decision and notice to appoint shall include:

(a) The staff category to which the applicant is appointed;
(b) The department to which the applicant is assigned;
(c) The clinical privileges the applicant may exercise; and
(d) Any special conditions attached to the appointment.
(e) Board approval date and expiration date

6.3-10 REAPPLICATION AFTER ADVERSE DECISION DENYING APPLICATION, ADVERSE CORRECTIVE ACTION DECISION, OR RESIGNATION IN LIEU OF MEDICAL DISCIPLINARY ACTION

(a) An applicant who:

(1) has received a final adverse decision regarding appointment or

(2) withdrew the application or request for membership or privileges following an adverse recommendation by the Medical Executive Committee or governing board;

(b) A former medical staff member who has:

(1) received a final adverse decision resulting in termination of medical staff membership and clinical privileges or

(2) resigned from the medical staff following the issuance of a medical staff or governing board recommendation adverse to the member's medical staff membership or clinical privileges; or

(c) A medical staff member who has received a final adverse decision resulting:

(1) termination or restriction of the staff member's clinical privileges or

(2) denial of the staff member's request for additional clinical privileges affected by the previous action for a period of at least thirty-six (36) months from the date the adverse decision became final, the date the application or request was withdrawn, or the date the former medical staff member's resignation became effective, whichever is applicable.

For the purpose of this section, a decision shall be considered to be adverse, for medical disciplinary action reasons, only if it is based on the type of occurrences which might give rise to corrective action and not if it is based upon reasons that do not directly pertain to medical or ethical conduct. Actions which are not considered adverse, for the purpose of this section, include actions based on a failure to maintain a practice in the area, which can be cured by a move, or to pay dues, which can be cured by paying dues, or to maintain professional liability insurance, which can be cured by securing such instance. Further, for the purpose of this section, an adverse decision shall be considered final at the time of completion of:

(a) all hearing, appellate review, and other quasi-judicial proceedings conducted by the hospital bearing on the decision; and

(b) all judicial proceedings bearing upon the decision which are filed and served within thirty-six (36) months after the completion of the hospital proceedings described in (1) above.

After the thirty-six (36) month period, the former applicant, former medical staff member, or medical staff member may submit an application for medical staff membership and/or clinical privileges, which shall be processed as an initial application. The former applicant, former medical staff member, or medical staff member shall also furnish evidence that the basis for the earlier adverse recommendation or action no longer exists and/or of

reasonable rehabilitation in those areas which formed the basis for the previous adverse recommendation or action, whichever is applicable. In addition, such an application shall not be processed unless the applicant or member submits satisfactory evidence to the MEC that the individual has complied with all of the specific requirements any such adverse decision may have included, such as completion of training or proctoring conditions. The Medical Executive Committee decision as to whether satisfactory evidence has been submitted shall be final subject only to further review by the governing board within forty-five (45) days after the Medical Executive Committee decision was rendered.

6.3-11 TIME PERIOD FOR PROCESSING

Applications shall be considered in a timely and good faith manner by all individuals and groups required by these bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in Section 6.3-11 and 6.3-12. The Medical Staff Services Office shall transmit an application to the department chair or designee and Credentials Committee within fifteen (15) days after all information collection and verification tasks are completed and all relevant materials have been received. The relevant department chair or designee shall act on an application within fifteen (15) days after receiving it from the Medical Staff Services Office. The Credentials Committee or designee shall then make its recommendation within thirty (30) days after the department chair has acted. The Medical Executive Committee shall review the application and make its recommendation to the governing board within thirty (30) days after receiving the Credentials Committee report. The governing board shall then take final action on the application within thirty (30) days. The time periods specified herein are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the applicant to have the application processed within those periods.

In the event that relevant materials are not received within sixty (60) days after the application is received, the applicant shall be notified, and the application shall remain pending until either the materials are received by the Medical Staff Services Office or the expiration of six (6) months from the date the application was received. Applications that are not completed within six (6) months after receipt shall automatically be removed from consideration as specified in Section 6.3-2.

6.3-12 EXPEDITED REVIEW

The Medical Staff Services Office will process the application according to written policies and procedures as defined in the Credentials Policies and Procedures Manual. If the Medical Staff Services Administrative Supervisor determines an applicant has no negative information in the file, as defined in the Expedited Credentialing Evaluation Process Policy and Procedure, the file will be referred to the relevant department chair or designee, who will determine whether the applicant qualifies for expedited action and s/he will, also, make a recommendation for membership and privileges. If they agree the applicant qualifies for expedited action, the file shall be referred to the Credentials Committee Chair or the duly appointed designee for review and recommendation to the Medical Executive Committee. The Medical Executive Committee will act upon the recommendation at its next scheduled meeting and will then forward its recommendation to the Governing Board for final action.

6.4 REAPPOINTMENTS

6.4-1 APPLICATION FOR REAPPOINTMENT; SCHEDULE FOR REVIEW

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

The schedule for review shall be established in the Credentials Policies and Procedures.

A member's request for a change in membership category or in privileges may be processed in a year in which the member is not scheduled for biennial review; however, such member's appointment shall also be reviewed in accordance with the schedule set forth in the medical staff rules.

At least sixty (60) days prior to the expiration date of staff appointment, the medical staff member shall submit to the Medical Staff Services Office a completed reappointment application form. The reappointment application shall be in writing, on a form prescribed by the medical staff, and it shall require detailed information concerning changes in the applicant's qualifications since the last review. Specifically, the reappointment application form shall request all of the information and certifications requested in the appointment application form, as described in Section 6.2, including department chair recommendations, except for that information which cannot change over time, such as information regarding the member's premedical and medical education, date of birth, and so forth. The form shall also require information as to whether the applicant requests any change in staff status and/or clinical privileges, including any reduction, deletion, or additional privileges. Request for additional privileges must be supported by the type and nature of evidence which would be necessary for such privileges to be granted in an initial application for same.

6.4-2 VERIFICATION OF INFORMATION

The Medical Staff Services Office shall, in a timely fashion, seek to collect or verify the additional information made available on the reappointment application form and to collect any other material or information deemed pertinent. The Medical Staff Services Office shall transmit the reappointment application form and supporting material to the chair, or designee, of each department in which the staff member has or requests privileges and to the Credentials Committee.

6.4-3 DEPARTMENT ACTION

The department chair or designee shall review the application, the staff member's file, and shall transmit to the Credentials Committee a written report and recommendation, which are prepared in accordance with Section 6.4-6. The chair or designee's report shall include review of peer review performance and quality assessment activities.

6.4-4 CREDENTIALS COMMITTEE ACTION

Following receipt of the department chair or designee's report concerning the application for reappointment, the Credentials Committee or in cases eligible for expedited process, the duly appointed designee, shall review the application, the department chair or designee's report, and all other pertinent information available on the member who is being considered for reappointment and shall transmit to the Medical Executive Committee its report and recommendation, which are prepared in accordance with Section 6.4-6.

6.4-5 MEDICAL EXECUTIVE COMMITTEE ACTION

The Medical Executive Committee shall review the department chair or designee and Credentials Committee's reports as well as all other relevant information available to it and shall forward immediately to the governing board, through the hospital director, its favorable reports and recommendations, which are prepared in accordance with Section 6.4-6.

Section 9.2, either in respect to reappointment or clinical privileges, the chief of medical staff shall give the applicant written notice of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in Section 9.3-2; and the applicant shall be entitled to the procedural rights as provided in Article IX. The governing board shall be informed of, but not take action on, the pending recommendation until the applicant has exhausted or waived procedural rights.

Thereafter, the procedures specified in Sections 6.3-9 (Action by the Governing Board), 6.3-10 (Notice of Final Decision) and 6.3-11 (Reapplication After Adverse Decision Denying Application, Adverse Corrective Action Decision, or Resignation in Lieu of Medical Disciplinary Action) shall be followed. The committee may also defer action; however, any such deferral must be followed up within seventy (70) days with a subsequent recommendation.

6.4-6 REAPPOINTMENT REPORTS

The department chair, Credentials Committee, and Medical Executive Committee reports and recommendations shall be written and submitted in the form prescribed by the Medical Executive Committee. The report and recommendation shall specify whether the applicant's appointment should be renewed, renewed with modified membership category, department affiliation, and/or clinical privileges, or terminated. Where nonrenewal, denial of requested privileges, a reduction in status, or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

6.4-7 BASIS FOR REAPPOINTMENT

The recommendation concerning the reappointment of a medical staff member and the clinical privileges to be granted upon reappointment shall be based upon whether such member has met the qualifications specified in Section 3.2, carried out the responsibilities specified in Section 3.6, and met all of the standards and requirements set forth in all sections of these bylaws and in the medical staff rules and regulations. Specifically, recommendations shall also be based upon the practitioner's compliance with legal requirements applicable to the practice of the practitioner's profession, with the medical staff bylaws and rules and regulations and hospital policies, rendition of services to patients, any physical or mental impairment which might interfere with the ability to practice medicine with reasonable skill and safety, and the provision of accurate and adequate information to allow the medical staff to evaluate the practitioner's competency and qualifications.

6.4-8 FAILURE TO FILE REAPPOINTMENT FORM

A member shall be deemed to have voluntarily resigned his/her medical staff membership and clinical privileges if the member fails to file a complete application for reappointment at least seventy (75) days prior to the expiration date of medical staff membership and clinical privileges. If a practitioner subsequently wishes to apply for membership and clinical privileges at Riverside County Regional Medical Center, s/he shall be required to apply for membership and clinical privileges as a new applicant.

6.4-9 BETWEEN ROUTINE REAPPOINTMENT DATES

Whenever a member of the medical staff is first made aware of any interim changes from the previous appointment or reappointment (as listed below), s/he must *immediately* notify the Medical Staff Services Office by telephone and shall furnish the information in

writing within two-business days to the Medical Staff Services Office. If the Medical Staff Services Office is closed when the member first calls to report the change(s), the immediate notification by telephone will be made to the medical director or the administrator on call prior to doing any clinical work. Immediate is defined as "occurring or accomplished without loss or interval of time."

(a) The unstayed suspension, revocation, or non-renewal of license to practice medicine in California;

(b) Any suspension, revocation, or non-renewal of DEA or other controlled substance registration;

(c) Any cancellation or non-renewal of professional liability insurance coverage;

(d) Any change in health status that would pose a direct threat to the safety of patients;

(e) Receipt of written notice of any adverse action by the Medical Board of California (or appropriate licensing authority) taken or pending, including, but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation, or limitations, affecting the license to practice medicine;

(f) Any adverse action by any healthcare organization which has resulted in the filing of a Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank;

(g) The denial, revocation, suspension, reduction, limitation, non-renewal or voluntary relinquishment by resignation of medical staff membership and/or clinical privileges at any healthcare organization;

(h) Any material reduction in professional liability insurance coverage;

(i) Receipt of written notice of any legal action, including without limitation any filed and served malpractice suit or arbitration action;

(j) Conviction of any crime (excluding minor traffic violations);

(k) Receipt of written notice of any adverse action under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

ARTICLE VII
CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

A practitioner providing direct clinical services at this hospital, in connection with such practice and except as otherwise provided in Section 7.5 (Emergency Privileges) shall treat and service patients as assigned by the department chair and shall be entitled to exercise only those clinical privileges specifically approved by the medical staff and granted to the member by the governing board. Said privileges must be within the scope of any license, certificate, or other legal credential authorizing the member to practice in this state and consistent with any restrictions thereon.

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2-1 REQUESTS

The application for appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. Request from an applicant for privileges, or from a member for modification of privileges, must be supported by documentation of the requisite training, experience, qualifications and competency to exercise such privileges.

7.2-2 BASIS FOR PRIVILEGES DETERMINATION

Request for clinical privileges shall be evaluated on the basis of the member's education, training, experience, and demonstrated ability and judgment. The elements to be considered in making determination regarding privileges, whether in connection with periodic reappointment or otherwise, shall include education, training, observed clinical performance and judgment, performance of a sufficient number of procedures each year to develop and maintain the practitioner's skills and knowledge, and the documented results of the patient care audit and other quality review, evaluation, and monitoring activities required by these, and the hospital corporate bylaws to be conducted at the hospital. Privileges determination shall also take into account pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges.

7.2-3 PROCEDURE

All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article VI.

7.3 SPECIAL CONDITIONS APPLICABLE TO DENTAL AND PODIATRIC PRIVILEGES

Surgical procedures performed by a dentist shall be under the overall supervision of the chair of the department of surgery or designee. Surgical procedures performed by a podiatrist shall be under the overall supervision of the chair of the department of orthopaedic surgery or designee. All dental and podiatric patients shall be co-admitted by a physician medical staff member and shall receive the same basic medical appraisal as patients admitted to other surgical services.

The co-admitting physician medical staff member shall be responsible for the care of any medical problems that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient. A request for clinical privileges from a dentist or podiatrist shall be processed in the manner specified in Section 7.2

7.4 TEMPORARY PRIVILEGES

7.4-1 PENDING APPLICATION

Temporary clinical privileges may be granted to a physician, dentist, podiatrist, clinical psychologist, or an allied health professional under strictly defined and enforced circumstances. Temporary privileges may be granted up to 120 days when a complete and clean application for membership or clinical privileges is pending review and recommendation by the Medical Executive Committee and Governing Body.

7.4-2 SPECIFIC PATIENT CARE

Temporary clinical privileges may be granted on a case-by-case basis when an important patient care issue exists that mandates an immediate authorization to practice, for a limited period of time, to a physician, dentist, podiatrist, clinical psychologist, or an allied health professional to fulfill an important patient care, treatment, and service need provided that the procedure described in the medical staff organization's Temporary Privileges Policy and Procedure, in the Credentials Policies and Procedures Manual, are followed.

7.4-3 CONDITIONS

(a) If granted temporary privileges, the applicant shall act under the supervision of the department chair to which the applicant has been assigned, and shall ensure the chair, or the chair's designee, is kept closely informed of his/her activities within the hospital.

(b) Temporary privileges shall automatically terminate at the end of the designated period, unless terminated earlier by the Medical Executive Committee upon recommendation of the department, the Credentials Committee, or the medical director. As necessary, the appropriate department chair or in the chair's absence, the chief of medical staff, shall assign a member of the medical staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement medical staff member.

(c) Temporary privileges may at any time be terminated with or without cause by the chief of medical staff, the chair of the department, or the hospital director after conferring with either of the foregoing. The practitioner shall be entitled to the procedural rights afforded in Article IX of these bylaws only if temporary privileges are terminated or suspended for a medical disciplinary cause or reason. In all other cases, the individual shall not be entitled to any procedural rights based upon an adverse action involving temporary privileges. All persons requesting or receiving temporary privileges shall be bound by the bylaws and rules and regulations of the medical staff.

(d) There is no right to temporary privileges. Temporary privileges shall not be granted if the available information is incomplete, inconsistent or casts any reasonable doubt on the applicant's qualifications. Action on a request for temporary privileges shall be deferred until doubts have been satisfactorily resolved. A decision to defer shall not be deemed a denial of a request for temporary privileges. Such deferral shall not give rise to the rights set forth in Section IX.

7.5 EMERGENCY PRIVILEGES

In the case of an emergency, any member of the medical staff, to the degree permitted by his/ her California license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. 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 chair with respect to further care of the patient at the hospital.

In the event of **emergency disaster privileging**, refer to the Emergency Privileging During Disaster Policy in the Credentials Policy/Procedure Manual. The procedures as described in the policy will be implemented.

ARTICLE VIII
CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1-1 FOCUSED PROFESSIONAL PRACTICE REVIEW

The Medical Executive Committee shall define, on a continuous basis, the circumstances warranting further intensive review of a member or other practitioner's services provided under privileges held and establish the parameters for participation of the subject under review in the focused review process. When circumstances warrant, the Medical Executive Committee shall refer the matter to the Professional Practice Evaluation Committee (PPEC) who shall conduct the review following the timeframes set for that focused review by the Medical Executive Committee. A focused professional review triggered by an adverse event will result in recommendations for changes to improve the member's performance; recommendations for system, protocol or policy changes; a request for investigation or corrective action or other action.

8.1-2 CRITERIA FOR INITIATION

Whenever a practitioner with clinical privileges shall engage in, make, or exhibit acts, statements, demeanor, or professional conduct, either within or outside of the hospital, and the same is, or is reasonably likely to be detrimental to patient safety or to the delivery of quality patient care at the hospital, to be disruptive to hospital operations, or improper use of hospital resources, or act contrary to the bylaws, or to constitute fraud or abuse; or the same results in the imposition of sanctions by any governmental authority; an investigation or corrective action against such person may be requested by any medical staff officer, by the medical director, or by the chair or vice chair of any department in which the practitioner is a member to exercise clinical privileges. Department Chairs may initiate Focused Professional Practice Review (FPPE). If the FPPE initiated by the Department Chair results in any corrective action, it must be approved by the Medical Executive Committee. The chair of any standing medical staff committee, the governing board, or the hospital director may also request an investigation or corrective action.

8.1-3 INITIATION

Proposed corrective action, including a request for an investigation, must be initiated by the Medical Executive Committee on its own initiative or by a written request which is submitted to the Medical Executive Committee that identifies the specific activities or conduct which are alleged to constitute the grounds for proposing an investigation or specific corrective action. The chief of medical staff shall promptly notify the hospital director of all proposals for corrective action so initiated and shall continue to keep the hospital director fully informed of all actions taken in conjunction therewith.

8.1-4 INVESTIGATION

Upon receipt, the Medical Executive Committee may act on the proposal or direct that an investigation be undertaken. The Medical Executive Committee may conduct that

investigation itself or may assign this task to an appropriately charged officer or to a standing or ad hoc medical staff committee. No such investigation process shall be deemed to be a "hearing" as that term is used in Article IX.

If the investigation is delegated to an officer or committee other than the Medical Executive Committee, such officer or committee shall forward a written report of the investigation to the Medical Executive Committee as soon as is practicable after the assignment to investigate has been made. The Medical Executive Committee may at any time within its discretion, and shall at the request of the governing board, terminate the investigative process and proceed with action as provided in Section 8.1-5 below.

An external peer review consultant may be considered when:

(a) Litigation seems likely.

(b) The hospital is faced with ambiguous or conflicting recommendations from medical staff committees, or where there does not appear to be a strong consensus for a particular recommendation. In these circumstances consideration may be given by the Medical Executive Committee or the governing board to retain an objective external review.

(c) There is no one on the medical staff with expertise in the subject under review, or when the only physicians on the medical staff with appropriate expertise are direct competitors or partners of the physician under review.

(d) In addition, the Medical Executive Committee or Governing Body may require external peer review in any circumstances deemed appropriate by either of these bodies.

8.1-5 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as is practicable after the conclusion of the investigative process, if any, but in any event within sixty (60) days after the initiation of proposed corrective action, unless deferred pursuant to Section 8.1-6, the Medical Executive Committee shall act thereon. Such action may include, without limitation, the following actions or recommendations:

(a) Determine no corrective action to be taken, and if the Medical Executive Committee determines there was no credible evidence for the complaint

(b) In the first instance, removing any adverse information from the member's file.

(b) Refer the member to the Physician Well-Being Committee for evaluation and follow-up as appropriate.

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

(d) Recommend 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-admission, mandatory

consultation, or monitoring.

(e) Recommend reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care.

(f) Recommend suspension, revocation or probation of medical staff membership.

(g) Take other actions deemed appropriate under the circumstances.

Nothing set forth herein shall inhibit the Medical Executive Committee from implementing summary suspension at any time, in the exercise of its discretion pursuant to Section 8.2. (Summary Restriction or Suspension).

8.1-6 DEFERRAL

If additional time is needed to complete the investigative process, the Medical Executive Committee may defer action on the request, and it shall so notify the affected practitioner. A subsequent recommendation for any one or more of the actions provided in Section 8.1-5, Paragraphs (a) through (g) above must be made within the time specified by the Medical Executive Committee, and if no such time is specified, then within thirty (30) days of the deferral.

8.1-7 PROCEDURAL RIGHTS

Any recommendation by the Medical Executive Committee pursuant to Section 8.1-5 which constitutes grounds for a hearing as set forth in Section 9.2 shall entitle the practitioner to the procedural rights as provided in Article IX. In such cases, the chief of medical staff shall give the practitioner written notice of the adverse recommendation and of the right to request a hearing in the manner specified in Section 9.3-2.

8.1-9 OTHER ACTION

(a) If the Medical Executive Committee's recommended action is to recommend no corrective action, such recommendation, together with such supporting documentation as may be required by the governing board, shall be transmitted thereto. Thereafter, the procedure to be followed shall be the same as that provided for applicants in Sections 6.3-9 (Action by the Governing Board) and 6.3-10 (Notice of Final Decision), as applicable.

(b) If the Medical Executive Committee's recommended action is an admonition, reprimand, or warning to a practitioner, it shall, at the practitioner's request, grant the applicant an interview. Following the interview, if one is requested, if the Medical Executive Committee's final recommendation to the hospital director is an admonition, reprimand, or warning this shall conclude the matter when approved by the governing board without substantial modification, and notice of the final decision shall be given to the governing board, hospital director, Medical Executive Committee, the chair and vice chair of each department concerned, and the practitioner.

(c) If any proposed corrective action by the governing board will substantially modify the Medical Executive Committee's recommendation, the governing board may submit the matter to the Joint Conference Committee for review and recommendation before making its decision final. Any recommendation

of the governing board which constitutes grounds for a hearing, as set forth in Section 9.2, shall entitle the practitioner to the procedural rights as provided in Article IX. In such cases, the governing board shall give the practitioner written notice of the tentative adverse recommendation and of the right to request a hearing in the manner specified in Section 9.3-2.

(d) Should the governing board determine that the Medical Executive Committee's failure to investigate, or initiate disciplinary action, is contrary to the weight of the evidence, the governing board may direct the Medical Executive Committee to initiate an investigation or a disciplinary action, but only after consultation with the Medical Executive Committee. In the event the Medical Executive Committee fails to take action in response to a direction from the governing board, the governing board, after notifying the Medical Executive Committee in writing, may take action on its own initiative. If such action is favorable to the practitioner, or constitutes an admonition, reprimand or warning to the practitioner, it shall become effective as the final decision of the governing board. If such action is one of those set forth in Section 9.2, the governing board shall give the practitioner written notice of the adverse recommendation and of the right to request a hearing in the manner specified in Section 9.3-2 and the rights shall be as provided in Article IX.

8.2 SUMMARY RESTRICTION OR SUSPENSION

8.2-1 CRITERIA FOR INITIATION

Whenever a member's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient, prospective patient, or other person, the medical director, the Medical Executive Committee, or the chair of department or designee in which the member holds privileges may summarily restrict or suspend the medical staff membership or clinical privileges of such member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the governing board, the Medical Executive Committee and the hospital director. In addition, the affected medical staff member shall be provided with a written notice of the action which notice fully complies with the requirement of Section 8.2-2 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 medical director, considering where feasible, the wishes of the patient in the choice of a substitute member.

8.2-2 WRITTEN NOTICE OF SUMMARY SUSPENSION

Within one (1) working day 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 an imminent danger to the health of an individual. The statement of facts provided in this initial notice shall also include a summary of one 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 9.3-1 (which applies in all cases where the MEC does not immediately terminate the summary suspension). The notice under Section 9.3-1 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.

8.2-3 MEDICAL EXECUTIVE COMMITTEE ACTION

Within one (1) week after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee (or a subcommittee appointed by the chief of medical staff) shall be convened to review and consider the action. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical 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 IX, nor shall any procedural rules apply. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the member with notice of its decision within two (2) working days of the meeting.

8.2-4 PROCEDURAL RIGHTS

Unless the Medical Executive Committee terminates the summary restriction or suspension, within 14 days the member shall be entitled to the procedural rights afforded by Article IX. In addition, the affected practitioner shall have the following rights:

(a) Any affected practitioner shall have the right to challenge imposition of the summary suspension, particularly on the issue of whether or not the facts stated in the notice present a reasonable possibility of "imminent danger" to an individual. Initially, the practitioner may present this challenge to the Medical Executive Committee at the meeting held within one (1) week of imposition of the suspension. If the MEC's decision is to continue the summary suspension, beyond 14 days, then any practitioner who has properly requested a hearing under the medical staff bylaws may request that the hearing be bifurcated, with the first part of the hearing being devoted exclusively to procedural matters, including the propriety of summary suspension.

(b) At the conclusion of the procedural portion of the hearing, the hearing officer (or hearing panel) shall issue a written opinion on the issues raised, including whether or not the facts stated in the written notice to the affected practitioner adequately support a determination that failure to summarily restrict or suspend could reasonably result in "imminent danger" to an individual. Such written opinion shall be transmitted to both the affected practitioner and the Medical Executive Committee within one (1) week of the date of the procedural hearing.

(c) If the hearing officer's (or hearing panel's) determination is that the facts stated in the notice required by Section 8.2-2 do not support a reasonable determination that failure to summarily restrict or suspend the practitioner's privileges could result in imminent danger, the summary suspension shall be immediately stayed pending the outcome of the hearing and any appeal.

(d) If the hearing officer (or hearing panel) determines that the facts stated in the notice required by Section 8.2-2 support a reasonable determination that summary suspension was necessary to avoid imminent danger to an individual, the summary suspension shall remain in effect pending conclusion of the hearing and any appellate review.

8.2-5 INITIATION BY THE GOVERNING BOARD

If the medical director, members of the Medical Executive Committee and the chair of the department (or designee) in which the member holds privileges are not available to summarily restrict or suspend the member's membership or clinical privileges, the governing board (or designee) may immediately suspend a member's privileges if a failure to suspend those privileges is likely to result in an imminent danger to the health of any patient, prospective patient, or other person, provided that the governing board (or designee) made reasonable attempts to contact the medical director, members of the Medical Executive Committee and the chair of the department (or designee) before the suspension. Such a suspension is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two (2) working days, excluding weekends and holidays, the summary suspension shall terminate automatically. If the Medical Executive Committee does ratify the summary suspension, all other provision under Section 8.2 of these bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the Medical Executive Committee for purposes of compliance with notice and hearing requirements.

8.3 AUTOMATIC AND IMMEDIATE SUSPENSION OR LIMITATION

In the following instances, the member's privileges or membership may be immediately suspended or limited as described, and all patient care activity shall immediately cease, if requested, shall be limited to the question of whether the grounds for automatic suspension as set forth below have occurred.

8.3-1 LICENSURE

(a) **Revocation and Suspension**: Whenever a member's license or other legal credential authorizing practice in this state is revoked or 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 this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges that the member has been granted at the hospital, 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, the member's membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation, as of the date such action becomes effective and throughout its term.

8.3-2 CONTROLLED SUBSTANCES

(a) **Revocation, Limitation, Suspension**: Whenever a member's Drug Enforcement Administration (DEA) certificate is revoked, limited or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

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

8.3-3 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

Failure of a member without good cause to appear and satisfy the requirements of Section 13.7-3 shall be a basis for corrective action.

8.3-4 MEDICAL RECORDS

Members of the medical staff are required to complete medical records within such reasonable time as may be prescribed in the Medical Staff Rules and Regulations. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, shall be imposed by the medical director, or designee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this Section, "related privileges" means scheduling surgery, assisting in surgery, consulting on hospital cases, and providing professional services at the hospital for future patients. Bona fide vacation or illness may constitute an excuse subject to approval by the Medical Executive Committee. Members whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until lifted by the medical director or designee.

8.3-5 FAILURE TO PAY DUES/ASSESSMENTS

Failure without good cause, as determined by the Medical Executive Committee, to pay fees, dues or assessments as required under Section 15.4 shall be grounds for automatic suspension of a member's clinical privileges, and if within thirty (30) days after written warning of delinquency the member does not pay the required dues or assessments, the member's membership shall be automatically terminated.

8.3-6 EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable after action is taken or warranted as described in Section 8.3-1 (b) or (c), Section 8.3-2, 8.3-3, or 8.3-4, 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 9.3-1.

8.3-7 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance, if any is required, shall be grounds for automatic 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, the member's membership shall be automatically terminated.

ARTICLE IX

HEARINGS AND APPELLATE REVIEWS*

*California Business & Professions Code Sections 809 et seq. hearing requirements are applicable to all physicians, dentists, podiatrists, and clinical psychologists practicing at the hospital whether or not on the medical staff.

9.1 GENERAL PROVISIONS

9.1-1 EXHAUSTION OF REMEDIES

If adverse action described in Section 9.2 (Grounds for Hearing) is taken or recommended, the applicant or member must exhaust the remedies afforded by these bylaws before resorting to legal action.

9.1-2 APPLICATION OF ARTICLE

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

9.1-3 TIMELY COMPLETION OF PROCESS

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

9.1-4 FINAL ACTION

Recommended adverse actions described in Section 9.2 shall become final only after the hearing and appellate rights set forth in these bylaws have either been exhausted or waived.

9.2 GROUNDS FOR HEARING

Except as otherwise specified in these bylaws, any one or more of the following actions or recommended actions shall be deemed actual or potential adverse action and constitute grounds for a hearing:

- **(a)** denial of medical staff membership;
- **(b)** denial of requested advancement in staff membership status, or category;
- **(c)** denial of medical staff reappointment;
- **(d)** demotion to lower medical staff category or membership status;
- **(e)** suspension of staff membership;
- **(f)** revocation of medical staff membership;
- **(g)** denial of requested clinical privileges;
- **(h)** involuntary reduction of current clinical privileges;
- **(i)** suspension of all 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 3.8); or
- **(l)** any other action which requires a report to be made to the Medical Board of California under the provision of Section 805 of the California Business and Professions Code.

*Subsections b, d and e would be applicable only if there is an competence or conduct concern and the restriction of privileges exceeded 14 day or more.

9.3 REQUESTS FOR HEARING

9.3-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which action has been taken or a recommendation made as set forth in Section 9.2, said person or body shall give the member prompt written notice of:

(a) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the Medical Board of California pursuant to Section 805 of the California Business and Professions Code, if required;

(b) the reasons for the proposed action including the acts or omissions with which the member is charged;

(c) the right to request a hearing pursuant to Section 9.3-2, and that such hearing must be requested within thirty (30) days; and

(c) a summary of the rights granted in the hearing pursuant to the medical staff bylaws.

If the recommendation or final proposed action adversely affects the clinical privileges of a practitioner a period longer than thirty (30) days and is based on competence or professional conduct, said written notice shall state that the action, if adopted, will be reported to the National Practitioner Data Bank and shall state the text of the proposed report.

9.3-2 REQUEST FOR HEARING

The member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Medical Executive Committee with a copy to the governing board. 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 recommendations or actions involved and, thereupon, said recommendations or actions shall be final.

9.3-3 TIME AND PLACE FOR HEARING

Upon receipt of a request for hearing, the Medical Executive Committee shall schedule a hearing and, within fifteen (15) days give notice to the member of the time, place, and date of the hearing. Unless extended by the Judicial Review Committee, the date of the commencement of the hearing shall be within thirty (30) days, of notice to the practitioner for a hearing;

9.3-4 NOTICE OF HEARING

Together with the notice stating the place, time and date of the hearing, which date shall not be less than thirty (30) days after the date of the notice unless waived by a member under summary suspension, the Medical Executive Committee shall provide a list of the charts in question, where applicable, and a list of the witnesses (if any) expected to testify at the hearing on behalf of the Medical Executive Committee. The content of this list is subject to update pursuant to Section 9.4-1.

9.3-5 JUDICIAL REVIEW COMMITTEE

When a hearing is requested, the Medical Executive Committee shall recommend a Judicial Review Committee to the governing board for appointment. The governing board shall be deemed to approve the selection unless it provides written notice to the Medical Executive Committee stating the reasons for its objections within five (5) days. The Judicial Review Committee shall be composed of not less than five (5) members of the medical staff. The Judicial Review Committee shall gain no direct financial benefit from the outcome, and shall not have acted as accuser, investigator, fact finder, and initial decision maker or otherwise have not 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 member of the Judicial Review Committee. In the event that it is not feasible to appoint a Judicial Review Committee from the active medical staff, the Medical Executive Committee may appoint members from other staff categories or practitioners who are not members of the medical staff. Such appointment shall include designation of the chair. Membership on a Judicial Review Committee shall consist of one (1) member who shall have the same healing arts licensure as the accused, and where feasible, include an individual practicing the same specialty as the member. All other members shall have MD or DO degrees or their equivalent as defined in Section 3.2-2 (a).

9.3-6 FAILURE TO APPEAR OR PROCEED

Failure of the member to personally attend and proceed at such a hearing in an efficient and orderly manner without good cause or otherwise withdraws the request for hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions involved and, thereupon, said recommendations or actions shall be final.

9.3-7 POSTPONEMENTS AND EXTENSIONS

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

9.4 HEARING PROCEDURE

9.4-1 PREHEARING PROCEDURE

(a) If either side to the hearing requests in writing a list of witnesses, within fifteen (15) days of such request, 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. The member shall have the right to inspect and copy documents or other evidence upon which the charges are based, and shall also have the right to receive, at least thirty (30) days prior to the hearing, a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the member to prepare a defense, including all evidence which was considered by the Medical Executive Committee in determining whether to proceed with the adverse action, and any exculpatory evidence in the possession of the hospital or medical staff. The member and the Medical Executive Committee shall have the right to receive all evidence which will be made available to the Judicial Review Committee.

(b) The Medical Executive Committee shall have the right to inspect and copy at its expense any documents or other evidence relevant to the charges which the member has in possession or control as soon as practicable after receiving the request.

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

(d) The hearing officer shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the hearing officer shall consider:

(i) whether the information sought may be introduced to support or defend the charges;

(ii) the exculpatory or inculpatory nature of the information sought, if any;

(iii) the burden imposed on the party in possession of the information sought, if access is granted; and

(iv) any previous requests for access to information submitted or resisted by the parties to the same proceeding.

(e) The member shall be entitled to a reasonable opportunity to question and challenge the impartiality of Judicial Review Committee members and the hearing officer. Challenges to the impartiality of any Judicial Review Committee member or the hearing officer shall be ruled "as required by the California Business and Professions Code."

(f) It shall be the duty of the member and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the chair of the Judicial Review Committee 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.

9.4-2 REPRESENTATION

The hearings provided for in these bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, or character.

The member shall be entitled to representation by legal counsel in any phase of the hearing, should the member so choose, 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 by an individual, who is not an attorney, of the member's choosing, 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 by an attorney at law if the member is not so represented.

9.4-3 THE HEARING OFFICER

The Medical Executive Committee shall recommend a hearing officer to the governing board to preside at the hearing. The governing board shall be deemed to approve the selection unless it provides written notice to the Medical Executive Committee stating the reasons for its objections within five (5) days. The hearing officer may be an attorney at law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the hospital, 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. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of, or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances. If requested by the Judicial Review Committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

9.4-4 RECORD OF THE HEARING

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

9.4-5 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, as 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.

9.4-6 MISCELLANEOUS RULES

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the Judicial Review Committee may request or permit both sides to file written arguments.

9.4-7 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 applicant shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, of the applicant's qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning current qualifications for membership and privileges. An applicant shall not be permitted to introduce information requested by the medical staff, which was not produced during the application process, unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(c) Except as provided above for applicants, throughout the hearing, the Medical Executive Committee shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

9.4-8 ADJOURNMENT AND CONCLUSION

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

9.4-9 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. The decision of the Judicial Review Committee shall be subject to such rights of appeal as described in these bylaws, but shall otherwise be affirmed by the governing board as the final action if it is supported by substantial evidence, following a fair procedure.

9.4-10 DECISION OF THE JUDICIAL REVIEW COMMITTEE

Within thirty (30) days after final adjournment of the hearing, the Judicial Review Committee shall render a decision which shall be accompanied by a report in writing and shall be delivered to the Medical Executive Committee. If the member is currently under suspension, however, the time for the decision and report shall be fifteen (15) days. A copy of said decision also shall be forwarded to the hospital director, the governing board and to 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. If the final proposed action adversely affects the clinical privileges of a physician or dentist for a period longer than thirty (30) days and is based on competence or professional conduct, the decision shall state that

the action if adopted will be reported to the National Practitioner Data Bank, and shall state the text of the report as agreed upon by the committee. 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 subject to such rights of appeal or review as described in these bylaws, but shall otherwise be affirmed by the governing board as the final action if it is supported by substantial evidence, following a fair procedure.

9.5 APPEAL

9.5-1 TIME FOR APPEAL

Within ten (10) 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 medical director, the hospital director, and the other party in the hearing. If a request for appellate review is not requested within such period, that action or recommendation shall be affirmed by the governing board as the final action if it is supported by substantial evidence, following a fair procedure.

9.5-2 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;

(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 9.5-5;

(c) the text of the report to be filed to the National Practitioner Data Bank is not accurate.

9.5-3 TIME, PLACE AND NOTICE

If an appellate review is to be conducted, the appeal board shall, within fifteen (15) 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 date of appellate review shall not be less than thirty (30) nor more than sixty (60) days from the date of such notice, provided however, that when a request for appellate review concerns a member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed fifteen (15) days from the date of the notice. The time for appellate review may be extended by the appeal board for good cause.

9.5-4 APPEAL BOARD

The governing board may sit as the appeal board, or it may appoint an appeal board which shall be composed of not less than three (3) members of the governing board. Knowledge of the matter involved shall not preclude any person from serving as a member

matter. The appeal board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal. The attorney selected by the governing board shall not be the attorney that represented either party at the hearing before the Judicial Review Committee.

9.5-5 APPEAL PROCEDURE

The proceeding by the appeal 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 appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the judicial review hearing; or the appeal 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, to present a written statement in support of his/her position on appeal, and to personally appear and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The appeal board shall present to the governing board its written recommendations as to whether the governing board should affirm, modify, or reverse the Judicial Review Committee's decision, or remand the matter to the Judicial Review Committee for further review and decision.

9.5-6 DECISION

(a) Except as provided in Section 9.5-6 (b), within thirty (30) days after the conclusion of the appellate review proceedings, the governing board shall render a final decision and shall affirm the decision of the Judicial Review Committee if the Judicial Review Committee's decision is supported by substantial evidence, following a fair procedure.

(b) Should the governing board determine that the Judicial Review Committee decision is not supported by substantial evidence, the board may modify or reverse the decision of the Judicial Review Committee and may instead, or shall, where a fair procedure has not been afforded, remand the matter to the Judicial Review Committee for reconsideration, stating the purpose for the referral. If the matter is remanded to the Judicial Review Committee for further review and recommendation, the committee shall promptly conduct its review and make its recommendations to the governing board. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the chair of the governing board and the Judicial Review Committee.

(c) The decision shall be in writing, shall specify the reasons for the action taken, shall include the text of the report which shall be made to the National Practitioner Data Bank, if any, and shall be forwarded to the medical director, the Medical Executive Committee, the Credentials Committee, the subject of the hearing, and the hospital director, at least ten (10) days prior to submission to the Medical Board of California.

9.5-7 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.

9.6 EXCEPTIONS TO HEARING RIGHTS

9.6-1 MEDICO-ADMINISTRATIVE OFFICER

The fair hearing rights of Articles VIII and IX do not apply to those persons serving the hospital in a medico-administrative capacity. Removal from office of such persons shall instead be governed by the terms of their individual contracts and agreements with the hospital or Riverside County Ordinance 440 where applicable. However, the hearing rights of the preceding sections of this Article IX and of Article VIII shall apply to the extent that medical staff membership status or clinical privileges, which are independent of the practitioner's contract, are also removed or suspended, unless the contract includes a specific provision establishing alternative procedural rights applicable to such decisions.

9.6-2 FAIR HEARING AND APPEALS FOR ALLIED HEALTH PROFESSIONALS

AHPs are not entitled to the hearing and appeals procedures set forth in the medical staff bylaws. In the event one of these practitioners receives notice of a recommendation by the Medical Executive Committee that will adversely affect his/her exercise of clinical privileges, the practitioner and his/her supervising physician shall have the right to meet personally with two physicians and a peer assigned by the Chief of Staff to discuss the recommendation. The practitioner and the supervising physician must request such a meeting in writing to the Medical Staff Office within 10 working days from the date of receipt of such notice. At the meeting, the practitioner and the supervising physician must be present to discuss, explain, or refute the recommendation, but such meeting shall not constitute a hearing and none of the procedural rules set forth in article IX of the medical staff bylaws with respect to hearings shall apply. Findings from this review body will be forwarded to the affected practitioner, the Medical Director and the Medical Executive Committee

The practitioner and the supervising physician may request an appeal in writing to the Medical Staff Office within 10 days of receipt of the findings of the review body. Two members of the Medical Executive Committee assigned by the President of the Medical Staff shall hear the appeal from the practitioner and the supervising physician. A representative from the medical staff leadership may be present. The decision of the appeal body will be forwarded to the Board for final decision. The practitioner and the supervising physician will be notified within 10 days of the final decision of the Board.

AHP AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

In the following instances, the allied health professional privileges may be immediately suspended or limited as described, and all patient care activity shall immediately cease, if requested, shall be limited to the question of whether the grounds for automatic suspension as set forth below have occurred.

(a) The medical staff membership of the supervising physician, if any, is terminated, whether such termination is voluntary or involuntary.

(b) The supervising physician, if any, no longer agrees to act as the supervising physician, for any reason, or the relationship between the AHP and the supervising physician, if any, is otherwise terminated, regardless of the reason therefore.

(c) The AHP's certification or license expires, is revoked or suspended.

9.6-3 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

No hearing is required when a member's license or legal credential to practice has been revoked or suspended as set forth in Section 8.3-1 (a). In other cases described in Section 8.3-1 and 8.3-2, 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 of the DEA was unwarranted, but only whether the member may continue practice in the hospital with those limitations imposed.

9.6-4 DEPARTMENT/DIVISION FORMATION OR ELIMINATION

A medical staff department/division can be formed or eliminated only following a determination by the medical staff of appropriateness of department/division elimination or formation. The governing board decision shall uphold the medical staff's determination unless the governing board makes specific written findings that the medical staff's determination is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.

(a) The medical staff shall determine the formation or elimination of a department/division to be appropriate based upon consideration of its effects on quality of care in the facility and/or community. A determination of the appropriateness of formation or elimination of a department/division must be based upon the preponderance of the evidence, viewing the record as a whole, presented by any and all interested parties, following notice and opportunity for comment.

9.7 NATIONAL PRACTITIONER DATA BANK REPORTING

9.7-1 ADVERSE ACTIONS

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

9.7-2 DISPUTE PROCESS

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

ARTICLE X
CLINICAL DEPARTMENTS AND DIVISIONS

10.1 ORGANIZATION OF DEPARTMENTS AND DIVISIONS

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 department chair selected and entrusted with authority, duties and responsibilities as specified in Section 11.3; and a department vice chair elected and entrusted with the authority, duties and responsibilities as specified in Section 11.4. A department may be further divided, as appropriate, into divisions which shall be directly responsible to the department within which it functions, and shall have a division chair selected and entrusted with the authority, duties and responsibilities specified in Section 11.5. The clinical department or division may meet separately or jointly.

10.2 DESIGNATION

The departments and divisions are:

(a) Anesthesiology

(b) Emergency Medicine

(c) Family Medicine

(d) Medicine with Divisions of General Internal Medicine, Cardiology, Gastroenterology, Geriatrics, Hematology/Oncology, Nephrology, Neurology, Pulmonary & Critical Care Services, Inpatient Medicine Services, and Ambulatory Care Services with subdivisions of Dermatology, Endocrinology, Infectious Disease, and Rheumatology

(e) Clinical Neurological Sciences (Neurological Surgery)

(f) Obstetrics and Gynecology

(g) Ophthalmology

(h) Orthopaedic Surgery and Rehabilitation and Division of Spine Surgery

(i) Pathology, including Clinical Laboratory

(j) Pediatrics with Division of Neonatology and Division of Critical Care

(k) Psychiatry

(l) Radiology, including Diagnostic, Therapeutic, Nuclear Medicine, and Neuroradiology

(m) Surgery with Divisions of General Surgery, Thoracic Surgery, Vascular Surgery, Hyperbaric Medicine, Plastic Surgery, Dental, Oral & Maxillofacial Surgery, Head, Neck Surgery & Otolaryngology, and Urology

10.3 ASSIGNMENT TO DEPARTMENTS AND DIVISIONS

The member shall be assigned membership in at least one department or division, as applicable, and may also be granted membership and/or clinical privileges in other departments or divisions consistent with the practice privileges that have been granted. The exercise of clinical privileges in any department is subject to the rules and regulations of that department and to the authority of the relevant department chair and vice chair.

10.4 FUNCTIONS OF DEPARTMENTS

The primary responsibility delegated to the department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and appropriateness of patient care provided in the department.

To carry out this responsibility the department shall:

(a) Conduct patient care reviews to analyze and evaluate the quality of care and appropriateness of treatment provided to patients within the department. The number of such reviews conducted during the year shall be reviewed by the Medical Executive Committee and shall be conducted in accordance with such procedures as may be adopted by the Professional Practice Evaluation Committee. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work subject to review is a member of that department. The criteria to be used in these reviews shall be objective and reflect current knowledge and clinical experience. The department shall also identify actions that should be taken in order to resolve identified problems in patient care and clinical performance and evaluate the effectiveness of actions which have been taken in resolving such problems.

(b) Submit written reports to the Medical Executive Committee concerning:

(1) The department's review, monitoring and evaluation activities, actions taken thereon, and the result of such action taken.

(2) Recommendations for maintaining and improving the quality of care provided in the department and the hospital.

(c) Meet at least quarterly to receive, review, and consider patient care review findings and the results of other department's review, evaluation, and monitoring activities, as well as reports about other departments and staff functions.

(d) Conduct, participate, and make recommendations regarding continuing education programs pertinent to the department's clinical practice, changes in state-of-the-art, and findings of review, evaluation and monitoring activities.

(e) Review, evaluate and monitor on a continuous and concurrent basis, the department's adherence to:

(1) Medical staff and hospital policies and procedures.
(2) Requirements for alternate coverage and for consultations.
(3) Sound principles of clinical practice.
(4) Fire and other regulations designed to promote patient safety.

(f) Coordinate patient care provided by the department members with nursing and ancillary patient care services and administrative support services.

(g) Establish such committees or other mechanisms as necessary and

perform properly the functions assigned to it, including clinical privileges and proctoring protocols.

(h) Formulate recommendations for departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval of the Medical Executive Committee.

10.5 FUNCTIONS OF DIVISIONS/SUBDIVISIONS

Subject to approval of the Medical Executive Committee, the division/subdivision shall perform the functions assigned to it by the department chair. Such functions may include, without limitation, retrospective patient care reviews, continuous evaluation and monitoring of patient care practices, credentials review and privileges delineation, peer reviews, and continuing education programs. The division/subdivision shall systematically transmit quality assessment/improvement reports and other pertinent reports to the department chair on the conduct of its assigned functions. The department shall specify the timetable for quality assessment/improvement reports in its departmental rules and regulations. Quality assessment/ improvement reports shall be submitted at least annually.

10.6 MODIFICATIONS IN CLINICAL ORGANIZATION UNIT

When deemed appropriate, the Medical Executive Committee may create, eliminate, subdivide, further subdivide, or combine departments, divisions and/or subdivisions as follows:

(a) **Creation of a Division or Subdivision**:

(i) A sufficient number of practitioners are available for appointment to, and will be appointed to, and/or actively participate in the new organizational component to enable accomplishment of the functions generally assigned to such components in these bylaws, and relevant rules and regulations adopted pursuant hereto; and,

(ii) the patient or service activity to be associated with the new component is substantial enough to impose on its members the responsibility to accomplish those functions.

(b) **Elimination:** The number of members available is no longer adequate, and will not be so in the foreseeable future, to accomplish assigned functions, or when the patient or service activity associated with the component to be dissolved is no longer substantial enough to warrant the responsibility imposed on members of each division/subdivision to accomplish those functions.

(c) **Combination:** The union of the two or more organizational components will result in more effective and efficient accomplishment of assigned functions and the patient or service activity to be associated with the combination is substantial enough, without being unwieldy, to warrant the responsibility imposed on the members of such combined components to accomplish those assigned functions.

In all instances of modification, the hospital's written plan of development, as currently being implemented, and any constraints or mandates imposed by external planning authorities, shall also be considered.

ARTICLE XI
OFFICERS

11.1 GENERAL OFFICERS OF THE MEDICAL STAFF

11.1-1 IDENTIFICATION

The general officers of the medical staff shall be the chief of medical staff, the chief of medical staff-elect, the immediate past chief of medical staff, the secretary-treasurer, and the medical director.

11.1-2 QUALIFICATIONS

General officers must be members of the active staff category at the time of nomination and election, and they 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. All officers must be licensed as physicians and surgeons, given the nature of their duties in office.

11.1-3 NOMINATIONS

(a) **Nominating Committee:** Medical staff elections shall be held biennially. The Nominating Committee shall consist of seven (7) members of the medical staff: the chief of medical staff, the immediate past chief of medical staff, the chief of medical staff-elect, the medical director, and three (3) active staff category members elected from the floor at the preceding year of nomination. The chief of medical staff-elect shall preside at this meeting. The nominations of the committee shall be reported to the Medical Executive Committee at least sixty (60) days prior to the Annual Meeting and shall be delivered or mailed to the active staff category members at least twenty (20) days prior to the election.

(b) **Slate of Nominees:** The Nominating Committee shall prepare a slate of at least one (1) nominee for each of the elective officers of the medical staff: the chief of medical staff-elect, the secretary-treasurer, and the member-at-large of the Credentials Committee. Nominees for office should be selected on the basis of leadership and administrative ability, scientific achievement, and ability to work with confreres.

11.1-4 ELECTION

Officers shall be elected at the Annual Medical Staff Meeting. Only active staff category members shall be eligible to vote. Voting shall be by voice, show of hands, or if there are two (2) or more nominees for any office, by secret written ballot. The nominee receiving a majority of the valid votes cast shall be elected. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two (2) candidates receiving the highest number of votes. If the second ballot is also a tie, the Medical Executive Committee, by majority vote, shall decide the election by secret ballot at its next meeting or at a special meeting called for that purpose.

11.1-5 CHIEF OF MEDICAL STAFF AND IMMEDIATE PAST CHIEF OF MEDICAL STAFF PROVISIONS

Sections 11.~~1-3~~ -2 and 11.~~1~~ 2-4 shall not apply to the chief of medical staff and the immediate past chief of medical staff. The chief of medical staff-elect, upon completion of term of office, shall immediately succeed to the office of chief of medical staff and then to the office of immediate past chief of medical staff.

11.1-6 TERM OF ELECTED OFFICERS

Officers shall serve for a term of two (2) medical staff years, commencing on the first day of the medical staff year following their election. The officers shall serve until the end of their term and until successors are elected, unless they shall sooner resign or are removed from office. A general officer may not hold the same office for more than two (2) consecutive terms.

11.1-7 REMOVAL OF ELECTED OFFICERS

Any officer whose election is subject to these bylaws may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. Except as otherwise provided in these bylaws, removal of a general officer may be initiated by the Medical Executive Committee or by a petition signed by at least one third (1/3) of the medical staff members eligible to vote for officers. Removal shall be considered by the Medical Executive Committee or by a special meeting called for that purpose. Removal shall require a two-third (2/3) vote of the medical staff members eligible to vote for medical staff officers; who actually cast votes at the special meeting in person or by mail ballot. Voting on removal of an elected officer shall be by secret written mail ballot, as defined in Article XV, Section 15.10. The written mail ballots shall be sent to each voting member at least twenty-one (21) days before the voting date and the ballots shall be counted by the secretary-treasurer of the medical staff (except when the secretary-treasurer is the subject of the balloting, in which case the chief of medical staff shall count the ballots) and the medical staff services manager.

11.1-8 VACANCIES IN ELECTED OFFICE

Vacancies, other than the chief of medical staff, shall be appointed by the Medical Executive Committee until the next regular election. If there is a vacancy in the office of chief of medical staff, the existing chief of medical staff-elect shall complete the remaining term and shall then serve as chief of medical staff the following year. If there is a vacancy in the office of immediate past chief of medical staff, that office need not be filled, except that the Medical Executive Committee may appoint a qualified successor to serve as the chair and/or member of any committee that the immediate past chief of medical staff is automatically appointed to pursuant to these bylaws or the Medical Staff Committees and Functions Manual.

11.2 DUTIES OF GENERAL OFFICERS

11.2-1 MEDICAL DIRECTOR

The hospital will appoint a physician as the medical director to act in a liaison capacity between hospital administration and medical staff departments and/or divisions.

The medical director shall:

(a) Plan, organize, direct and coordinate the medical staff services and medical training programs at the hospital.

(b) Cooperate with and assist the chief of medical staff in carrying out responsibility for the clinical organization functions of the hospital and supervision over clinical work in each department and division.

(c) Evaluate and transmit the appropriate recommendations concerning the qualifications of applicants who request initial adjunct staff appointments and biennial reappointments.

(d) Evaluate and transmit to the appropriate authorities, recommendations concerning initial medical membership appointment, clinical privileges, classification and reappointment of the department chair.

(e) Serve as a voting member of the Medical Executive Committee, the Medical Executive Committee Council, the Performance Improvement Committee, the Bylaws Committee, the Credentials Committee, and an ex-officio member of all other medical staff committees with the power to vote unless otherwise specified in these bylaws and in the Medical Staff Committees and Functions Manual.

(f) Perform such other functions as may be assigned by these bylaws, the Credentials Policies and Procedures Manual, the Medical Executive Committee, the hospital director or the governing board.

11.2-2 CHIEF OF MEDICAL STAFF

The chief of medical staff shall serve as the chief executive officer of the medical staff. The chief of medical staff shall:

(a) Act in coordination and cooperation with the hospital director and/or the medical director in all matters of mutual concern within the hospital.

(b) Call, preside at, and be responsible for the agenda of the Annual Medical Staff meeting and special meetings of the medical staff.

(c) Serve as chair of the Medical Executive Committee and the Medical Executive Committee Council; and a voting member of the Performance Improvement Committee, the Bylaws Committee, the Credentials Committee, and the Joint Conference Committee.

(d) Be responsible and serve as an ex-officio member of all other medical staff committees with the power to vote unless otherwise specified in these Bylaws and in the Medical Staff Committees and Functions Manual.

(e) Appoint committee members to all standing, special, ad hoc and multidisciplinary medical staff committees, except the Medical Executive Committee or unless otherwise specified in these bylaws or in the Medical Staff Committees and Functions Manual.

(f) Enforce the medical staff bylaws and rules and regulations, implement sanctions when indicated, and promote compliance with procedural safeguards when corrective action has been requested or initiated against a practitioner.

(g) Present the views, policies, needs and grievances of the medical staff to

the governing board and to hospital administration.

(h) Receive and interpret the policies of the governing board to the medical staff and report to the governing board on the performance and maintenance of quality with respect to the medical staff's delegated responsibility to provide medical care.

(i) Be a spokesperson for the medical staff in external, professional, and public relations.

(j) Be responsible for the educational activities of the medical staff.

(k) Perform such other functions as may be assigned by these bylaws, the Credentials Policies and Procedures Manual, the medical staff membership, the Medical Executive Committee or the governing board.

11.2-3 CHIEF OF MEDICAL STAFF-ELECT

The chief of medical staff-elect, in the absence of the chief of medical staff, shall assume all duties and authority of the chief of medical staff.

The chief of medical staff-elect shall:

(a) Chair the Bylaws Committee.

(b) Be a voting member of the Medical Executive Committee, the Medical Executive Committee Council, the Performance Improvement Committee, and the Credentials Committee.

(c) Serve as an ex-officio member of the Joint Conference Committee without the power to vote unless serving as the alternate for the chief of medical staff or the immediate past chief of medical staff.

(d) Be an ex-officio member of all other medical staff committees with the power to vote, unless otherwise specified in these bylaws or in the Medical Staff Committees and Functions Manual.

(e) Perform other supervisory duties as assigned by the chief of medical staff.

(f) Automatically succeed the chief of medical staff if the chief of medical staff fails to serve for any reason.

11.2-4 IMMEDIATE PAST CHIEF OF MEDICAL STAFF

The immediate past chief of medical staff shall:

(a) Be a voting member of the Bylaws Committee, the Medical Executive Committee, the Medical Executive Committee Council, the Credentials Committee, the Performance Improvement Committee and the Joint Conference Committee.

(b) Be an ex-officio member of all other medical staff committees with the power to vote unless otherwise specified in these bylaws or in the Medical Staff Committees and Functions Manual.

(c) Perform such other functions and duties as assigned by the chief of medical staff or delegated by these bylaws, the medical staff membership or the Medical Executive Committee.

11.2-5 SECRETARY-TREASURER

The secretary-treasurer shall:

(a) Be a voting member of the Medical Executive Committee and the Medical Executive Committee Council.

(b) Maintain a roster of members.

(c) Keep accurate and complete minutes of all Medical Executive Committee and medical staff meetings.

(d) Call meetings on the order of the chief of medical staff or the Medical Executive Committee.

(e) Attend to all appropriate correspondence and notices on behalf of the medical staff.

(f) Receive, safeguard, and be accountable for all funds of the medical staff.

(g) Excuse absence from meetings on behalf of the Medical Executive Committee.

(h) Perform such other duties that ordinarily pertain to the office or are assigned by the chief of medical staff or the Medical Executive Committee.

11.3 DEPARTMENT CHAIR

11.3-1 QUALIFICATIONS

The department chair shall be a member of the active medical staff and a member of the department that the practitioner will head. The department chair shall be qualified by licensure, training, experience, interest, and demonstrated current ability in the clinical area covered by the department, and shall be willing and able to discharge the administrative responsibilities of the office. The department chair shall be certified by an appropriate specialty board or recognized equivalent. In the event that there is no qualified active staff member, a provisional chair may be appointed to perform the functions of the department. The chief of medical staff, in consultation with the medical director, may assign an active staff member of a department to act as a mentor to the provisional chair.

11.3-2 SELECTION

The hospital will appoint a physician to act as the department chair, with the concurrence of the involved department and the Medical Executive Committee. The department chair shall be responsible to the medical director and work in cooperation with the department vice chair.

11.3-3 TERM OF OFFICE

The department chair shall serve commencing on appointment and shall serve until a successor is chosen, unless the department chair shall sooner resign or be removed from office. A department chair may be removed by the governing board or the Medical Executive Committee.

11.3-4 DUTIES

The department chair shall:

(a) Be responsible for all administratively related activities of the department, unless otherwise provided by the hospital, and be accountable to the medical director and to the Medical Executive Committee for the effective operation of the department.

(b) Develop, implement, and maintain the department's quality control programs as appropriate.

(c) Have continuing surveillance of the professional performance of all individuals who have delineated clinical or practice privileges in the department.

(d) Make recommendation for a sufficient number of qualified and competent persons to provide care, treatment, and services.

(e) Determine the qualifications and competency of department service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services and transmit information to appropriate authorities.

(f) Recommend to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department; participate in the evaluation of practitioners practicing within the department and transmit to the appropriate authorities the department's recommendations concerning membership appointment, clinical privileges, classification, reappointment, monitoring and proctoring, and corrective action.

(g) Be responsible for orientation and continuing education of all persons in the department or service.

(h) Make an evaluation of the health status for initial appointments, reappointments and/or clinical privileges. In those instances where there is doubt about an applicant's health, an evaluation by someone other than the applicant's department chair or vice chair may be necessary to resolve the issue. The request for such an evaluation will rest with the Medical Executive Committee.

(i) Develop and implement policies and procedures that guide and support the provision of care, treatment and services.

(j) Be responsible for all clinically-related activities of the department and exercise general supervision of all clinical work performed within the department, including review of medical records.

(k) Act as the presiding officer at all departmental meetings.

(l) Have oversight responsibility for each of the department division's quality assessment/improvement activities if applicable.

(m) Assess and recommend to the relevant hospital authority off-site resources for needed patient care services not provided by the department/service or the hospital.

(n) Integration of the department or service into the primary function of the hospital.

(o) Recommends space and other resources needed by the department or service.

(p) Provides continuous assessment and improvement of the quality of care, treatment, and services.

(q) Coordination and integration of inter-department and intra-department services.

(r) Perform other duties commensurate with the office as may from time to time be reasonably requested by the medical director, the Medical Executive Committee or the governing board.

11.4 DEPARTMENT VICE CHAIR

11.4-1 QUALIFICATIONS

The department vice chair shall be a member of the active medical staff and shall be qualified by licensure, training, experience and demonstrated ability in at least one of the clinical areas covered by the department. The department vice chair shall be certified by an appropriate specialty board or recognized equivalent. The department vice chair shall be willing and able to faithfully discharge the functions of the position. In the event that there is no qualified active staff member, a provisional vice chair may be elected to perform the functions of the department.

11.4-2 SELECTION

The department vice chair shall be elected by the department members who are eligible to vote for general officers of the medical staff with the concurrence of hospital administration and the Medical Executive Committee. The election of the vice chair shall occur at the departmental meeting and only active staff members of the department may vote.

11.4-3 TERM OF OFFICE

The department vice chair shall serve a two (2) year term that coincides with the medical staff year or until a successor is chosen, unless the vice chair shall sooner resign, be removed from office, or lose medical staff membership in that department. A department vice chair shall be eligible to succeed himself/herself.

11.4-4 REMOVAL

A department vice chair may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. The request of the removal of a department vice chair from office may be initiated by the Medical Executive Committee or by written request from the majority members of that department who are eligible to vote. The request of the removal maybe effected by a majority vote of the Medical Executive Committee and a majority vote of the department members eligible to vote on department matters. Voting shall be by secret mail ballot as defined in Article XV, Section 15 13 and ballots shall be sent to those eligible to vote within forty-five (45) days after the initiation of removal pursuant to this section. The ballots must be received no later than twenty one (21) days after they are mailed and

shall be counted by the chief of medical staff, the secretary-treasurer, and the medical staff services administrative supervisor. Removal shall be effective upon the approval of the Medical Executive Committee.

11.4-5 DUTIES

The department vice chair shall have the following authority, duties, and responsibilities:

(a) Serve on the Medical Executive Committee and give guidance on the overall medical policies of the medical staff and hospital and make specific recommendations and suggestions regarding the department.

(b) Assist the department chair in ongoing review of the professional performance of all practitioners granted clinical privileges in the department and report thereon to the Medical Executive Committee.

(c) Assist the department chair in the enforcement of the hospital and medical staff bylaws, rules and regulations, and policies within the department, including initiation of corrective action, and investigation of clinical performance and consultation orders when necessary.

(d) Assist the department chair in implementation of department actions taken by the Medical Executive Committee and the governing board.

(e) Assist the department chair in administration of the department, including cooperation with nursing service and hospital administration.

(f) Assist the department chair in the preparation of such annual reports, including budget planning, relating to the department as may be required by the Medical Executive Committee or the governing board.

(g) Serve as an ex-officio member of all committees in the department and give guidance and help when needed.

(h) Available for consultation in the vice chair's field.

(i) Represent the department in a medical advisory capacity to hospital administration.

(j) Perform other duties commensurate with the office as may from time to time be reasonably requested by the department chair, the chief of medical staff, the Medical Executive Committee or the governing board.

11.5 DIVISION/SUBDIVISION CHAIR

11.5-1 QUALIFICATIONS

The division/subdivision chair shall be a member of the active medical staff and a member of the division/subdivision that the practitioner is to head. The chair shall be qualified by licensure, training, experience, interest and demonstrated current ability in the clinical area covered by the division/subdivision and shall be willing and able to discharge the administrative responsibilities of the office. The division/ subdivision chair shall be certified by an appropriate specialty board or affirmatively established through the Credentials Committee that the individual possesses comparable competence based on the practitioner's practice. In the event that there is no qualified active staff member, a

provisional division/subdivision chair shall be appointed to perform the functions of the division/subdivision.

11.5-2 SELECTION

The department chair may, with the concurrence of administration, appoint a physician to act as the chair of a division or subdivision. The division/subdivision chair will be responsible to the department chair.

11.5-3 TERM OF OFFICE

The division/subdivision chair shall serve commencing on appointment and shall serve until a successor is chosen, unless the division/subdivision chair shall sooner resign or be removed from office.

11.5-4 DUTIES

The division/subdivision chair shall perform the functions assigned by the department chair. Such functions may include, without limitation:

(a) Retrospective patient care reviews.
(b) Continuous evaluation and monitoring of patient care practices.
(c) Credentials review and recommendation, privileges delineation, monitoring and proctoring.
(d) Continuing education programs.

ARTICLE XII

COMMITTEES

12.1 GENERAL

The medical staff organization shall have a Medical Executive Committee and such other committees as are necessary to carry out the functions of the medical staff. At a minimum these functions shall include executive review, credentialing, medical records, tissue review, utilization management, infection control, performance improvement and patient safety, and assisting the medical staff members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation service. The composition, officers, duties and meetings of the Medical Executive Committee are described in Section 12.2. Other medical staff committees are described in committee descriptions, which must be approved by the Medical Executive Committee. Committee descriptions are maintained in the Medical Staff Committees and Functions Manual. Committee descriptions must, at a minimum, describe the purpose of the committee, regulatory requirements, composition (including voting and non-voting members), reporting relationships, quorum requirements and committee responsibilities. The committees named in the Medical Staff Committees and Functions Manual shall be constituted as committees of the medical staff.

Unless otherwise specified in the committee description, the chairs and members of all medical staff committees shall be appointed by the chief of medical staff, after consultation with and approval by the Medical Executive Committee. Medical staff committees shall ultimately report to and be responsible to the Medical Executive Committee.

12.1-1 AD HOC COMMITTEES

Ad hoc committees may be created by the Medical Executive Committee to perform specified tasks. These committees shall terminate at the end of the medical staff year unless renewed by the Medical Executive Committee. The membership of an ad hoc committee shall be appointed by the chief of medical staff, after consultation with and approval by the Medical Executive Committee.

12.1-2 TERMS AND REMOVAL OF COMMITTEE CHAIRS

Unless otherwise specified in the committee description, committee chairs shall be appointed for a term of two (2) medical staff years, and shall serve until the end of this period or until a successor is appointed, unless the chair shall sooner resign or be removed from the committee. Committee chairs may be reappointed. Committee chairs are encouraged to accrue expertise in the area of their committee purview.

12.1-3 TERMS AND REMOVAL OF COMMITTEE MEMBERS

Unless otherwise specified in these bylaws or in the committee description, a committee member's term shall be for two (2) medical staff years, and the member shall serve until the end of this period or until a successor is appointed, unless the member shall sooner resign or be removed from the committee. Any committee member appointed by the chief of medical staff may be removed by a majority vote of the Medical Executive Committee. The removal of any committee member who is automatically assigned to a committee because the individual is a general officer or other official shall be governed by the provisions pertaining to removal of that officer or official.

12.1-4 VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that of an individual who obtains membership by virtue of these bylaws is removed for cause, a successor may be selected by the Medical Executive Committee.

12.1-5 CONDUCT AND RECORDS OF MEETINGS

Committee meetings shall be conducted and documented in the manner specified in Article XIII (Meetings).

12.2 MEDICAL EXECUTIVE COMMITTEE (MEC)

12.2-1 COMPOSITION

The Medical Executive Committee shall consist of the chief of medical staff, the immediate past chief of medical staff, the chief of medical staff-elect, the secretary-treasurer, the medical director, the and the vice chair and chair of clinical departments. When the department vice chair and chair are both present at the meeting, only one vote will be cast, with the vice chair having the vote. When either the chair or vice chair is also an elected officer of the medical staff (i.e., chief of medical staff, immediate past chief of medical staff, chief of medical staff-elect, or secretary-treasurer), their presence and vote will be counted as an elected officer of the medical staff. The chief executive officer or designee and the chief nursing officer shall be ex-officio members without the power to vote. The associate medical director shall serve as medical director designee (with vote) in the absence of the medical director.

12.2-2 OFFICERS

The chief of medical staff, the chief of medical staff-elect, and the secretary-treasurer shall serve as chair, vice chair, and secretary-treasurer of the Medical Executive Committee, respectively.

12.2-3 DUTIES

Duties of the Medical Executive Committee include, but are not limited to the following:

(a) Recommendations made directly to the governing board pertaining to the following:

(1) The structure of the medical staff.

(2) The mechanism used to review credentials and to delineate individual clinical privileges.

(3) Recommendations regarding medical staff initial appointments, reappointments, and clinical privileges for eligible individuals.

(4) The organization of quality care activities of the medical staff as well as the mechanism used to conduct, evaluate and revise such activities.

(5) The mechanism in which membership on the medical staff may be terminated.

(6) The mechanism for fair hearing procedures.

(7) The MEC's review of actions on reports of medical staff committees, departments, and other assigned activity groups.

(b) Represent and empowered to act on behalf of the medical staff between meetings of the organized medical staff.

(c) Coordinate and implement the professional and organizational activities and policies of the medical staff.

(d) Upon good cause, and in consultation with hospital administration, eliminate, establish and determine the composition and duties of medical staff committees. Said actions shall be incorporated into the Medical Staff Committees and Functions Manual as approved by the Medical Executive Committee.

(e) Participate in the development of medical staff and hospital policy, practice and planning.

(f) Take reasonable steps to promote ethical conduct and competent clinical performance on part of all members and AHPs to the extent required by these bylaws, including the initiation of and participation in medical staff corrective or review measures when warranted.

(g) Fulfill the medical staff's accountability to the governing board for medical care rendered to patients at the hospital.

(h) Take reasonable steps to develop continuing education activities and programs for the medical staff.

(i) Report to the medical staff at the regular staff meeting.

(j) Assure the medical staff is informed about the accreditation program and status of the hospital, and assist in obtaining and maintaining of hospital accreditation.

(k) Evaluate the medical care provided to patients at the hospital.

(l) Receive and review reports and recommendations of the Environment of Care Committee, including methods for the protection and care of patients and others in the event of internal or external disaster.

(m) Appoint 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.

(n) Request evaluation of practitioners privileged through the medical staff process in instances where there is doubt about a practitioner's ability to perform the privileges requested.

(o) Perform other functions as may be assigned to it by these bylaws, the medical staff or the governing board.

(p) Affirmatively implement, enforce, and safeguard the self-governance rights of the medical staff to the fullest extent permitted by law; such rights of the medical staff include, but are not limited to, the ability to retain and be represented by independent legal counsel at the expense of the medical staff.

By action of 2/3 of the medical staff members present and entitled to vote, the medical staff may, at a regular or special meeting, pursuant to Section 13.1, at which a quorum is achieved, remove and reassign a duty or duties delegated to the Medical Executive Committee for a stated period of time, for a reason identified and supported by the meeting.

12.2-4 MEETINGS

The MEC shall meet as often as necessary, but at least ten (10) times a year, and shall maintain a record of its proceedings and actions. Fifty (50) percent of the membership shall constitute a quorum. The requirements for a quorum of the Medical Executive Committee shall be bifurcated. In order to meet urgent requirements of any department for credentialing and granting of clinical privileges or when necessary to meet requirements of any regulatory agency, a meeting of the MEC may be called by any medical staff officer, and three (3) members will be sufficient to constitute a quorum. Any actions taken will be reported at the next regularly scheduled MEC meeting.

ARTICLE XIII

13-1 MEETINGS

13.1-1 ANNUAL STAFF MEETING

There shall be an annual meeting of the medical staff held in June. The election of officers shall take place at this meeting on a biennial basis as required by these bylaws. The chief of medical staff shall report on actions taken by the Medical Executive Committee

during the preceding year and on matters believed to be of interest and value to the members. Notice of this meeting shall be given to the members at least twenty (20) days prior to the meeting. The chief of medical staff shall preside at this meeting. Attendance at the Annual Staff Meeting will be strongly encouraged of all active staff members.

13-1-2 AGENDA

The order of business shall be determined by the chief of medical staff and the Medical Executive Committee. The agenda shall include, at a minimum:

(a) Review and acceptance of the minutes of the last Annual Staff Meeting and all special meetings held since the last Annual Staff Meeting.

(b) Administrative reports from the chief of medical staff, the medical director, departments, committees, and the hospital director.

(c) Election of officers when required by these bylaws.

(d) Reports by responsible officers, committees, and departments on the overall results of patient care audit and other quality review, evaluation, and monitoring activities of the medical staff and on the fulfillment of the other required staff functions.

(e) Recommendations for improving patient care at the hospital.

(f) Old Business.

(g) New Business.

13.1-3 SPECIAL MEETINGS

Special meetings of the medical staff may be called at any time by the chief of medical staff or the Medical Executive Committee, or shall be called upon the request of ten percent (l0%) of the active medical staff members. The Medical Executive Committee, upon written request of the governing board, shall call a special meeting of the medical staff. The person calling or requesting the special meeting shall state the purpose of such a meeting in writing. The meeting shall be scheduled by the Medical Executive Committee within thirty (30) days after receipt of such request. No later than seven (7) days prior to the meeting, notice shall be mailed or delivered to the members of the staff which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

13.2 COMMITTEE AND DEPARTMENT MEETINGS

13.2-1 REGULAR MEETINGS

Committees and departments, by resolution, may be provided the time for holding regular meetings and no notice other than such resolution shall then be required.

13.2-2 SPECIAL MEETINGS

A special meeting of any medical staff committee, department or division may be called by the chair thereof, the Medical Executive Committee or the chief of medical staff, and shall be called by written request of one-third of the current members of the medical staff that are eligible to vote.

13.3 NOTICE OF MEETINGS

When notice stating the place, day, and hour of any regular or special medical staff meeting or of any regular or special committee or department meeting not held pursuant to resolution shall be delivered either personally or by mail to each person entitled to be present thereat not less than seven (7) days nor more than twenty (20) days before the date of such meeting, in the manner specified in Section 15.10, hereof. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

13.4 QUORUM

13.4-1 DEPARTMENT AND COMMITTEE MEETINGS

The number of active staff members present at any meeting shall constitute a quorum, said quorum shall apply to regular, department, division and committee meetings for which proper notification has been given to all voting members, except as otherwise specified in these bylaws or in the Medical Staff Committees and Functions Manual.

13.4-2 ANNUAL STAFF MEETING

The presence of 51% of the total members of the active medical staff at any regular or special meeting of the medical staff shall constitute a quorum for the purpose of removing and reassigning a duty or duties delegated to the Medical Executive Committee. For all other actions, the number of active staff members present at any regular or special meeting of the medical staff shall constitute a quorum.

13.5 MANNER OF ACTION

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

13.6 MINUTES

Minutes of all meetings shall be prepared and retained as specified in these bylaws and in the Medical Staff Committee and Department Meetings Policy and Procedure. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters. The minutes shall be signed by the presiding officer of the meeting and forwarded to the Medical Executive Committee. Each committee and department shall maintain a file copy of its minutes. The Medical Staff Services Office shall be responsible for maintaining the original set of department and standing committee minutes.

13.7 ATTENDANCE REQUIREMENT

13.7-1 REGULAR ATTENDANCE

The active staff member shall be strongly encouraged to attend:

(a) The Annual Medical Staff meeting.
(b) General medical staff meetings duly convened pursuant to these bylaws.
(c) Meetings of the department, division, and committee of which the practitioner is a member.

All members of the medical staff shall be encouraged to attend departmental meetings, the Annual Medical Staff meeting, and to participate in scientific presentations of the medical staff.

13.7-2 ABSENCE FROM MEETINGS

Any member who is compelled to be absent from any medical staff, department, division, or committee meeting shall promptly provide to its regular presiding officer thereof the reason for such absence.

13.7-3 SPECIAL APPEARANCE

A member shall be notified, in advance, when his/her patient's clinical course of treatment is scheduled for discussion at a regular department, division, or committee meeting. If an apparent or suspected deviation from standard clinical practice is involved, notice shall be sent to the member by certified mail, return receipt requested, at least seven (7) days prior to the meeting, Said notice shall include the time and place of the meeting, a statement of the issue involved and that the member's appearance is mandatory. If a member fails to appear at any meeting for which notice was given, unless excused by the Medical Executive Committee on a showing of good cause, all or such portion of the member's clinical privileges, as the Medical Executive Committee shall direct, shall be automatically suspended. This suspension shall remain in effect until the matter is resolved by subsequent action of the Medical Executive Committee as provided in Section 8.2-5.

13.8 CONDUCT OF MEETINGS

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

ARTICLE XIV
CONFIDENTIALITY, IMMUNITY, AND RELEASES

14.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising clinical privileges (or practice privileges) at this hospital, an applicant:

(a) Authorizes representatives of the hospital and the medical staff 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 and hospital.

(c) Agrees to be bound by the provisions of this article and to waive all legal claims against any representatives of the medical staff or the hospital who acts in accordance with the provisions of this article.

(d) Acknowledges that the provisions of this article are express conditions to an application for medical staff membership, the continuation of such membership, and to the exercise of clinical privileges at this hospital.

(e) Acknowledges medical staff participation with the hospital in an Organized Health Care Arrangement (OHCA) under the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA), and agrees to be bound by the provisions of the Notice of Privacy Practices given to hospital patients when they access care at any hospital and county affiliated facility.

14.2 CONFIDENTIALITY OF INFORMATION

14.2-1 GENERAL

Medical staff, department, division and committee minutes, files, records, and oral discussions, including information regarding staff members or applicants to this medical staff, including AHPs, collected or prepared for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality or contributing to clinical research, shall be confidential to the fullest extent permitted by law. Dissemination of this information and these records shall only be made when expressly required by law, pursuant to officially adopted policies of the medical staff and the hospital or, if no officially adopted policy exists, only with the express approval of the Medical Executive Committee or the governing board. This information shall be 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.

14.2-2 BREACH OF CONFIDENTIALITY

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

14.2-3 CONFIDENTIALITY AGREEMENT

By signing the application form for appointment or reappointment to the medical staff, or by participation in medical staff activities, a practitioner agrees to be bound by both this

article and the following statement of hospital policy, which is in amplification, and not limitation, of other parts of this article.

Confidentiality is vital to the free, open and candid discussions necessary for medical staff quality assessment and peer review activities designed to improve the quality of care at the hospital. The medical staff member's participation in such activities is in reliance on the confidential treatment of those activities by all members of the medical staff and other individuals involved. For these reasons, a practitioner agrees to keep confidential all information (oral or written) communicated in connection with medical staff quality assessment and peer review activities. Disclosure of such information except as specifically required by law, pursuant to medical staff and hospital policy, to law enforcement agencies, or to professional or institutional licensing agencies, is prohibited. Corrective action including suspension or termination of medical staff membership or eligibility to hold office, to serve on committees, or to hold clinical privileges may be taken against any practitioner who fails to maintain the confidentiality of such information. Agreement to keep medical staff information confidential is a material condition to appointment or reappointment to the medical staff. The practitioner agrees to notify the medical staff of any request or demand made (whether by subpoena or otherwise) to disclose confidential information related to the practitioner's participation as a member of the staff or any committee thereof, and agrees to not voluntarily disclose confidential medical staff information except as specifically provided in this article. The practitioner further agrees that the medical staff or the hospital may seek to enjoin his/her violation of this article if necessary.

14.3 IMMUNITY FROM LIABILITY

14.3-1 FOR ACTION TAKEN

The representative of the medical staff and hospital shall be exempt from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the medical staff or hospital.

14.3-2 FOR PROVIDING INFORMATION

The representative of the medical staff and hospital and all third parties, acting pursuant to these bylaws, shall be exempt from liability to an applicant or member for damages or other relief by reason of providing information, actions taken or statements or recommendations made within the scope of duties, or for providing information concerning any person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this hospital.

14.4 ACTIVITIES AND INFORMATION COVERED

14.4-1 ACTIVITIES

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

(a) Applications for appointment and reappointment, clinical privileges (practice privileges) and prerogatives and periodic reappraisals of members' status, privileges, and/or prerogatives.

(b) Corrective action.

(c) Hearing and appellate reviews.

(d) Utilization reviews.

(e) Other department or division, committee, or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

(f) The National Practitioner Data Bank queries and reports, peer review organizations, the Medical Board of California, and similar reports.

14.5 RELEASES

The applicant or member shall, on the request of the medical staff or hospital, execute general and specific releases in accordance with the express provisions and general intent of this article. The execution of such releases shall not be deemed a prerequisite to the effectiveness of this article.

ARTICLE XV
GENERAL PROVISIONS

15.1 BYLAWS, RULES AND REGULATIONS, POLICIES AND GOVERNING BOARD BYLAWS

The medical staff bylaws, rules and regulations, policies and procedures, and the governing board bylaws do not conflict.

15.1-1 MEDICAL STAFF RULES AND REGULATIONS

The medical staff shall initiate and adopt such rules and regulations as it may deem necessary and shall periodically review and revise its rules and regulations to comply with current medical staff practice. Recommended changes to the rules shall be submitted to the Medical Executive Committee for review and approval. Following approval by the Medical Executive Committee, a rule and regulation shall become effective following approval of the governing board. Neither the medical staff nor the governing body may unilaterally amend the medical staff bylaws or rules and regulations. Applicants and members of the medical staff shall be governed by such rules and regulations as are properly initiated and adopted. If there is a conflict between the bylaws and the medical staff rules and regulations, the bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the medical staff rules and regulations.

15-1-2 DEPARTMENTAL RULES AND REGULATIONS

Each department shall formulate its own rules and regulations for the conduct of its affairs and for the supervision of the house staff. Departmental rules and regulations will be reviewed and amended periodically. Proposed changes to the departmental rules shall be submitted to the Medical Executive Committee for review and approval and then to the governing board for review and approval. Departmental rules and regulations shall be consistent with these bylaws, the general rules and regulations of the medical staff, and other policies of the hospital.

15.3 MEDICAL STAFF COMMITTEES AND FUNCTIONS MANUAL

The Medical Executive Committee shall initiate and adopt committee descriptions for all

medical staff standing and ad hoc committees. The committee descriptions shall be periodically reviewed and revised to comply with current medical staff practice and regulatory requirements. Recommended changes to the Medical Staff Committees and Functions Manual shall be submitted to the Medical Executive Committee for review and approval.

The Medical Staff Committees and Functions Manual shall be submitted annually to the governing board for review and approval.

The Medical Executive Committee may make periodic changes in the Medical Staff Committees and Functions Manual in the intervals between the annual governing board review and approval. These changes shall be to reflect current medical staff organization practice and to remain in compliance with regulatory requirements.

15.4 CREDENTIALING POLICIES AND PROCEDURES MANUAL

This manual describes the process for credentialing, re-credentialing, and privileging licensed independent practitioners and allied health professionals, including the process for appointment and reappointment to membership on the medical staff. Other processes included in the manual are the granting of temporary privileges and emergency disaster privileges, provisional evaluation, focused professional practice evaluation, etc. This manual is reviewed periodically by the Credentials Committee of the medical staff organization and recommendations for revisions are forwarded to the Medical Executive Committee and the governing board for approval and adoption.

15.5 MEDICAL STAFF POLICIES AND PROCEDURES MANUAL

This manual describes the policies and procedures of the medical staff including the process for resolving conflicts between the medical staff and the Medical Executive Committee, impaired physicians, etc. This manual is reviewed periodically by the Bylaws Committee and recommendations for revisions are forwarded to the Medical Executive Committee and the governing board for approval and adoption.

15.6 FEES/DUES

All members of the medical staff and allied health staff, except for Honorary staff, shall be required to pay biennial fees/dues, unless waived by the Medical Executive Committee. Fees/dues shall become delinquent if not paid within 30 days from when notice is sent for payment. A failure to pay fees/dues shall result in those actions specified in Section 8.3-5 (Failure to Pay Dues/Assessments). The Medical Executive Committee shall have the power to set the amount of fees/dues for each medical staff category, the amount of the processing fee for initial application, application for temporary privileges, and reapplication, and the amount to be paid by a practitioner whenever any unusual expenses are involved. The Medical Executive Committee shall determine the expenditure of all medical staff funds.

15.7 CONSTRUCTION OF TERMS AND HEADINGS

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

15.8 AUTHORITY TO ACT

Action of the medical staff in relation to any person other than the members thereof shall be expressed only through the chief of medical staff or the Medical Executive Committee, or its designee, and they shall first confer with the hospital director. Any member or members who act in the name of the medical staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee or governing board may deem appropriate.

15.9 ACCEPTANCE OF PRINCIPLES

The member regardless of class or category, by application for medical staff membership, agrees to be bound by the provisions of these bylaws, a copy of which shall be delivered to the member upon request for an initial medical staff application, and thereafter a copy of all amendments to be promptly delivered after adoption. Any violation of these bylaws shall subject the applicant or member to such disciplinary action as the Medical Executive Committee or governing board may deem appropriate.

15.10 DIVISION OF FEES

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

15.11 MEDICAL STAFF REPRESENTATION BY LEGAL COUNSEL

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

15.12 NOTICES

Except where specific notice provisions are otherwise provided in these bylaws, any and all notices, demands, requests, or other communications required or permitted to be mailed, pursuant to these bylaws, shall be in writing, properly sealed, and shall be sent through the United States Postal Service, first-class postage prepaid, certified or registered, return receipt requested. In the case of notice to the hospital, governing board, medical staff or its officers or committees, the notice shall be addressed as follows:

Riverside County Regional Medical Center
26520 Cactus Avenue
Moreno Valley, CA 92555

Mailed notices to a member, applicant, or other party shall be to the addressee at the address as it last appears on the official records of the medical staff or the hospital. If personally delivered, such notice shall be effective upon delivery. If mailed as provided above, such notice shall be effective two (2) days after it is placed in the mail. Any party may change its address as indicated above, by giving written notice of such change to the other party in the manner as above indicated.

15.13 SECRET WRITTEN BALLOT

Whenever these bylaws require a secret, mail ballot vote, the mail ballots shall be returned in an unmarked envelope. The ballot shall be placed inside a properly identified return envelope, and the staff member will print and sign his/her name. The staff member's name shall be verified against the medical staff records.

ARTICLE XVI
ADOPTION AND AMENDMENT OF BYLAWS

16.1 ADOPTION AND AMENDMENT

The medical staff adopts and amends medical staff bylaws, rules and regulations. The adoption or amendment of medical staff bylaws cannot be delegated.

The medical staff bylaws will be reviewed periodically. These bylaws may be adopted, amended, or repealed at any regular or special meeting of the medical staff, provided that notice of such business is sent to all members no later than twenty (20) days before such meeting. The notice shall include the exact wording of the proposed addition or amendment, if applicable, and the time and place of the meeting. In order to enact a change, the affirmative vote of a majority of the active medical staff members present at the meeting shall be required. The amendment shall become effective when approved by the governing board. Neither the medical staff nor the governing board may unilaterally amend the medical staff bylaws or rules and regulations. The governing board shall approve and comply with the medical staff bylaws. The organized medical staff shall comply with and enforce the medical staff bylaws, rules and regulations, and policies.

The organized medical staff has the ability to adopt medical staff bylaws, rules and regulations, policies, and amendments thereto, and to propose them directly to the governing board.

If the voting members of the organized medical staff propose to adopt a rule, regulation, or policy, or an amendment thereto, they first communicate the proposal to the Medical Executive Committee. If the Medical Executive Committee proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the medical staff; when it adopts a policy or an amendment thereto, it communicates this to the medical staff.

In cases of documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the Medical Executive Committee, as delegated by the voting members of the organized medical staff, may provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the medical staff will be immediately notified by the Medical Executive Committee. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment at the annual medical staff meeting. If there is no conflict between the organized medical staff and the Medical Executive Committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the Medical Executive Committee is implemented. If necessary, a revised amendment is then submitted to the governing body for action.

The organized medical staff has a process which is implemented to manage conflict between the medical staff and the Medical Executive Committee on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto. This process begins with the Conflict Management Committee. Nothing in the foregoing is intended to prevent medical staff members from communicating with the governing body on a rule, regulation, or policy adopted by the organized medical staff or the Medical Executive Committee. The governing body determines the method of communication.

16.2 TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Executive Committee shall have the power to adopt such amendments to the bylaws as are, in its judgment, technical modifications or clarifications, reorganization or renumbering of the bylaws, or amendments made necessary because of punctuation, spelling, or

other errors of grammar or expression, or inaccurate cross-references. Such amendments shall be effective immediately and shall be permanent if not disapproved by the medical staff or the governing board within 90 days after adoption by the Medical Executive Committee. The action to amend may be taken by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such amendments shall be communicated in writing to the medical staff and to the governing board.

ADOPTED by the Medical Staff on _____, 2015

Afshin Molkara, M.D., Chief Medical Officer **Dr. Arnold Tabuenca, Chief Medical**

APPROVED by the Governing Board on _____, 2015

Board of Supervisors of Riverside County

_____
Supervisor Marion Ashley, Chairman

FORM APPROVED COUNTY COUNSEL
BY: ANITA C. WILLIS 4-16-15 DATE

RULES AND REGULATIONS

The medical staff shall adopt such rules and regulations as may be necessary for the proper conduct of its work. The rules and regulations of the medical staff shall be adopted by the medical staff and approved by the governing board prior to becoming effective. Neither the medical staff nor the governing board may unilaterally amend the medical staff bylaws or rules and regulations.

1. **Assignment of Patients.** Patients shall be admitted only upon the order and under the care of a member of the medical staff of the hospital who is lawfully authorized to diagnose, prescribe and treat patients. The patient's condition and provisional diagnosis shall be established at the time of admission by the member of the medical staff who admits the patient. The house staff may perform these functions as outlined in the Rules and Regulations, Graduate Education Programs. The medical staff member shall be responsible for the following: the medical care and treatment of the member's patient at the hospital; the prompt completeness and accuracy of the medical record, including medical history and physical examination to be done not more than thirty (30) days prior to admission or within 24 hours after admission; for necessary special instructions; and for transmitting reports of the patient's condition to the referring practitioner and to the patient's relatives. If these responsibilities are transferred to another staff member, a note documenting the transfer of responsibility shall be entered on the order form of the medical record. Assignment of patient care duties shall be in accordance with departmental rules and regulations.

2. **Attending Staff Notes.** Each department attending staff member should use the Multidisciplinary Note to chart his/her notes and recommendations.

3. **Attending Staff Private Patient Charges.**

   (a) An attending staff member may admit and charge for identifiable services rendered to the member's private patients, including those under Medicare and Medi-Cal. An attending staff member may not charge for County indigent patients except to the extent that these patients are covered by Medi-Cal or other insurance. Identifiable medical services may be construed as those services normally provided to private patients, as evidenced by histories, physicals, progress notes, physician's orders, etc.

   (b) An attending staff member may charge the County of Riverside for special services rendered to indigent patients, who are referred to the member's private office by the hospital director, for services that the attending medical staff may deem important to patient care and not provided at this hospital.

4. **Autopsies.** All autopsies shall be obtained as specified in the *Protocol for Autopsy Request*, Administrative Patient Care Services Manual, Policy No. 653. An autopsy should not be performed without the proper written consent of the responsible relative or legal-authorized agent. All autopsies shall be performed by the hospital pathologist or by a physician delegated this responsibility. Also, refer to the Department of Clinical Laboratory and Anatomic Pathology, Policy No. 3.1, for additional direction.

5. **Clinic Patients.** Service patients referred to the hospital clinic solely for diagnostic laboratory studies shall be followed as hospital clinic patients.

6. **Consent Form.** Written, signed, and informed consent shall be obtained by the physician prior to the procedure except in those situations where the patient's life is in jeopardy and suitable signatures cannot be obtained due to the emergency condition of the patient. In an emergency, in which a consent cannot be immediately obtained, the circumstance should be fully explained on the patient's medical record. A consultation, in such instance, may be desirable before the emergency operative procedure is undertaken if time permits.

7. **Consultation Criteria.**

   Inpatient Consultation Criteria. The primary service shall request consultation as required for optimal patient care. In addition, each consulting department may indentify criteria that trigger automatic consultation to expedite care. Written consultation is considered complete only when signed/co-signed by the attending physician and placed in the medical record.

   Routine Consults. The consult should be completed within 24 hours of request unless otherwise agreed upon by the Primary Attending Physician and/or Consultant. The primary service will place a written order in the chart and also verbally notify the consultant. Notification of consult completion must occur. The consultant may ask a non-physician (i.e. nurse, unit clerk, etc.) to contact the primary service.

   Urgent/Emergent Consults. The consult will be performed as soon as possible to ensure patient safety but not to exceed 24 hours from time of request, unless specified by another policy. The primary service will place a written order in the chart and also verbally notify the consultant. The consultant will contact the primary attending or senior level resident and give verbal notification of consult completion and recommendations in addition to written recommendations.

8. **Drugs.** All drugs and medications administered to patients shall be those as listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or A.M.A. Drug Evaluation. Drugs for bona fide clinical investigations may be exceptions, and these shall be used in full accordance with the Statement of Principles Involved in the Use of Investigation Drugs in Hospitals and all regulations of the Federal Drug Administration. The hospital drug formulary is to be used for prescribing medicine. When drugs that are not listed on the hospital formulary are ordered for private patients, as signed for by the attending medical staff physician, said drugs will be secured and a special charge will be made to the patient.

9. **Graduate Education Programs**: The following shall apply to the hospital's graduation education programs:

   (a) The departments who participate in professional graduate education programs shall in their departmental rules and regulations and policies specify the mechanism by which house staff members are supervised by medical staff members in carrying out their patient care responsibilities.

   (b) The hospital shall not permit any physician, dentist, podiatrist, or resident, intern or student to perform any service for which a license, certificate or registration or other form of approval is required unless such person is licensed, registered, approved or exempted, unless such services are

performed under the direct supervision of a licensed practitioner wherever so required by law.

(c) If patient care is provided by residents, interns and medical students, such care shall be in accordance with the provisions of an approved program.

(d) Except in an emergency, all other patient care by interns, house officers, residents or persons with equivalent titles, not provided as specified in (c) of this section, must be provided by a practitioner with current license to practice in California.

(e) The departmental residency requirements are subject to review by the Graduate Medical Education (GME) Committee. The department shall present an annual report, outlining its residency requirements, to the GME Committee.

(f) House staff members may write orders as outlined in Records Authentication, Rule #28.

(g) The Family Medicine (FM) chair may assign residents to serve on medical staff committees. FM residents will serve on committees without the power to vote, unless otherwise specified in the Medical Staff Committees and Functions Manual.

10. **Medical History and Physical for Inpatient and Outpatient Services.** The components of a medical history and physical for inpatient and outpatient services shall be defined in accordance with the CPT standards for documentation for the specific levels of service provided. The organized medical staff shall monitor the quality of medical histories and physical examinations.

11. **Media Release.** Release of information concerning activities at Riverside County Regional Medical Center to the public media will be done only with the approval of hospital administration.

12. **Medical Record.** All patients' charts shall be completed fourteen (14) days after discharge. The summary of case sheet is to be completed at the time of discharge. The house staff and attending staff will be notified of the time frame for record completion as noted in the Medical Records Policy, No. 1300.1, *Chart Completion*. Also, see RCRMC Policy No. 600.3, *Patient Medical Records,* for additional information regarding components of a complete patient medical record, record authentication, timeliness, urgent/emergent care services, operative and high-risk procedures, summary/problem lists, discharge information, etc.

13. **Medical Records Property of the Hospital.** All medical records are the property of the hospital and shall not be removed from the hospital's jurisdiction and safekeeping except in accordance with a court order, subpoena or statute. In the case of multiple admissions, all of the patient's previous records shall be made available to the treating physician. This shall apply whether the same or another physician sees the patient. All medical records needed for patient care or review must be requested and issued in the computer by the medical records staff before removing them from the Medical Records Department. All medical records must be returned before the end of the day. Returned medical records can be placed on "hold" in the Medical Records Department/Chart Room if needed again the next day.

14. **Medical Screening Examination**: The depth of evaluation and level of expertise required to fulfill the Federal requirements to perform a Medical Screening Examination (MSE) is dependent on the patient's condition. Screening may be

performed by a RCRMC medical staff physician or by appropriately trained personnel or resident with oversight from the supervising attending physician. Refer to Administration Policy and Procedure Manual, Policy No. 600, "*Inpatient Admitting and Emergency Department Consultations*" and Policy No. 639, "*Evaluation Treatment and/or Transfer of RCRMC Emergency Patients.*"

15. **Medical Staff Requirement.** Each member of the medical staff shall be required to serve when called upon by the practitioner's department/division chair or vice chair. A staff member who fails to serve, as requested, shall be reported to the MEC for action. A staff member who does not comply with this requirement may be dropped from the medical staff.

16. **Notification of Attending Staff.** All seriously-ill patients shall be seen by a member of the attending medical staff as soon as possible after notification and, in all such cases, within 24 hours.

17. **Operative Record.** A report of all operations performed shall be immediately dictated by the attending or resident physician or a procedure progress note shall be immediately written and dictation done within 24 hours. All tissues, excluding those exempted by the department of Health Services, Program Flexibility, under Section 70129 (a), Title 22, California Administrative Code, that are removed during the operation shall be sent to the hospital pathologist. The pathologist shall perform examinations that may be considered necessary to arrive at a pathological diagnosis. The report shall be signed by the pathologist. (See RCRMC Policy No. 604, *Surgery and Operating Room Scheduling.*)

18. **Orders, Standing.** Standing orders may be formulated and may be changed as deemed necessary with the approval of the appropriate committees. Standing orders shall be signed by the house staff. Standing orders shall be posted or circulated to all patient units at the hospital and shall be a part of hospital manuals.

19. **Orders, Verbal.** Verbal orders (oral or by telephone) for administration of medications may be received and recorded by licensed health professionals who are expressly authorized under their practice acts to receive orders to administer drugs. This includes registered nurses, (RNs), pharmacists, physicians, physician assistants from supervising physician only, physical therapists (for certain topical drugs only), and respiratory therapists when the orders relate specifically to respiratory therapy. These orders are to be countersigned by the physician or any physician by the team caring for the patient within forty-eight (48) hours. (See RCRMC Policy No. 803, *Verbal/Telephoned Orders for Drugs.*)

20. **Orders, Written.** All orders shall be written, dated, timed and signed by the ordering physician. The physician's order must be written clearly, legibly and completely. Orders that are illegibly or improperly written will not be carried out until rewritten or understood by the nurse. All automatic cancellation of orders will be done in accordance with the policy of the Pharmacy & Therapeutic Committee.

21. **Patients' Bill of Rights.** In accordance with Section 70707 of the CA Administrative Code, the medical staff will agree to honor the list of Patients' Rights in California.

22. **Pregnancy Test.**

    (a) A negative pregnancy test result on any patient is mandatory prior to any procedure that might adversely affect a pregnancy, e.g.,

hysterosalpingogram, hysteroscopy, hysterectomy.

(b) A pregnancy test is desirable for any patient who might be pregnant prior to elective surgery, but may be waived at the attending physician's discretion.

(c) No case with any urgency should be delayed to await a pregnancy test result.

23. **Preoperative Procedures.** A complete medical history and physical examination must be performed within thirty (30) days prior to the patient's admission or within 24 hours after inpatient admission. For a medical history and physical examination that was performed within thirty (30) days prior to inpatient admission, an update documenting any changes in the patient's condition shall be completed within 24 hours after inpatient admission or prior to surgery. Appropriate screening tests, based on the needs of the patient, shall be accomplished and recorded in the patient's chart within 72 hours prior to the patient's surgery. As in the ASA (American Society of Anesthesiology) Class I and II patients, appropriate screening tests will be considered acceptable if done within seven (7) days prior to the patient's surgery. (See RCRMC Policies No. 600, *Inpatient Admitting and Emergency Department Consultations,* and No. 604, *Surgery and Operating Room Scheduling*.)

24. **Preoperative Record.** If a history and physical examination (to include blood pressure, urinalysis and blood count) is not completed and in the chart prior to the patient's operation, the operation shall be canceled unless the attending physician states, in writing, that such delay would constitute a hazard to the patient.

25. **Private Patients.** A private patient who is admitted to the hospital may be attended by the patient's private physician and by the resident assigned to the division or department. A physician, who admits a private patient to the hospital, shall provide information and orders necessary to adequately and completely record the management of the private patient. The hospital shall have the right, through the medical director or the chief of medical staff, to require the attending private physician to obtain a consultation through the chair of the relevant department or designee.

26. **Provisional Diagnosis.** Except in an emergency, a patient shall not be admitted to the hospital until after a provisional diagnosis has been stated. In the case of an emergency, the provisional diagnosis shall be stated as soon as possible after admission.

27. **Publications.** Case reports may be submitted to the chair of the appropriate department and the medical director rather than the IRB. All requests for permission to publish scientific papers, books or reports and photographs arising out of work performed at the hospital shall be in writing, utilizing the approved forms, stating the specific purposes for which the material will be employed, and shall be approved in writing by the chair of the relevant department before being presented to the Institutional Review Board Committee. These forms can be obtained from the chair of the IRB. No member shall offer for publication any scientific paper, book or report arising out of work done at the hospital without first securing approval of the Institutional Review Board Committee. All publications arising out of work done at the hospital shall give credit to the hospital. A copy of every article or book approved for publication shall be furnished to the medical director for inclusion in the medical library file devoted to contributions from the attending medical staff. A violation of any of the regulations of this rule, in regard to research of publication, shall subject the

offender to such disciplinary action as the Medical Executive Committee may deem appropriate. All newspaper and/or television releases must be approved by hospital administration.

28. **Records Authentication.** The attending physician shall be identified on the history and physical, consultation, operative report, discharge summary and labor and delivery note. The orders and discharge summary must be signed by a physician. A licensed physician must authenticate the history and physical, operative report and labor and delivery note. Medical records shall be authenticated in accordance with the laws and regulations applicable to the hospital in the manner set forth in the *Physician Reference Manual.*

29. **Research Projects.** Medical staff members, including residents and medical students shall not undertake any type of biomedical or clinical research project within the jurisdiction of this hospital without first obtaining approval of the Riverside County Regional Medical Center (RCRMC) Institutional Review Board (IRB) and the Medical Executive Committee (MEC). Research projects shall have the approval of the relevant department chair, the IRB, and the MEC respectively. A quarterly progress report will be reviewed by the IRB on all ongoing hospital research projects. Closure of a research project must be reported to the IRB within the quarterly progress report during which time the research was terminated. Retrospective Record Reviews by an outside source of funding shall not be undertaken without first obtaining approval of the RCRMC IRB Design Review Subcommittee (DRs).

30. **Responsibility for Private Patients.** When a physician has a private patient in the hospital, a history and physical examination may be performed by a member of the house staff unless specifically not requested by the attending physician treating the case. The attending physician is required to provide a medical history and physical examination on the private patient. A physician who has a private patient in the hospital will be expected to abide by the bylaws, rules and regulations.

31. **Restraint and/or Seclusion.** The procedures relating to restraint and/or seclusion are in the RCRMC Policies No. 630, 630.1 and 630.2 (Restraint and/or Seclusion) and shall apply to all units using restraint and/or seclusion.

32. **Retrospective Record Reviews**: Attending medical staff will encourage the use of the Design Review Subcommittee (DRs) of the RCRMC IRB to review and facilitate quality designee of proposed Retrospective Record Reviews at RCRMC. Any Retrospective Record Review to be done at RCRMC and that is to be funded by an outside source must have the review and approval of the DRs prior to start of the chart review.

33. **Sterilization.** The Obstetric-Gynecology Department, Family Medicine Department, and the Urology Division will each have a policy regarding sterilization that will include appropriate informed consent, and it will also comply with all existing state and federal statutes pertaining to this procedure.

34. **Suicide.** An attempted suicide or chemical overdose patient shall be offered psychiatric consultation and it will be documented in the patient's medical record.

35. **Surgery Schedule.** When a surgical operation is scheduled by a resident physician, it shall be only after consultation with the attending member of the involved service.

36. **Surgical Assistants.** When it is necessary that two members of the attending medical staff scrub on the same case, one of them shall act as the second assistant if a resident is available as the first assistant, unless in the opinion of the operating surgeon such an arrangement would not be in the best interest of the patient.

37. **Symbols and Abbreviations.** Only symbols and abbreviations approved by the medical staff shall be regularly used. A list of these shall be maintained by the Medical Records Department and shall be available to those authorized to make entries in the medical record.

38. **Tissue.** No tissue shall be removed from the hospital without the consent or permission of the pathologist and the medical director.

39. **Physician Reference Manual.** There shall be a reference manual to assist practitioners, allied health professionals, and physicians in training and orientation to various hospital units and functions.