

**Marin General Hospital**

**Medical Staff**

**Bylaws**

***Approved by: MGH Board of Directors – July 12, 2007***

MARIN GENERAL HOSPITAL  
MEDICAL STAFF BYLAWS

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**MARIN GENERAL HOSPITAL  
MEDICAL STAFF BYLAWS RULES & REGULATIONS**

**PREAMBLE**

These Bylaws are adopted in order to provide for the organization of the Medical Staff of Marin General hospital and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Directors ("Board"), and relations with applicants to and Members of the Medical Staff.

These Medical Staff Bylaws ("Bylaws") are adopted in recognition of the mutual accountability, interdependence and responsibility of the Medical Staff and the Board of the Hospital in protecting and enhancing the quality of care in the Hospital and are prepared for compliance with appropriate licensing and certification laws and accreditation standards. These Bylaws are not intended to, and do not constitute, an express or implied contract with any individual or entity unless otherwise expressly determined by state statute.

As part of its right to self government, the Bylaws address the Medical Staff's responsibility to establish criteria and standards for Medical Staff membership and Privileges, and to enforce those criteria and standards at initial appointment and at reappointment; they establish clinical criteria and standards to oversee and manage quality improvement; they describe the standards for selection and removal of Medical Staff officers; they address the Medical Staff's right to independent legal counsel, and they address the respective rights and responsibilities of the Medical Staff and the Board.

Finally, notwithstanding these Bylaws and the Medical Staff's responsibility for the quality of care in the Hospital, the Medical Staff acknowledges that the Board must act to protect the quality of care provided and the competency of the Medical Staff, and to ensure the responsible governance of the Hospital. In adopting these Bylaws, the Medical Staff commits to exercise its responsibilities with diligence and in good faith, and in approving these Bylaws, the Board commits that it will not assume a duty or responsibility of the Medical Staff unreasonably or in bad faith.

## **DEFINITIONS**

**ALLIED HEALTH PROFESSIONAL** means a duly licensed individual, other than a physician, clinical psychologist, dentist, or podiatrist, who is privileged to attend patients in the Hospital setting under the direction of the Medical Staff.

**BEHAVIOR DISRUPTIVE TO HOSPITAL OPERATIONS** means behavior which may compromise the quality of patient care, either directly or because it disrupts the ability of other professionals to provide quality care or interferes with the orderly conduct of the Hospital and has the potential to adversely affect patient care, either directly or indirectly.

**BOARD OF DIRECTORS** means the governing body of the Hospital.

**Chief Executive Officer** means the person appointed by the Board of Directors to act on its behalf in the overall management of the Hospital.

**CHIEF OF STAFF** means the Chief Officer of the Medical Staff elected by Members of the Medical Staff.

**CLINICAL PRIVILEGES** or **PRIVILEGES** means the permission granted to Medical Staff Members to provide patient care and includes unrestricted access to those Hospital resources (including equipment, facilities and Hospital personnel) which are necessary to effectively exercise those Privileges except that HOSPITAL may, through exclusive contracts, limit access to equipment and facilities to holders of an exclusive contract.

**DATE OF RECEIPT** means the date any Notice, Special Notice or other communication was delivered personally; or if such Notice, Special Notice or communication was sent by mail, it shall mean seventy two (72) hours after the Notice, Special Notice or communication was deposited, postage prepaid, in the United States mail.

**GOOD STANDING** means a Medical Staff Member is in good standing when, at the time of the assessment of standing, his/her membership and/or Privileges are not voluntarily or involuntarily limited, restricted, suspended, or otherwise encumbered for medical disciplinary cause or reason (excluding medical leaves of absence and participation in the Medical Board of California Diversion Program).

**HOSPITAL** means Marin General Hospital.

**MEDICAL EXECUTIVE COMMITTEE** means the executive committee of the Medical Staff which shall constitute the governing body of the Medical Staff as described in these Bylaws.

**MEDICAL STAFF** or **STAFF** means those physicians (M.D. or D.O.), dentists, podiatrists and clinical psychologists who have been granted recognition as Members of the Medical Staff pursuant to the terms of these Bylaws.

**MEDICAL STAFF YEAR** means the period from July 1 to June 30.

**MEMBER** means, unless otherwise expressly limited, any physician (M.D. or D.O.), dentist, podiatrist or clinical psychologist holding a current license to practice within the scope of that license who is a Member of the Medical Staff.

**PATIENT ENCOUNTER** means admitting or attending the patient, performing a procedure on the patient (inpatient or Hospital outpatient), consulting on a patient, actively participating in the care management of the patient, as determined by the Department Chair and as reflected in the Practitioner's notes in the medical record, or assisting at surgery.

**PHYSICIAN** means an individual with an M.D. or D.O. degree who is currently licensed to practice medicine.

**PRACTITIONER** - means an appropriately licensed Physician, dentist, Oral Surgeon, clinical psychologist, or podiatrist. In the context of corrective action and fair hearings pursuant to Article VIII, it shall also include those categories of licentiates described at California Business and Professions Code Section 809(b).

**SPECIAL NOTICE** means the transmission of information is deemed conveyed when 1) placed in the mail via the United States Postal Service, certified or registered mail, return receipt requested, to the Staff Member's or applicant's address on file at the Hospital, 2) faxed to the Member's or applicant's current fax number and telephone or printed confirmation of receipt is obtained (noting the name of the confirming individual when confirmed by telephone), and placed in regular mail, or, 3) when personally delivered to the Member or the applicant.

**SYSTEM** means Sutter Health.

**SYSTEM AFFILIATE** means a facility or entity (such as an affiliated hospital, urgent care center, surgery center, foundation or other entity) that is part of the System.

**TELEMEDICINE** means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video, or data communications. Neither a telephone conversation nor an electronic message between a health care Practitioner and patient constitutes "telemedicine" for purposes of this section. For purposes of this definition, "interactive" means an audio, video or data communication involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information.

## ARTICLE I

### NAME, PURPOSE AND AUTHORITY

#### 1.1 NAME

The name of this organization is the Medical Staff of Marin General Hospital.

#### 1.2 PURPOSE

The purposes of this organization are:

- (a) To promote and maintain high quality patient care that is commensurate with available resources for all patients treated in any facilities or services of the Hospital;
- (b) To strive to maintain and improve the quality of care rendered by all Practitioners authorized to practice in the Hospital through an appropriate delineation of Clinical Privileges and through an ongoing review and evaluation of each Practitioner's performance in the Hospital;
- (c) To support an educational program which furthers medical education and leads to continuous advancement in professional knowledge and skill;
- (d) To initiate and maintain the Rules and Regulations and Policies and Procedures of the Medical Staff;
- (e) To provide for self-government of the Medical Staff by initiating and maintaining Bylaws and Rules and Regulations;
- (f) To strive for cooperation between all clinical services;
- (g) To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Board and the Administration;
- (h) To provide care and access to services in a manner which does not discriminate on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or

sexual orientation; age; economic status; political affiliation or any other protected category;

- (i) To facilitate Medical Staff representation and participation in Hospital deliberations affecting the discharge of Medical Staff responsibilities.

### **1.3 MEDICAL STAFF RIGHT TO SELF-GOVERNANCE**

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

- (a) Establish in these Bylaws and Rules and Regulations the criteria and standards for Medical Staff membership and Privileges, and enforcing those criteria and standards;
- (b) Establish in the Bylaws and Rules and Regulations clinical criteria and standards to oversee and manage quality improvement, utilization review and other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff and its committees and Clinical Services and review and analysis of patient medical records;
- (c) Select and remove Medical Staff Officers;
- (d) Assess Medical Staff dues and utilization of the Medical Staff dues as appropriate for the purposes of the Medical Staff;
- (e) The ability to retain and be represented by independent legal counsel at the expense of the Medical Staff; and
- (f) Initiate, develop and adopt Medical Staff Bylaws, Rules and Regulations, and amendments thereto, subject to the approval of the Board, which approval shall not be unreasonably withheld.

### **1.4. DISPUTE RESOLUTION**

With respect to any dispute regarding the Medical Staff's rights of self-governance and/or discharge of Medical Staff responsibilities, the Medical Staff and the Board shall meet and confer in good faith to resolve the dispute. The forum established in these Bylaws for this meet and confer obligation is the Joint Conference Committee; however, the Medical Staff and the Board can utilize additional or different forums or processes, such as mediation, so long as both the Medical

Staff and the Board mutually agree to the forum or process as well as any procedures that would govern the meet and confer function. Whenever any person or entity, including the Board, has engaged in, or is about to engage in, acts or practices that hinder, restrict or obstruct the Medical Staff's ability to exercise its rights, obligations or responsibilities, the Medical Staff may apply for, and the Superior Court of the County in which the Hospital is located, may issue an injunction, writ of mandate or other appropriate order. Prior to seeking judicial relief, the Medical Staff must first make a reasonable effort to resolve the dispute, including the pursuit of any reasonable administrative remedies provided in these Bylaws.

### **1.5 HEALTH SYSTEM AFFILIATION**

This Hospital is part of or affiliated with the System. One of the purposes of the System is to maintain comparably high professional standards among its patient care facilities and to strive to provide efficient patient care and support services. In keeping with the foregoing, cooperative credentialing, peer review, remedial action and procedural rights are hereby authorized in accordance with the guidelines in these Bylaws.

### **1.6 CREDENTIALING**

The Medical Staff may enter into arrangements with other System Affiliates or other NCQA approved Central Verification Organizations to assist it in credentialing activities. This may include, without limitation, relying on information in other System Affiliates' credentials and peer review files in evaluating applications for appointment and reappointment, and utilizing the other System Affiliates medical or professional staff support services to process or assist in processing applications for appointment and reappointment.

### **1.7 PEER REVIEW**

The Medical Staff may enter into arrangements with other System Affiliates and/or other hospitals or peer review bodies to assist it in peer review activities. This may include, without limitation, relying on information in other System Affiliates' credentials and

peer review files, and utilizing the other System Affiliates' medical or professional staff support resources to conduct or assist in conducting peer review activities.

### **1.8 REMEDIAL ACTION**

The Medical Staff may work cooperatively with any other System Affiliates at which a Medical Staff Member holds Privileges to develop and impose coordinated, cooperative or joint remedial action measures as deemed appropriate to the circumstances. This may include, but is not limited to, giving timely notice of emerging or pending problems, as well as notice of remedial actions imposed.

### **1.9 FINAL AUTHORITY**

The Medical Staff shall be responsible to the Board of Marin General Hospital for the quality of medical care and ethical standards of practice of its Members in the Hospital.

## **ARTICLE II**

### **MEMBERSHIP**

#### **2.1 NATURE OF MEMBERSHIP**

Medical Staff membership is a privilege, which shall be extended only to those who strictly and continuously meet the qualifications, standards and requirements set forth in these Bylaws. No physician, dentist, podiatrist or clinical psychologist including those in a medical administrative position by virtue of a contract with the Hospital, shall admit or provide medical or health-related services to patients in the Hospital unless the physician is a Member of the Medical Staff or has been granted temporary Privileges in accordance with the procedures set forth in these Bylaws. Appointment to the Medical Staff shall confer only such Clinical Privileges and prerogatives as have been granted in accordance with these Bylaws.

## 2.2 QUALIFICATIONS FOR MEMBERSHIP

### 2.2-1 GENERAL QUALIFICATIONS

Only physicians, dentists, podiatrists and clinical psychologists who:

- (a) Document their (1) current valid, unsuspended licensure, (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and (5) adequate physical and mental health status (subject to any necessary reasonable accommodation),, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care. No application for initial Medical Staff membership or Privileges shall be processed if the applicant's medical license is currently subject to probationary conditions, restrictions, or a Medical Board of California Accusation.
- (b) Are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care or jeopardize, either directly or indirectly, the ability of members of the treatment team to provide quality patient care, and (3) to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff.
- (c) Maintain in force professional liability insurance with an insurer acceptable to the Medical Executive Committee and Board, in not less than the minimum amounts as from time to time may be jointly determined by the Medical Executive Committee and subject to approval by the Board which policy shall be kept in effect for as long as the applicant remains a Staff Member. Any cancellation, reduction in coverage below the minimum limits, or any change of this policy related to Clinical Privileges shall be reported to the Medical Staff Services department within fifteen (15) days.
- (d) Must not be currently excluded from participating in Medicare, Medicaid or any other federal health care program when such exclusion has been imposed by government

enforcement authorities, or accepted by applicant, as a sanction for unlawful conduct;

- (e) Shall be deemed to possess basic qualifications for membership in the Medical Staff, except for the honorary and retired staff categories in which case these criteria shall only apply as deemed individually applicable by the Medical Staff.

## 2.2-2 PARTICULAR QUALIFICATIONS

- (a) Physicians. An initial applicant for physician membership in the Medical Staff, except for the honorary staff, must hold an M.D. or D.O. degree issued by a medical or osteopathic school approved at the time of the issuance of such degree by the Medical Board of California or the Board of Osteopathic Examiners of the State of California and must also hold a valid and unsuspended, unrestricted and unencumbered (i.e., not subject to probationary conditions) certificate to practice medicine issued by the Medical Board of California or the Board of Osteopathic Examiners of the State of California.
- (b) Except for dentists and applicants to the Office Based Staff, applicants (including oral surgeons) shall be Board Certified, or have completed an approved residency in their intended field of practice;<sup>1</sup> and have practiced in the applicant's intended field of practice in a Joint Commission (or equivalent) accredited acute care hospital for two (2) of the previous four (4) years, or have completed an accredited (by ACGME or AOA or otherwise accepted by the MBC or OMBC) clinical residency or fellowship in the intended field of practice within the previous twenty-four (24) months.

Applicants to the Office Based Category must satisfy all criteria stated in this section except the recent acute care hospital experience requirement. Instead, applicants to the Office Based category shall be eligible to apply if they can demonstrate that they have undergone individual peer review

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<sup>1</sup> Current members of the Medical Staff who were not, as of date of adoption of this amendment, board certified or had not completed a residency in the intended field of practice, and who cannot reasonably be expected to pursue board certification or residency training, may be considered for renewal of medical staff membership if they can document sufficient training, experience, and competence, and otherwise meet the requirements of Medical Staff membership.

in a NCQA approved (or acceptable equivalent which includes a demonstrated peer review function, as determined by the Medical Executive Committee) outpatient setting for two (2) of the previous four (4) years or completed an accredited (by ACGME or AOA or otherwise accepted by the MBC or OMBC) clinical residency or fellowship in the intended field of practice within the previous twenty-four (24) months.

(c) Practitioners Other than Physicians

- (1) Dentists. An initial applicant for dental membership in the Medical Staff, except for the honorary staff, must hold a D.D.S. or equivalent degree issued by a dental school approved at the time of the issuance of such degree by the Board of Dental Examiners of California and must also hold a valid, and unsuspended, unrestricted and unencumbered (i.e., not subject to probationary conditions) certificate to practice dentistry issued by the Board of Dental Examiners of California.
- (2) Podiatrists. An initial applicant for podiatric membership on the Medical Staff, except for the honorary staff, must hold a D.P.M. degree conferred by a school approved at the time of issuance of such degree by the Medical Board of California and must hold a valid and unsuspended, unrestricted and unencumbered (i.e., not subject to probationary conditions) certificate to practice podiatry issued by the Podiatry Division of the Medical Board of State of California.
- (3) Clinical Psychologists. An applicant for clinical psychologist membership on the Medical Staff must, except for the honorary staff, hold a clinical psychologist degree conferred by a school approved at the time of issuance of such degree by the Medical Board of California and must hold a valid and unsuspended certificate to practice clinical psychology issued by the California Board of Psychology.

### **2.3 WAIVER OF QUALIFICATIONS**

Insofar as is consistent with applicable laws, the Board has the discretion to deem a Practitioner to have satisfied a qualification, based upon the recommendation of the applicable clinical Department, the Credentials Committee and the Medical Executive Committee, if it determines that the Practitioner has demonstrated he or she has substantially comparable qualifications and that this waiver is necessary to serve the best interests of the patients and of the Hospital. There is no obligation to grant any such waiver, and Practitioners have no right to have a waiver considered and/or granted. A Practitioner who is denied a waiver or consideration of a waiver shall not be entitled to any hearing and appeal rights under these Bylaws.

### **2.4 EFFECT OF OTHER AFFILIATIONS**

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

### **2.5 NONDISCRIMINATION**

No aspect of Medical Staff membership or Clinical Privileges shall be denied on the basis of race, religion, color, national origin, ancestry, marital status, sex or sexual orientation; age; economic status; political affiliation or any other protected category, or any physical or mental impairment that does not pose a threat to the quality of patient care, if, after any necessary reasonable accommodation, the applicant complies with the Bylaws and Rules of the Medical Staff and the Hospital. 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 group, IPA, PPO, PHO, Hospital sponsored foundation, or other organization or contracts with a third party which contracts with this Hospital.

## 2.6 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for the honorary and retired staff, the ongoing responsibilities of each Member of the Medical Staff, and each Practitioner exercising temporary Privileges include:

- (a) Providing patients with the quality of care meeting the professional standards of the Medical Staff of this Hospital.
- (b) Abiding by the Medical Staff Bylaws and Medical Staff Rules and Regulations and all other lawful standards, policies and rules of the Medical Staff as well as those Hospital policies required by state or federal law or by the standards of national accrediting organizations such as The Joint Commission (or equivalent at the discretion of the Medical Executive Committee);
- (c) Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the Member by virtue of Medical Staff membership, including committee and peer review activities, including proctoring assignments.
- (d) Preparing and completing in timely fashion medical records for all the patients to whom the Member provides care in the Hospital.
- (e) Abiding by the lawful ethical principles of the American and California Medical Associations, or Member's professional association;
- (f) Working cooperatively with Members, nurses, Hospital administration and others so as not to adversely affect patient care or jeopardize, either directly or indirectly, the ability of the treatment team to provide quality patient care.
- (g) Making appropriate arrangements for coverage of that Member's patients as determined by the Medical Staff.
- (h) Refusing to engage in improper inducements for patient referral.

- (i) Participating in continuing education programs as determined by the Medical Staff.
- (j) Participating in such emergency service coverage or consultation panels as may be determined by the Medical Staff.
- (k) Refraining from any unlawful harassment against any person (including any patient, Hospital employee, Hospital independent contractor, Medical Staff Member, volunteer or visitor) based upon the person's race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation; age; economic status; political affiliation or any other protected category.
- (l) Discharging such other staff obligations as may be lawfully established from time to time by the Medical Staff or executive committee.
- (m) Providing information to and/or testifying on behalf of the Medical Staff or an accused Practitioner regarding any matter under an investigation pursuant to paragraph 7.1-3, and those which are the subject of a hearing pursuant to Article VII.
- (n) Report to his/her Clinical Service Chairperson any extended illness, disability, or absence which will prevent him/her from participating in Hospital practice and/or Medical Staff business;
- (o) Report to his/her Clinical Service Chairperson any reduction, suspension, or revocation of his/her Clinical Privileges, for medical disciplinary cause or reason, at another hospital or surgicenter, or any termination, reduction or suspension, for medical disciplinary cause or reason, of his/her status as a contracted provider for a managed care organization, or any licensing agency's accusation, action or settlement;
- (p) Upon request, provide information from his or her office records or from outside sources as necessary to facilitate the care of or review of the care of specific patients;

- (q) Pay, in a timely fashion as determined by the Medical Executive Committee, dues and assessments as determined by the Medical Staff;
- (r) Attend meetings of a Medical Staff peer review committee at which the Member's practice or conduct is scheduled for discussion, if the Member's attendance has been requested at least seven (7) days prior to the meeting, or responding within thirty (30) days to a written request on behalf of any such committee, identifying questions or concerns pertaining to a Member's practice or conduct and requesting that he/she review and respond to the applicable committee meeting minutes and medical records;
- (s) Adhere to the Medical Staff Standards of Conduct and prohibition against harassment as set forth in the Bylaws, Rules and Regulations or Medical Staff policies.

A Member may be required to demonstrate continuing satisfaction of any of the requirements of these Bylaws upon the reasonable request of the Medical Executive Committee.

## **2.7 HARASSMENT PROHIBITED**

Harassment by a Medical Staff Member against any individual (e.g., against another Medical Staff Member, Hospital employee, or patient, or visitor) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation; age; economic status; political affiliation, or any other protected category, 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 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 Medical Staff Privileges or membership, if warranted by the facts.

## **2.8 STANDARD OF CONDUCT**

Members of the Medical Staff are expected to adhere to the following Medical Staff Standard of Conduct.

### **2.8-1 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, or willful refusal to communicate or refusal to 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 interactions at any level of the Hospital, in that all personnel play an important part in the ultimate mission of delivering quality patient care.

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.

## **2.8-2 Conduct Guidelines**

- (a) Upon receiving Medical Staff membership and/or Privileges at the Hospital, the Member agrees to endeavor to maintain the quality of patient care and to engage in 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 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 nondemeaning manner, and through official channels.

Cooperation and adherence to the reasonable rules of the Hospital and the Medical Staff is required.

## **2.8-3 Definition of Disruptive Behavior**

Disruptive behavior by a Practitioner is defined as conduct that interferes with the orderly operation of the Hospital and has the potential to adversely impact patient care. It is not necessary to wait for an adverse impact or outcome. Disruptive behavior includes, but is not limited to, the following types of behavior towards other Practitioners, Hospital staff, patients or visitors.

- a) Hostile, angry or aggressive confrontational voice or body language;
- b) Attacks (verbal or physical) that go beyond the bounds of fair and appropriate professional conduct;

- c) Inappropriate expressions of anger such as throwing items or destroying property;
- d) Abusive language or criticism directed at the recipient in such a way as to have the effect of ridiculing, humiliating, intimidating, undermining confidence or belittling the individual;
- e) Derogatory comments that go beyond differences of opinion and are directed at patients, patients' families or visitors or Hospital personnel. (This does not prohibit comments that deal constructively with the care provided.)
- f) Writing of inappropriate comments in the medical record; and
- g) Any behavior deemed inappropriate as outlined in any Medical Staff Code of Conduct.

Members of the Medical Staff shall not engage in conduct that is offensive or disruptive, whether it is written, oral or behavioral.

## **2.9 HIPAA.**

All Members of the Medical Staff will be deemed to be Members of the Hospital's Medical Staff Organized Healthcare Arrangement ("MSOHCA") as such term is defined by the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and all implementing regulations, as amended from time to time ("HIPAA"). The Hospital will issue a Joint Notice of Privacy Practices ("JNPP") to its patients, and will obtain acknowledgement of patient's receipt of the JNPP, on behalf of the MSOHCA; Medical Staff Members shall not issue a separate notice of privacy practices to hospitalized patients. MSOHCA members are individually responsible for compliance with the terms of the JNPP. The JNPP does not fulfill Practitioners' obligations when seeing patients outside of the Hospital or in their private offices.

## **ARTICLE III**

### **CATEGORIES OF MEMBERSHIP**

#### **3.1 CATEGORIES**

The categories of the Medical Staff shall include the following: Active, Courtesy, Consulting, Provisional, Office Based, Honorary and Retired. At each time of reappointment, the Member's staff category shall be determined.

#### **3.2 ACTIVE STAFF**

##### **3.2-1 QUALIFICATIONS**

The Active staff shall consist of Members who:

- (a) Meet the general qualifications for membership set forth in Section 2.2.
- (b) Have offices or residences which, in the opinion of the Medical Executive Committee, are located closely enough to the Hospital to provide continuity of quality care.
- (c) Have twelve (12) or more Patient Encounters every two (2) years at the Hospital. Actually working the equivalent of ten (10) or more assigned eight (8) hour shifts in the Hospital per year equals twelve (12) encounters.
- (d) Except for good cause shown as determined by the Medical Staff, have satisfactorily completed their designated term in the provisional staff.

##### **3.2-2 PREROGATIVES**

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

- (a) Admit patients and exercise such Clinical Privileges as are granted pursuant to Article V.
- (b) Attend and vote on matters presented at general and special meetings of the Medical Staff and of the

department and committees to which the Member is duly appointed.

- (c) Hold staff, division, or department office and serve as a voting member of committees to which the Member is duly appointed or elected by the Medical Staff or duly authorized representative thereof.

### **3.2-3 TRANSFER OF ACTIVE STAFF MEMBER**

After two (2) consecutive years in which a Member of the Active Staff fails to satisfy the requisite volume requirements set forth in the Bylaws, that Member may be transferred to the appropriate category, if any, for which the Member is qualified. A Member who does not wish to be transferred has the burden to clearly demonstrate that unusual circumstances unlikely to occur again in his or her practice caused the failure to meet the minimum or maximum requirements.

## **3.3 THE COURTESY MEDICAL STAFF**

### **3.3-1 QUALIFICATIONS**

The Courtesy Medical Staff shall consist of Members who:

- (a) Meet the general qualifications set forth in subsections (a)-(b) of Section 3.2-1.
- (b) Maintain Active staff status at another Joint Commission accredited acute care hospital; or
- (c) If Active status at another Joint Commission accredited acute care hospital is not maintained, be able to document his/her qualifications for all Privileges requested at the time of membership renewal. Failure to submit documentation which in the opinion of the Credentials Committee demonstrates continued proficiency shall result in automatic expiration of such Privileges as specified in Section 5-8, Lapse of Privileges.
- (d) Have at least two (2) but not more than eleven (11) Patient Encounters every two (2) years at the Hospital, as determined by the Medical Staff. Courtesy Staff

Members who have more than eleven (11) patient encounters over a two (2) year period in the Hospital shall, upon review of the Medical Executive Committee, be obligated to seek appointment to the appropriate Staff category.

- (e) Have satisfactorily completed appointment in the Provisional category.

### **3.3-2 TRANSFER OF COURTESY STAFF MEMBER**

A Courtesy Staff Member who has exceeded the maximum activity permitted for two (2) consecutive years may be deemed to have requested transfer to the appropriate category. The Medical Executive Committee shall approve these assignments and transfers. The transfers shall be done at the time of reappointment.

### **3.3-3 PREROGATIVES**

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

- (a) Admit patients to the Hospital within the limitations of Section 3.3-1(b) and exercise such Clinical Privileges as are granted pursuant to Article V.
- (b) Attend in a non-voting capacity meetings of the Medical Staff and the department of which the individual is a Member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.
- (c) Courtesy Staff Members shall not be eligible to hold office in the Medical Staff.

### **3.3-4 LIMITATION**

Courtesy Staff Members who admit patients or regularly care for patients at the Hospital shall, upon review of the Medical Executive Committee, be obligated to seek appointment to the appropriate staff category.

### **3.4 THE CONSULTING MEDICAL STAFF**

#### **3.4-1 QUALIFICATIONS**

Any Member of the Medical Staff in Good Standing may consult in that Member's area of expertise; however, the Consulting Medical Staff shall consist of such Practitioners who:

- (a) Are not otherwise Members of the Medical Staff and meet the general qualifications set forth in Section 2.2, except that this requirement shall not preclude an out-of-state Practitioner from appointment as may be permitted by law if that Practitioner is otherwise deemed qualified by the Medical Executive Committee.
- (b) Possess adequate clinical and professional expertise.
- (c) Are willing and able to come to the Hospital on schedule or promptly respond when called to render clinical services within their area of competence.
- (d) Are Members of the Active Medical Staff of another hospital licensed by California or another state, although exceptions to this requirement may be made by the Medical Executive Committee for good cause.
- (e) Have satisfactorily completed appointment in the provisional category. At the time of application, Practitioners seeking appointment to the Consulting Staff must provide documentation that he or she has satisfactorily completed a proctor program at their Primary Hospital. Such documentation may be accepted in lieu of actual observation and or other proctor program requirement, at the discretion of the Chairperson of the Department to which the Practitioner is assigned.

#### **3.4-2 PREROGATIVES**

The Consulting Medical Staff Member shall be entitled to:

- (a) Exercise such Clinical Privileges as are granted pursuant to Article V.

- (b) Attend meetings of the Medical Staff and the department of which that individual is a Member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment. Consulting Staff Members shall not be eligible to hold office in the Medical Staff organization, but may serve upon committees.

### **3.5 PROVISIONAL STAFF**

#### **3.5-1 QUALIFICATIONS**

The Provisional Staff shall consist of Members who:

- (a) Meet the general Medical Staff membership qualifications set forth in Sections 3.2-1(a) and (b) or 3.5-1(a)-(d) and
- (b) Immediately prior to their application and appointment were not Members (or were no longer Members) in good standing of this Medical Staff.

#### **3.5-2 PREROGATIVES**

The Provisional Staff Member shall be entitled to:

- (a) Admit patients and exercise Clinical Privileges granted pursuant to Article V.
- (b) Attend meetings of the Medical Staff and the department of which the physician is a Member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

Provisional Staff Members shall not be eligible to hold office in the Medical Staff organization, but may serve upon committees.

**3.5-3 OBSERVATION OF PROVISIONAL STAFF MEMBER**

Each Provisional Staff Member shall undergo a period of observation by designated monitors as described in Section 5.3. The observation shall be to evaluate the Member's (1) proficiency in the exercise of Clinical Privileges initially granted and (2) overall eligibility for continued Staff membership and advancement within staff categories. Observation of Provisional Staff Members shall follow whatever frequency and format each department deems appropriate in order to adequately evaluate the Provisional Staff Member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records shall be maintained. The results of the observation shall be communicated by the Department Chair to the Credentials Committee.

**3.5-4 TERM OF PROVISIONAL STAFF STATUS**

A Member shall remain in the Provisional Staff for a period of twelve (12) months unless that status is extended by the Executive Committee for an additional period of up to twelve (12) months upon a determination of good cause, which determination shall not be subject to review pursuant to Articles VII or VIII.

**3.5-5 ACTION AT CONCLUSION OF PROVISIONAL 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 recommendation of the Medical Executive Committee.
- (b) In all other cases, the appropriate department shall advise the Credentials Committee which shall make its report to the Medical Executive Committee which, in turn shall make its recommendation to the Board of Directors regarding a modification or termination of Clinical Privileges.

### **3.5-6 FAILURE TO COMPLETE PROCTORING FOR SPECIAL PRIVILEGES**

The failure to complete proctoring for any Special (i.e., as distinguished from Core Privileges) Privilege shall not, of itself, preclude advancement from Provisional Staff. If advancement is approved prior to completion of proctoring, the proctoring will continue for the Special Privileges. The Special Privileges may be voluntarily relinquished or terminated by the Medical Executive Committee if proctoring is not completed thereafter within a reasonable time as established by the department with the approval of the Medical Executive Committee.

### **3.6 THE OFFICE BASED CATEGORY**

#### **3.6-1 QUALIFICATIONS**

The Office Based Staff shall consist of those applicants or existing Members who:

- (a) Have met all of the requirements set forth in Section 2.2 to qualify for Clinical Privileges except for the requirement that the applicants have practiced in the applicant's intended field of practice in a Joint Commission (or equivalent) accredited acute care hospital for two (2) of the previous four (4) years. Office Based Members must be involved in the care of outpatients at least twenty (20) hours per week in the outpatient or office based setting. Office Based Members shall not be granted Clinical Privileges or be allowed to write orders. An applicant may be appointed directly to the Office Based Category without first completing an appointment to the Provisional Staff.

#### **3.6-2 PREROGATIVES**

- (a) Office Based Staff Members may attend meetings of the Medical Staff and the department and/or division to which that person is assigned, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.
- (b) Office Based Staff Members shall not be eligible to hold office in the Medical Staff organization, but may serve on committees, as appointed by the department chair, Chief of Staff or Medical Executive Committee.

- (c) Office Based Members shall pay dues.
- (d) Office Based Staff Members who wish to apply for Clinical Privileges must demonstrate current competence in the care of acute inpatients and to exercise the specific Privileges requested as recommended by the appropriate clinical Department, the Credentials Committee and the Medical Executive Committee. This required demonstration will likely require the Practitioner to obtain recent education and training from a program approved by the appropriate clinical Department, the Credentials Committee and the Medical Executive Committee, and which is specifically designed to enable the Practitioner to demonstrate current competence in the care of acute inpatients. Office Based Staff Members applying for Clinical Privileges may be required to have an interview with the Credentials Committee. Successful applicants will be approved for provisional staff category and must satisfactorily complete all proctoring requirements before advancing to any other staff category.
- (e) Office Based Staff Members must provide documentation identifying a Medical Staff Member who shall be responsible for admitting and managing the care of the Office Based Staff Member's patients who present to the Hospital for admission.
- (f) At the time of reappointment, Practitioners seeking reappointment to the Office Based Staff must provide documentation acceptable to the Credentials Committee and Medical Executive Committee that he or she has been involved in the care of outpatients at least twenty (20) hours per week in the outpatient or office based setting. Additionally, the Practitioner must present evidence of successful completion of Board Certification, recertification or maintenance of specialty certification in the preceding two (2) years or objective, written evidence that adequate and satisfactory peer review has been performed on Practitioner's outpatient practice by an entity or agency acceptable to the Medical Executive Committee and that such peer review can be relied upon to determine current competency. Practitioners who cannot satisfy this requirement shall then be required to submit at least eight (8) complete office charts spanning a two (2) year period for review by either the Department Chair or his or her designee, or by an outside reviewer, as determined by the Medical

Executive Committee. The costs of such review shall be the responsibility of the Practitioner. The Department Chair may, at any time, within his or her discretion, request the Practitioner to produce complete copies of office charts for patients admitted to the Hospital so that the Department Chair, or his or her designee, can assess, or cause to be assessed, the quality and appropriateness of care provided in the office based setting.

### **3.7 HONORARY AND RETIRED STAFFS**

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

##### **(a) The Honorary Staff**

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

##### **(b) The Retired Staff**

The Retired staff shall consist of Members who have retired from active practice and, at the time of their retirement, were Members in good standing of the Active Medical Staff for a period of at least twenty (20) continuous years, and who continue to adhere to appropriate professional and ethical standards.

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

Honorary and Retired staff Members are not eligible to admit patients to the Hospital or to exercise Clinical Privileges in the Hospital, or to vote or hold office in this Medical Staff organization, but they may serve upon committees with or without vote at the discretion of the Medical Executive Committee. They may attend staff and department meetings, including open committee meetings and educational programs.

### **3.8 LIMITATION OF PREROGATIVES**

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

### **3.9 GENERAL EXCEPTIONS TO PREROGATIVES**

Regardless of the category of membership in the Medical Staff, unless otherwise required by law, Medical Staff Members other than physicians

- (a) Shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the Chair of the meeting, subject to final decision by the Medical Executive Committee.
- (b) Shall exercise Clinical Privileges only within the scope of their licensure and as set forth in Section 5.4.

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

On its own, upon recommendation of the Credentials Committee, or pursuant to a request by a Member under Section 4.6-1(b), or upon direction of the Board of Directors as set forth in Section 7.1-6, the Medical Executive Committee may recommend a change in the Medical Staff category of a Member consistent with the requirements of the Bylaws. However, category changes are usually made at the time of reappointment and no Member is entitled to have the Medical Executive Committee act on a request for a category change at any time other than in connection with a reappointment.

## **ARTICLE IV**

### **APPOINTMENT AND REAPPOINTMENT**

#### **4.1 GENERAL**

Except as otherwise specified herein, no person (including persons engaged by the Hospital in administratively responsible positions or, with respect to Allied Health Professionals, has been granted

Privileges under applicable Medical Staff Bylaws, Rules and Regulations and policies) shall exercise Clinical Privileges in the Hospital unless and until he or she applies for and receives appointment to the Medical Staff or is granted temporary Privileges as set forth in these Bylaws. By applying to the Medical Staff for appointment or reappointment (or, in the case of Members of the Honorary or Retired Staff, by accepting an appointment to that category), the applicant acknowledges responsibility to first review these Bylaws and agrees that throughout any period of membership that person will comply with the responsibilities of Medical Staff membership and with the Bylaws and Rules and Regulations and policies of the Medical Staff as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the appointee only such Clinical Privileges as have been granted in accordance with these Bylaws.

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

In connection with all applications for appointment, reappointment, advancement or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the Clinical Privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. This burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Executive Committee which may select the examining physician. If the applicant fails to complete the application within 6 months, or to provide additional information requested after written notice, the application shall be deemed automatically withdrawn. The provision of information containing significant misrepresentations or omissions and/or failure to sustain the burden of producing adequate information shall be grounds for denial of the application.

#### **4.3 APPOINTMENT AUTHORITY**

Appointments, denials and revocations of appointments to the Medical Staff shall be made as set forth in these Bylaws, but only after there has been a recommendation from the Medical Executive Committee, or as set forth in Section 7.1-6.

#### **4.4 DURATION OF APPOINTMENT AND REAPPOINTMENT**

Except as otherwise provided in these Bylaws, initial appointment to the Medical Staff shall be for a period of up to two (2) years. Reappointment shall be for a period of up to two (2) years.

#### **4.5 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT**

##### **4.5-1 APPLICATION FORM**

An application form shall be developed by the Medical Executive Committee. This form may be reviewed and amended as appropriate by the Board of Directors, based upon the recommendation of the Medical Executive Committee, in order to determine compliance with all applicable laws, including requirements of any applicable licensure and accreditation agencies. Disputes between the Medical Executive Committee and the Board of Directors concerning the contents of the application form shall be referred to the Quality Committee in accordance with the procedures set forth in Section 10.5-2. The form shall require detailed information which shall include, but not be limited to, information concerning:

- (a) The applicant's qualifications, including, but not limited to, professional training and experience, current licensure, and current DEA registration.
- (b) Peer references (preferably from the applicant's specialty area and preferably not including relatives, current partners or associates in practice) familiar with the applicant's professional competence in the care of patients in the Hospital and ethical character.
- (c) Requests for membership categories, departments, and Clinical Privileges.
- (d) Verified plans to provide continuous coverage for the Practitioner's patients, subject to the approval of the Medical Executive Committee;
- (e) Written clarification of any lapse in professional activity, (subsequent to graduation from medical school);

- (f) Past or pending professional disciplinary action, licensure limitations, or related matters. Related matters shall include, but not be limited to: voluntary or involuntary resignation of Medical Staff Privileges, Medical Staff membership, or state medical licensure, or DEA certificate.
- (g) Physical and mental health status.
- (h) Final judgments or settlements made against the applicant in professional liability cases, and any file cases pending. The applicant shall include information on any pending professional liability action filed and served, or any payment/dismissal made on their behalf.
- (i) Past or pending professional disciplinary action, voluntary or involuntary denial, revocation, suspension, reduction or relinquishment of Medical Staff membership or Privileges, or any licensure or registration, termination of participating provider status in any managed care organization for medical disciplinary cause or reason, and related matters;
- (j) Information detailing any prior or pending government agency or third party payor, investigation, proceeding, or litigation challenging or sanctioning the Practitioner's patient admission, treatment, discharge, charging, collection, or utilization practices, including, but not limited to, Medicare or Medi-Cal fraud and abuse proceedings or convictions;
- (k) Signed releases and authorizations necessary to complete a criminal background check.
- (l) Professional liability coverage
- (m) Evidence to ensure that the individual requesting Privileges is the same individual identified in credentialing documents.

Each application for appointment to the Medical Staff shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant.

When applicants request an application form, they shall be given copies of these Bylaws, the Medical Staff Rules and Regulations, the appropriate departmental rules and regulations, and as deemed appropriate by the Medical Executive Committee, copies or summaries of any other applicable Medical Staff policies relating to clinical practice in the Hospital.

#### **4.5-2 EFFECT OF APPLICATION**

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

- (a) Signifies willingness to appear for interviews in regard to the application.
- (b) Authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information.
- (c) Certifies that he/she will report to the Medical Executive Committee any changes in the information submitted on the application form which may subsequently occur during the pendency of the application;
- (d) Consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out Clinical Privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying.
- (e) Releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant.
- (f) Releases from any liability, to the fullest extent permitted by law, all individuals and organizations who

provide information regarding the applicant, including otherwise confidential information.

- (g) Consents to the disclosure to other hospitals, medical associations, and licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the Hospital or Medical Staff may have, and releases the Medical Staff and Hospital from liability for so doing to the fullest extent permitted by law.
- (h) If a requirement then exists for Medical Staff dues, acknowledges responsibility for timely payment.
- (i) Pledges to provide for continuous quality care for patients.
- (j) Pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing for continuous care of the applicant's patients, seeking consultation whenever necessary, refraining from providing "ghost" surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised Practitioners.
- (k) Pledges to be bound by the Medical Staff Bylaws, Rules and Regulations and policies;
- (l) Agrees to comply with the Standards of Conduct as set forth in the Medical Staff Bylaws or Rules and Regulations; and
- (m) Agrees to execute the releases and/or authorizations necessary for the Medical Staff to conduct, or cause to be conducted, a criminal background check.

**4.5-3 APPLICANT'S RESPONSIBILITY TO PRODUCED COMPLETE INFORMATION**

The applicant shall have the burden of producing adequate and complete information in a timely fashion for a proper evaluation of his/her competence, character, ethics, and other basic qualifications for membership. Only complete applications will

receive consideration. A complete application is one which provides responsive information to each inquiry on the application form and provides supplementary information reasonably necessary to enable the Medical Staff to make a sound recommendation regarding the application. Unresolved disciplinary action or unresolved malpractice litigation or the inability to verify information may render an application incomplete. An application which is not deemed complete shall not be considered. An application which remains incomplete after one hundred eighty (180) days, unless an exception is made for good cause by the Medical Executive Committee, will be deemed to have been withdrawn. The failure to consider applications deemed incomplete shall not entitle the applicant to due process rights pursuant to Article VII.

#### **4.5-4 VERIFICATION OF INFORMATION**

The applicant shall deliver a completed application and supporting documents to the appropriate Medical Staff officer or his or her designee and an advance payment of Medical Staff dues or fees, if any is required. The Chief Executive Officer shall be notified of the application. The application and all supporting materials then available shall be transmitted to the Chair of each department in which the applicant seeks Privileges and to the Credentials Committee. The Credentials Committee, and the Chief Executive Officer when requested by the Credentials Committee, shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain the required information. When collection and verification is accomplished, all such information shall be transmitted to the Credentials Committee and the appropriate department(s).

#### **4.5-5 DEPARTMENT ACTION**

After receipt of the application, the Chair or appropriate committee of each department to which the application is submitted, shall review the application and supporting documentation, and may conduct a personal interview with the applicant at his or her discretion. The Chair or appropriate committee shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of Privileges granted, and

shall transmit to the Credentials Committee a written report and recommendation as to appointment and, if appointment is recommended, as to membership category, department affiliation, Clinical Privileges to be granted, and any special conditions to be attached. The Chair may also request that the Medical Executive Committee defer action on the application.

#### **4.5-6 CREDENTIALS COMMITTEE ACTION**

The Credentials Committee shall review the application, evaluate and verify the supporting documentation, the department Chair's report and recommendations, and other relevant information. The Credentials Committee may elect to interview the applicant and seek additional information. As soon as practicable, the Credentials Committee shall transmit to the Medical Executive Committee a written report and its recommendations as to appointment and, if appointment is recommended, as to membership category, department affiliation, Clinical Privileges to be granted, and any special conditions to be attached to the appointment. The committee may also recommend that the Medical Executive Committee defer action on the application.

#### **4.5-7 MEDICAL EXECUTIVE COMMITTEE ACTION**

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

#### **4.5-8 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION**

- (a) Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the

applicant, it shall be promptly forwarded, together with supporting documentation, to the Board of Directors.

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

#### **4.5-9 ACTION ON THE APPLICATION**

The Board of Directors may accept the recommendation of the Medical Executive Committee or may refer the matter back to the Medical Executive Committee for further consideration, stating the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. The following procedures shall apply with respect to action on the application:

- (a) If the Medical Executive Committee issues a favorable recommendation the Board of Directors shall affirm the recommendation of the Medical Executive Committee if the Medical Executive committee's decision is supported by substantial evidence.
  - (1) If the Board of Directors concurs in that recommendation, the decision of the board shall be deemed final action.
  - (2) If the tentative final action of the Board of Directors is unfavorable, the Chief Executive Officer shall give the applicant written notice of the tentative adverse recommendation and the applicant shall be entitled to the procedural rights set forth in Article VIII. If the applicant waives his or her procedural rights, the decision of the board shall be deemed final action.
- (b) In the event the recommendation of the Medical Executive Committee, or any significant part of it, is unfavorable to the applicant, the procedural rights set forth in Article VIII shall apply.

- (1) If the applicant waives his or her procedural rights, the recommendations of the Medical Executive Committee shall be forwarded to the Board for final action, which shall affirm the recommendation of the Medical Executive Committee if the Medical Executive Committee's decision is supported by substantial evidence.
- 2) If the applicant requests a hearing following the adverse Medical Executive Committee recommendation pursuant to section 4.5-8(b) or an adverse Board of Directors tentative final action pursuant to 4.5-8(a)(2), the Board of Directors shall take final action only after the applicant has exhausted procedural rights as established by Article VIII. After exhaustion of the procedures set forth in Article VIII, the Board shall make 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. The Board's decision shall be in writing and shall specify the reasons for the action taken.

#### **4.5-10 NOTICE OF FINAL DECISION**

- (a) Notice of the final decision shall be given to the Chief of Staff, the Medical Executive and the Credentials Committees, the Chair of each department concerned, the applicant, and the administrator.
- (b) A decision and notice to appoint or reappoint shall include, if applicable: (1) the staff category to which the applicant is appointed; (2) the department assigned; (3) the Clinical Privileges granted; and (4) any special conditions attached to the appointment.

#### **4.5-11 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION**

- (a) An applicant who has received a final adverse decision regarding appointment or Privileges shall not be eligible to reapply to the Medical Staff for a period of three years from the date of the final decision.

Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

- (b) An action is considered adverse only if it is based on the type of occurrences which might give rise to corrective action. An action is not considered adverse if it is based upon reasons that do not pertain to medical or ethical conduct, such as actions based on a failure to maintain a practice in the area (which can be cured by a move), to pay dues (which can be cured by paying dues), or to maintain professional liability insurance (which can be cured by obtaining the insurance).

#### **4.5-12 TIMELY PROCESSING OF APPLICATIONS**

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

- (a) Evaluation, review, and verification of application and all supporting documents: ninety (90) days from receipt of all necessary documentation.
- (b) Review and recommendation by department(s): sixty (60) days after receipt of all necessary documentation.
- (c) Review and recommendation by Credentials Committee: sixty (60) days after receipt of all necessary documentation.
- (d) Review and recommendation by Medical Executive Committee: sixty (60) days after receipt of all necessary documentation.
- (e) Final action sixty (60) days after receipt of all necessary documentation or conclusion of hearings.

#### **4.6 REAPPOINTMENTS AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES**

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

- (a) At least five (5) months prior to the expiration date of the current staff appointment (except for temporary appointments), a reapplication form developed by the Medical Executive Committee shall be mailed or delivered to the Member. This form may be reviewed and amended as appropriate by the Board of Directors, based upon the recommendation of the Medical Executive Committee, in order to determine compliance with all applicable laws, including requirements of any applicable licensure and accreditation agencies. Disputes between the Medical Executive Committee and the Board of Directors concerning the contents of the reapplication form shall be referred to the Quality Committee in accordance with the procedures set forth in Section 11.5-2. If an application for reappointment is not received at least ninety (90) days prior to the expiration date, written notice shall be promptly sent to the applicant advising that the application has not been received. At least sixty (60) days prior to the expiration date, each Medical Staff Member shall submit to the Credentials Committee the completed application form for renewal of appointment to the staff for the coming year, and for renewal or modification of Clinical Privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 4.5-1, as well as other relevant matters. Applications for reappointment shall specifically include information regarding professional and clinical performance, including the applicant's patterns of practice, based at least in part on the findings of quality management measures, such as peer review, utilization management, infection control activities, tissue review, medical record review, and pharmacy and therapeutics activities. Upon receipt of the application, the information shall be processed as set forth commencing at Section 4.5-3.

- (b) A Medical Staff Member who seeks a change in Medical Staff status or modification of Clinical Privileges may submit a written request at any time, except that such application may not be filed within one (1) year of the time a similar request has been denied. All requests for expansion or addition of Privileges will be processed in the same manner as requests for initial Privileges.

#### **4.6-2 EFFECT OF APPLICATION**

The effect of an application for reappointment or modification of Staff status or Privileges is the same as that set forth in Section 4.5-2.

#### **4.6-3 STANDARDS AND PROCEDURE FOR REVIEW**

When a Staff Member submits the first application for reappointment, and every two years thereafter, or when the Member submits an application for modification of Staff status or Clinical Privileges, the Member shall be subject to an in- depth review generally following the procedures set forth in Section 4.5-3 through 4.5-11.

#### **4.6-4 FAILURE TO FILE REAPPOINTMENT APPLICATION**

Failure without good cause to timely file a completed application for reappointment shall result in the automatic suspension of the Member's admitting Privileges and expiration of other practice Privileges and prerogatives at the end of the current staff appointment, unless otherwise extended by the Medical Executive Committee with the approval of the Board of Directors. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article VII shall not apply.

### **4.7 LEAVE OF ABSENCE**

#### **4.7-1 LEAVE STATUS**

At the discretion of the Medical Executive Committee, a Medical Staff Member may obtain a voluntary leave of absence from the staff upon submitting a written request to the Medical Executive

Committee stating the approximate period of leave desired, which may not exceed two (2) years. During the period of the leave, the Member shall not exercise Clinical Privileges at the Hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the Medical Staff or Medical Executive Committee.

#### **4.7-2           TERMINATION OF LEAVE**

At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff Member may request reinstatement of Privileges by submitting a written notice to that effect to the Medical Executive Committee. Reinstatement at the end of any leave which exceeds sixty (60) days must be processed and approved in accordance with the standards and procedures set forth in the Bylaws and Rules for reappointment review. The Staff Member shall submit a summary of relevant activities during the leave. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the Member's Privileges and prerogatives, and the procedure provided in Sections 4.1 through 4.5-11 shall be followed.

#### **4.7-3           FAILURE TO REQUEST REINSTATEMENT**

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, Privileges, and prerogatives. A Member whose membership is automatically terminated shall be entitled to the procedural rights provided in Article VIII for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, or otherwise. A request for Medical Staff membership subsequently received from a Member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

## **ARTICLE V**

### **CLINICAL PRIVILEGES**

#### **5.1 EXERCISE OF PRIVILEGES**

Except as otherwise provided in these Bylaws, a Member providing clinical services at this Hospital shall be entitled to exercise only those Clinical Privileges specifically granted. Said Privileges and services must be specific to this Hospital, within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to the Rules and Regulations of the applicable clinical department(s) and the authority of the Department Chair, and the Medical Staff. Medical Staff Privileges may be granted, continued, modified or terminated by the governing body of this Hospital only upon recommendation of the Medical Staff, only for reasons directly related to quality of patient care and other provisions of the Medical Staff Bylaws, and only following procedures outlined in these Bylaws.

#### **5.2 CRITERIA FOR GENERAL COMPETENCIES**

The Medical Staff shall, in addition to criteria for Privileges, also develop areas of "general competencies" by which all Hospital Practitioners shall be measured for current proficiency. Each Department shall define how to measure these general competencies as applicable to that Department and use them to regularly monitor and assess each Practitioner's current proficiencies. Examples of general competencies that the Medical Staff may establish include, but are not limited to, patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems based practice.

#### **5.3 DEVELOPMENT OF CRITERIA FOR CLINICAL PRIVILEGES**

Subject to approval of the Medical Executive Committee and the Board, each Department will be responsible for developing criteria for granting Clinical Privileges, including, but not limited to, identifying and developing criteria for any Privileges that may be appropriately performed via Telemedicine. The criteria shall be designed to facilitate uniform quality patient care, treatment and services. Insofar as feasible, affected categories of Allied Health Professionals shall participate in developing criteria for Privileges to be exercised by Allied Health Professionals. Each Department's

approved criteria for granting Privileges shall be included in the Department's rules.

#### **5.4 DELINEATION OF PRIVILEGES IN GENERAL**

##### **5.4-1 REQUESTS**

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific Clinical Privileges desired by the applicant. A request by a Member for a modification of Clinical Privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request. Clinical Privileges are considered approved for the corresponding term of appointment or reappointment unless otherwise specified, but in any case for no more than two (2) years.

##### **5.4-2 BASES FOR PRIVILEGES DETERMINATION**

The Medical Staff shall make an objective and evidence-based decision with regard to each request for Clinical Privileges. Requests for Clinical Privileges shall be evaluated on the basis of the Member's education, training, experience, current demonstrated professional competence and judgment, evidence of current proficiency in the Hospital's general competencies, applicant specific information regarding applicant's clinical performance, comparisons made to aggregate information (when available) about performance, judgment and clinical or technical skills, morbidity and mortality data (when available) the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate and performance of a sufficient number of procedures to develop and maintain the Practitioner's skills and knowledge and compliance with any specific criteria applicable to the Privileges. Requested Privileges should be assessed individually to determine the Hospital's needs and ability to support the applicant with respect to the requested Privileges. The decision to grant or deny a Privilege and/or to renew an existing Privilege shall be based on peer recommendations which address the applicants: (i) medical/clinical knowledge; (ii) technical and clinical skills; (iii) clinical judgment; (iv) interpersonal skills; (v) communication skills; (vi) professionalism; and (vii) health status. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other

sources, especially other institutions and health care settings where a Member exercises Clinical Privileges. Additionally, the investigating person or body may, but is not required to, engage the services of one or more outside reviewers as deemed appropriate or helpful in light of the circumstances (e.g., to help assure an unbiased review, to firm up an uncertain or controversial review or to engage specialized expertise).

Criteria for granting of Privileges shall be developed by each Department Chair subject to the approval of the Medical Executive Committee and the Board, and shall be made in the interest of patient care. Any request for Privileges not currently listed in the Department's current delineation of Privileges shall be reviewed by the Department Chair, the Medical Executive Committee, and the Hospital for safety, efficacy, cost-effectiveness, and ability of the Hospital to provide appropriate equipment and facilities before recommending such criteria and Privileges.

Information regarding each Practitioner's scope of Privileges shall be updated as changes in Clinical Privileges for each Practitioner are made.

## **5.5 PROCTORING**

### **5.5-1 GENERAL PROVISIONS**

Except as otherwise determined by the Medical Executive Committee, all initial appointees to the Medical Staff and all Members granted new Clinical Privileges shall be subject to a period of proctoring. In addition, Members may be required to be proctored as a condition of renewal of Privileges (for example, when a Member requests renewal of a Privilege that has been performed so infrequently that it is difficult to assess the Member's current competence in that area). Proctoring may also be implemented whenever the Medical Executive Committee determines that additional information is needed to assess a Practitioner's performance. Each appointee or recipient of new Clinical Privileges shall be assigned to a department where performance on an appropriate number of cases as established by the Medical Executive Committee, or the department as designee of the Medical Executive Committee, shall be observed by the Chair of the department, or the Chair's designee, during the period of proctoring specified in the department's Rules and Regulations,

to determine suitability to continue to exercise the Clinical Privileges granted in that department. The exercise of Clinical Privileges in any other department shall also be subject to direct observation by the Chair of that department, or the Chair's designee. The Member shall remain subject to such proctoring until the Medical Executive Committee has been furnished with:

- (a) A report signed by the Chair of the department(s) to which the Member is assigned describing the types and numbers of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of Staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made; and
- (b) A report signed by the Chairs of the other department(s) in which the appointee may exercise Clinical Privileges, describing the types and number of cases observed and the evaluation of the applicant's performance and a statement that the Member has satisfactorily demonstrated the ability to exercise the Clinical Privileges initially granted in those departments.

#### **5.5-2 COMPLETION OF PROCTORING**

Proctoring shall be deemed successfully completed when the Practitioner completes the required number of proctored cases within the time frame established in the Bylaws and Rules and Regulations, and the Practitioner's professional performance in the cases meets the standard of care of the Hospital.

#### **5.5-3 EFFECT OF FAILURE TO COMPLETE PROCTORING**

- (a) Failure to Complete Necessary Volume: Any Member who fails to complete the required number of proctored cases within the time frame established in the Bylaws and Rules shall be deemed to have voluntarily withdrawn his or her request for membership (or the relevant Privileges), and he or she shall not be afforded the procedural rights provided in Article VIII. However,

the department has the discretion to extend the time for completion of proctoring in appropriate cases subject to ratification by the Medical Executive Committee. The inability to obtain such an extension shall not give rise to procedural rights described in Article VIII. Any Practitioner terminated pursuant to this section may not reapply to the Medical Staff for one (1) year, unless the Medical Executive Committee makes an exception for good cause.

- (b) Failure to Satisfactorily Complete Proctoring: If a Practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring, he or she may be terminated (or the relevant Privileges may be revoked), and he or she shall be afforded the procedural rights as provided in Article VIII.

#### **5.5-4 MEDICAL STAFF ADVANCEMENT**

The failure to obtain certification for any specific Clinical Privilege shall not, of itself, preclude advancement in Medical Staff category of any Member. If such advancement is granted absent such certification, continued proctorship on the uncertified procedure shall continue for the specified time period.

### **5.6 CONDITIONS FOR PRIVILEGES OF PRACTITIONERS OTHER THAN PHYSICIANS**

#### **5.6-1 ADMISSIONS**

When dentists, oral surgeons, podiatrists and clinical psychologists who are Members of the Medical Staff admit patients a physician Member of the Medical Staff must conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry, podiatry or clinical psychology), and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the Practitioner's lawful scope of practice. It is the responsibility of the non-physician Practitioner to secure the services of a physician to perform these functions prior to admitting the patient to the Hospital.

## **5.6-2 SURGERY**

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

## **5.6-3 MEDICAL APPRAISAL**

All patients admitted for care in a hospital by a dentist, podiatrist, or clinical psychologist shall receive the same basic medical appraisal as patients admitted to other services, and the dentist, podiatrists, or clinical psychologists shall seek consultation with a physician Member to determine the patient's medical status and a need for medical evaluation whenever the patient's clinical status indicates the development of a new medical problem. Where a dispute exists regarding proposed treatment between a physician Member and a Practitioner other than a physician based upon medical or surgical factors outside of the scope of licensure of said Practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate department(s).

## **5.7 TEMPORARY CLINICAL PRIVILEGES**

Temporary Privileges may be granted in two (2) circumstances. First, to meet an important patient care need and only after the Medical Staff verifies current licensure and current competence. Secondly, temporary Privileges may be granted when a new applicant with a complete application that raises no concerns is awaiting review and approval by the Medical Executive Committee and the Governing Body. There is no right to temporary Privileges. Accordingly, temporary Privileges should not be granted unless all of the information requested and obtained supports, with reasonable certainty, a favorable determination regarding the Practitioner's qualifications, ability, current competency and judgment to exercise the Privileges requested. If the available information is inconsistent or casts any reasonable doubts on the applicant's qualifications, action on the request for temporary Privileges may be deferred until the doubts have been satisfactorily resolved. Temporary Privileges may be granted by the Hospital Chief Executive Officer (or his or her

designee when the Hospital Chief Executive Officer is unavailable) on the recommendation of the Chief of Staff and the department chair where the Privileges will be exercised, or either's designee. A determination to grant temporary Privileges shall not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff. Temporary Privileges may not be granted for periods beyond one hundred twenty (120) days.

#### **5.7-1 REQUEST FROM APPLICANTS**

Temporary Privileges may be granted when a new applicant with a complete application that raises no concerns is awaiting review and approval by the Medical Executive Committee and the Board. Upon receipt of a completed application for Medical Staff membership from an appropriately licensed Practitioner, including verification of all data (including current licensure, relevant training or experience, current competence, ability to perform the procedures requested, a query and evaluation of the NPDB information, no previously successful challenges to licensure or registration, no subjection to involuntary termination of medical staff membership at another organization, and no subjection to involuntary limitation, reduction, denial or loss of Clinical Privileges), completion of the interview (if required) with the Department and/or Credentials Committee, and a favorable recommendation by the Credentials Committee, the Hospital Chief Executive Officer (or his or her designee when the Hospital Chief Executive Officer is unavailable) with the approval of the Chief of Staff or the Chairperson of the appropriate department, or their respective designees, may grant temporary Privileges for a period not to exceed ninety (90) days, to a Practitioner who is not a Member of the Medical Staff. Temporary Privileges may be extended for a thirty (30) day period where warranted under the circumstances, subject to the same approvals required for the initial granting of temporary Privileges.

#### **5.7-2 TEMPORARY PRIVILEGES - SPECIAL CONSULTANT**

Should the unique situation arise where a Practitioner with specific expertise is required for the care of a specific patient and the Practitioner is not a Member of the Medical Staff, then temporary Privileges may be granted by the Hospital Chief Executive Officer (or his/her designee when the Hospital Chief Executive Officer is unavailable), with the approval of the Chief

of Staff or the department chairperson. Such temporary Privileges shall be restricted to the treatment of not more than an aggregate of four (4) patients in any one (1) calendar year, after which such Practitioner shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients. Under extraordinary circumstances, a Practitioner may be granted temporary Privileges exceeding four (4) times per year without being required to apply for Medical Staff membership. Except for general dentistry, the Practitioner requesting temporary Privileges under this section must have Active Staff Privileges at another Joint Commission (or equivalent) - accredited acute care facility.

#### **5.7-3 TEMPORARY PRIVILEGES - LOCUM TENENS**

Temporary Clinical Privileges may be granted to a person serving as a locum tenens for a current Member of the Medical Staff, provided that the procedure described in Section 5.7-1 has been completed. Under exceptional circumstances, as determined by the Chief of Staff and the Chair (or his or her designee) of the Credentials Committee, the application process for locum tenens Privileges, including approval by the Credentials Committee, shall be completed within twenty-one (21) days. When this expedited process is utilized, the applicant for locum tenens Privileges shall be expected to work closely with the Medical Staff Office in the verification process and to promptly respond to all requests for information. A person granted locum may attend only patients of the Member for whom that person is providing coverage, or for the Member's call group, for a period not to exceed one hundred twenty (120) days, unless the Medical Executive Committee recommends a longer period for good cause.

#### **5.7-4 GENERAL 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 that the Chair, or the Chair's designee, is kept closely informed as to the applicant's activities within the Hospital.
- (b) Temporary Privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended or unless affirmatively renewed

as provided in Section. As necessary, the appropriate Department Chair or, in the absence of the Department Chair, the Chief of Staff, shall assign a Member of the Medical Staff to assume responsibility for the care of such Member's patient(s). The wishes of the patient shall be considered in the choice of a replacement Medical Staff Member.

- (c) Requirements for proctoring and monitoring, shall be imposed on such terms as may be appropriate under the circumstances upon any member granted temporary Privileges after consultation with the Department Chair or the Department Chair's designee.
- (d) At any time temporary Privileges may be suspended, restricted or terminated by the Chief Executive Officer upon the recommendation of the Department Chair or their designee, subject to prompt review by the Medical Executive Committee. In such cases, the appropriate Department Chair or, in the Chair's absence, the Chief of Staff, shall assign a Member of the Medical Staff to assume responsibility for the care of such Member's patient(s). The wishes of the patient shall be considered in the choice of a replacement Medical Staff Member.
- (e) The denial, suspension or termination of temporary Privileges shall entitle the Practitioner to a hearing if the action is taken for a medical disciplinary cause or reason reportable pursuant to Business and Professions Code section 805. Deferral of approval shall not entitle an applicant to any procedural rights if such deferral is due to the applicant's failure to timely submit necessary information or resolve information which casts reasonable doubt as to qualifications for Privileges.
- (f) All persons requesting or receiving temporary Privileges shall be bound by the Bylaws and Rules and Regulations of the Medical Staff.

## **5.8 EMERGENCY PRIVILEGES**

- (a) In the case of an emergency, any Member of the Medical Staff, to the degree permitted by licensure 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 Department Chair with respect to further care of the patient at the Hospital.
  
- (b) In the event of an emergency, and in particular when the disaster plan is activated, any person shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to qualified Members of the Medical Staff when it becomes reasonably available. If additional Practitioners are needed, the emergency credentialing procedure described in the Medical Staff Policy for Temporary Privileges shall be used to grant credentials to the Practitioner.

## **5.9 DISASTER PLAN CREDENTIALING**

The Hospital Chief Executive Officer or Chief of Staff, or their respective designees, may grant specialty-specific and time limited disaster Privileges to physicians and other licensed independent practitioners who volunteer their services during a disaster but who are not Members of the Medical Staff. Disaster plan credentialing shall only be available when the Hospital's Disaster plan is activated. The granting of such Privileges shall be in accordance with the Disaster Credentialing Policy, which shall comply with The Joint Commission requirements, as they may be amended from time to time. Any Privileges granted pursuant to this section shall exist only for the duration of the disaster as determined by the Hospital.

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

On its own, upon recommendation of the Credentials Committee, or pursuant to a request under Section 4.6-1(b), the Medical Executive Committee may recommend a change in the Clinical Privileges or department assignment(s) of a Member. The Medical Executive Committee may also recommend that the granting of additional Privileges to a current Medical Staff Member be made subject to monitoring in accordance with procedures similar to those outlined in Section 5.3-1. All requests for expansion or addition of Clinical Privileges shall be processed in the same manner as requests for initial Clinical Privileges.

## **5.11 LAPSE OF APPLICATION**

If a Medical Staff Member requesting a modification of Clinical Privileges or department assignments fails to timely furnish the information necessary to evaluate the request, the application shall automatically lapse, and the applicant shall not be entitled to a hearing as set forth in Article VIII.

# **ARTICLE VI**

## **ALLIED HEALTH PROFESSIONALS**

### **6.1 ALLIED HEALTH PROFESSIONALS**

Although Allied Health Professionals are not eligible for appointment to the Marin General Hospital Medical Staff individuals who meet criteria established by the MGH Board of Directors may apply for Allied Health Professional status in the same manner as applicants to the Medical Staff. The terms and conditions governing the practice of Allied Health Professionals at Marin General are set forth in protocols, standardized procedures, and guidelines approved by the Medical Staff and Hospital Board of Directors.

The Medical Staff shall have responsibility for reviewing and making recommendations to the Board regarding the credentials and Privileges or Clinical Privileges of each Allied Health Professional seeking or exercising Clinical Privileges, including those employed by or seeking employment with the Hospital. This will occur at the time of initial application and each time the Allied Health Professional seeks reappointment or renewal of Clinical Privileges. The Medical Staff

shall continuously monitor the quality of care provided at the Hospital by health care professionals who are permitted to treat patients at the Hospital by virtue of Allied Health Professional status. The Medical Staff may cede the monitoring responsibility, in accordance with applicable laws and accreditation standards, to the Hospital Administration in the case of individual Allied Health Professionals who are employed by the Hospital, where oversight by the Medical Staff would not be efficient or practicable. However, all Allied Health Professionals, including employees of the Hospital, shall be bound by the applicable Medical Staff Bylaws and Rules and Regulations governing the practice of Allied Health Professionals.

## **6.2 ADMISSION OF ALLIED HEALTH PROFESSIONAL CATEGORIES TO PRACTICE AT MARIN GENERAL HOSPITAL**

### **6.2.1 Policy**

It is the policy of Marin General Hospital to give fair consideration to the question of whether a specific category of Allied Health Professionals (AHP) should be permitted to practice on its premises as independent contractors. The question may be addressed either before an allied health professional in a given category applies to practice at Marin General Hospital, or upon receipt of the first application. The procedures below are intended to afford all interested persons an opportunity to make their views known, and to ensure that the ultimate decision is based upon appropriate considerations such as the quality of patient care, the availability of supervisors, compliance with all state and federal laws and regulations, and the ready access of patients to health care services. The procedures are intended to serve as guidelines, and may be varied for good cause in any particular case. Only those healthcare professions licensed in the State of California providing needed clinical services at MGH shall be given consideration for eligibility as an AHP category. Requests from independent contractors who are certificate holders or unlicensed healthcare providers cannot be considered.

### **6.2.2 PROCEDURE**

- (a) Requests for the acceptance of a new allied health professional category shall be submitted to Medical Staff Services for referral to the appropriate Department and Division of the Medical Staff.

- (b) If the category involves an employee of the Hospital who is neither an MD/DO, DDS, DPM or licensed clinical Psychologist, nor qualified to apply to an approved AHP category, an equivalent process shall be followed by the responsible Hospital Director, Medical Director, and the HR department in developing criteria-based clinical protocols, confirming legality of proposed treatment standards, confirming professional qualifications, and establishing objective criteria for ongoing monitoring. The standardized procedures or protocols shall be submitted for review and be granted final approval prior to care delivery. Such processes will be defined in written documents to ensure compliance with all state and federal laws and regulations.
- (c) The Department will consider the issue and, on the basis of its review, will make a recommendation to the Interdisciplinary Practice Committee (IPC), to be accompanied by a report setting forth the reasons for the recommendation.
- (d) The IPC will review the recommendation and report, and then will forward its own recommendations, together with a report, to the Medical Executive Committee. The Medical Executive Committee will forward their recommendation to the Board of Directors, through the Medical Policy Committee to the Hospital Board of Directors.
- (e) The Hospital Board of Directors will review the recommendation and report, and will consider the comments of Administration, the Medical Policy Committee, the Medical Staff, the nursing staff, and any other interested person or body within Marin General Hospital. It then will arrive at a decision.
- (f) If the Board of Directors decides to accept the category in question, it will communicate its decision to Administration and the Medical Executive Committee.
- (g) If the Board of Directors decides to reject the category in question, it will defer its decision

pending a forum in which it receives comments from all interested persons, both inside and outside Marin General Hospital. Comments will be in writing, unless the Board of Directors decides in its discretion to hold an oral proceeding. Notice of the forum will be sent to all persons who have demonstrated an interest in the matter, and will contain an account of the action being considered and an explanation of the process for making comments.

- (h) When all comments have been received, Administration shall prepare a report concerning them, and will forward it, together with a text of the comments themselves, to the Board of Directors. The Board of Directors then will make its final decision on the matter in the form of a resolution. The resolution will contain a concise statement of the reasons for the Board of Director's decision, and will indicate how various comments, arguments, and points of view were considered.

### **6.3 ELIGIBILITY FOR APPOINTMENT AND REAPPOINTMENT**

- 1. (a) Applied Health Professionals who practice in categories which have been accepted for admission to Marin General Hospital by the Board of Directors are eligible to be considered for appointment to Allied Health Professional status.

- (b) Appointment to Allied Health Professional status shall confer on the appointee only such status, rights, and Clinical Privileges as may be provided in these Guidelines and in the terms of appointment.

- (c) Qualifications

- 1. Allied Health Professionals are eligible for Clinical Privileges only if they:

- a) Hold any and all licenses or certificates which are required under the laws of the State of California for his/her professional field.

- b) Document their experience, background, training, competence, 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 level of quality and efficiency established by Marin General Hospital.
  - c) Are determined on the basis of documented references to adhere strictly to the lawful ethics of their profession, to work cooperatively with others in the hospital setting; and to be willing to commit to and regularly assist Marin General Hospital in fulfilling its obligations related to patient care, within the area of their professional competence and credentials.
  - d) Have obtained or are otherwise covered by professional liability insurance at limits determined by the Hospital Board of Directors.
  - e) Will be sponsored or supervised by one or more Members of the Medical Staff to the extent required by law.
2. Maintain all qualifications as defined in this document as written or changed in the future.

(d) Applications for Initial Appointment

- 1. An Allied Health Professional who submits a written request from a sponsoring Active Staff physician Member of the Medical Staff will be provided with an application and other forms necessary to apply and qualify for Clinical Privileges; and physicians who desire to supervise or direct AHPs must apply and qualify for Privileges, in order to supervise approved AHPs. Applications for initial Privileges shall be submitted and processed in a parallel manner to

that provided in Article III, Section 3, of the Medical Staff Bylaws, however the rights and prerogatives of applicants for membership on the Medical Staff shall not apply.

Evaluation of documents received in support of an application for AHP status will be reviewed by the Chair of the supervising physician's department and the Interdisciplinary Practice Committee.

Their evaluation and recommendation will be forwarded to the Medical Executive Committee, the Medical Policy Committee and on to the Hospital Board of Directors for consideration. The Board of Directors will advise the applicant of the outcome of their deliberations.

Applicants who are denied AHP status are entitled to a hearing as described under Section IV, Termination/Suspension (of this document).

2. An AHP who does not have licensure or certification in an AHP category listed in Section A.1 may not apply for Clinical Privileges, but may submit a written request to the Medical Staff, asking that the Board of Directors consider adding his/her category of AHPs as eligible to apply for Clinical Privileges. Allied Health professional Hospital employees or regular contractual dependent practitioners may be granted ongoing Privileges to function under standardized procedures and/or job descriptions as appropriate and as required by accreditation and regulatory standards.

(e) Applications for Reappointment

1. In order to maintain AHP status at Marin General, all AHPs must submit applications for biannual renewal. These documents shall be submitted and processed in a parallel manner to that provided in Article III, of the Medical Staff Bylaws and as described in C, above.

#### 6.4 DUTIES AND PREROGATIVES

- (a) An Allied Health Professional shall be expected to comply with these Guidelines, with all other applicable rules of Marin General Hospital and its Medical Staff, and with all applicable laws and standards.
- (b) Upon appointment, an Allied Health Professional may:
  - 1. Exercise independent judgment within his/her area of competence and as defined by delineated Privileges and/or standardized protocols, provided that a physician who is a current Member in good standing of the Medical Staff shall retain the ultimate responsibility for the patient's care; this may include the right to:
    - a) Participate directly in the management of patients to the extent authorized by his/her license, certificate, or other legal credentials.
    - b) Write orders to the extent authorized by Marin General Hospital;
    - c) Record reports and progress notes on patient charts to the extent authorized by Marin General Hospital.
    - d) Perform consultation on request if authorized by Marin General Hospital
- (c) Duties of Supervising Physician
  - 1. Supervising Physician shall notify the Chief of Staff in writing that he/she:
    - a) Accepts full legal and ethical responsibility for the performance of all professional activities of the AHP;
    - b) Will submit a signed, written protocol for approval by the Interdisciplinary Practice Committee, which sets forth and describes

those tasks and functions that the AHP shall be authorized to perform in the Hospital, especially those functions that the AHP shall be permitted to perform outside of the immediate supervision and control of the supervising physician.

## **6.5 TERMINATION/SUSPENSION OF PRIVILEGES**

### **6.5-1 TERMINATION.**

An AHP's Privileges shall automatically and immediately terminate in the event:

- (a) The Medical Staff membership of the supervising physician, if any, ceases or 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 AHPs licensure or certification expires, is revoked, or is suspended.

Allied Health Professionals shall be subjected to corrective action as described below for reasons related to the safe delivery of quality patient care or related matters, such as those specified in Article VII of the Medical Staff Bylaws.

### **6.5-2 SUSPENSION.**

The Chair of the appropriate Medical Department will also have the authority to summarily suspend an AHP whenever in his/her judgment, such suspension is necessary to protect patients and/or employees. Any such suspension shall afford the AHP the right to a hearing. The appropriate departmental AHP Committee will be appointed, and shall have the responsibility to investigate questions and concerns with regard to competence or performance. The appropriate, appointed AHP committee will recommend, when appropriate, suspension to the Chair of the Department, or

removal to the Board of Directors through the Medical Executive Committee. Removal of an AHP will be the prerogative of the Board of Directors. Any recommendation for removal shall afford the AHP the right to a hearing in accordance with this section below.

**6.5-3 HEARING.**

In the event of any of the following, the AHP will be entitled to a hearing:

- (a) Refusal of the initial application or of any Privileges requested;
- (b) Failure to grant an application for reappointment;
- (c) A recommendation for removal or reduction in scope of Privileges for a medical disciplinary cause or reason;
- (d) A summary suspension or limitation of Privileges.

The affected AHP may within ten (10) days of the receipt of notice of such action, request a hearing before the appropriate AHP Committee, as determined by the Department Chairman. The Medical Staff shall thereupon prepare a notice of the reasons for the adverse action and notify the AHP, by personal delivery or registered mail, of such notice of reasons together with the time, date, and place of hearing. Unless otherwise agreed to by all parties the hearing shall be held no later than sixty (60) days after receipt of request for hearing, provided that the AHP shall be entitled to a hearing within twenty (20) days if he/she is summarily suspended. The hearing shall be conducted informally without the application of technical rules of evidence. The decision of the appropriate AHP Committee will be final as to all substantive matters.

The affected AHP may appeal the Committee's decision to the Board of Directors only with respect to the fairness of the hearing, provided that a written request to the Board of Directors is made within ten (10) days after receipt of notice of the decision of the Committee.

## **6.6 RELATIONSHIP TO MEDICAL STAFF**

Because they are not Medical Staff Members, Allied Health Professionals shall not be entitled to vote on Medical Staff matters nor shall they be required to pay Medical Staff dues. They shall, however, be permitted to attend and participate actively in the clinical meetings of their respective departments to the extent permitted by the Division Chief or Department Chair.

## **6.7 CONFIDENTIALITY**

Allied Health Professionals shall at all times respect the confidentiality of patient and Medical Staff information obtained in the course of their practice at Marin General Hospital. Inasmuch as effective peer review and consideration of the qualifications of AHPs and applicants to perform specific functions must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations is outside appropriate standards of conduct and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems necessary.

# **ARTICLE VII**

## **CORRECTIVE ACTION**

### **7.1 CORRECTIVE ACTION**

#### **7.1-1 ROUTINE MONITORING AND EVALUATION.**

The departments and committees are responsible for carrying out delegated review and quality management functions. They may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the Practitioner is only required to provide reasonable notice of admissions and procedures) in the course of carrying out their duties without initiating formal corrective action. Comments, suggestions and warnings may be issued orally or in writing. The Practitioner shall be given an opportunity to meet with the department or committee. Any notices of informal actions, monitoring, or counseling should be documented in the Practitioner's file. Medical Executive Committee approval is not

required for such actions, although the actions may be reported to the Medical Executive Committee. The actions shall not constitute a restriction of Privileges or grounds for any formal hearing or appeal rights under Article VIII.

#### **7.1-2 CRITERIA FOR INITIATION OF INVESTIGATION**

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its Members. A corrective action investigation may be initiated whenever reliable information indicates a Member may have engaged in, made, or exhibited acts, statements, demeanor, or professional conduct, either within or outside of the Hospital, and the same is or is reasonably likely to be: (a) detrimental to patient safety or to the delivery of quality patient care; (b) disruptive to the Hospital operations; (c) unethical conduct; (d) in contravention of these Bylaws, the Rules and Regulations of the Medical Staff, departmental policies and procedures and those policies of the Hospital required by state or federal law or by the standards of national accrediting organizations such as The Joint Commission (or equivalent) and NCQA; or (e) the Member has sustained a summary suspension or limitation of Privileges at another hospital, for a medical disciplinary cause or reason, .

#### **7.1-3 INITIATION OF INVESTIGATION**

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

#### **7.1-4 INVESTIGATION**

If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself, or may assign the task to an appropriate Medical Staff officer, Medical Staff department, or standing or ad hoc committee of the Medical Staff. The Medical Executive Committee in its discretion may appoint Practitioners who are not Members of the Medical Staff as temporary Members of the Medical Staff for the sole purpose of serving on a standing or ad hoc

committee, should circumstances warrant. If the investigation is delegated to an officer of a committee other than the Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action. The Member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a "hearing" as that term is used in Article VIII, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

#### **7.1-5 MEDICAL EXECUTIVE COMMITTEE ACTION**

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

- (a) Determining no corrective action be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the Member's file.
- (b) Deferring action for a reasonable time where circumstances warrant.
- (c) Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude department heads from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected Member may make a written response which shall be placed in the Member's file.

- (d) Recommending the imposition of terms of probation, proctoring (other than as a fact finding tool to assess competence) or special limitation upon continued Medical Staff membership or exercise of Clinical Privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring.
- (e) Recommending reduction, modification, suspension or revocation of Clinical Privileges.
- (f) Recommending reduction of membership status or limitation of any prerogatives directly related to the Member's delivery of patient care.
- (g) Recommending suspension, revocation or probation of Medical Staff membership.
- (h) Taking other actions deemed appropriate under the circumstances.

**7.1-6 SUBSEQUENT 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 Body shall be transmitted thereto.
- (b) If corrective action as set forth in Section 8.2(a)-(k) is recommended by the Medical Executive Committee, that recommendation shall be transmitted to the Board of Directors. So long as the recommendation is supported by substantial evidence the recommendation of the Medical Executive Committee shall be adopted by the Board as final action unless the Member requests a hearing, in which case the final decision shall be determined as set forth in Article VIII.
- (c) If the Medical Executive Committee recommends an action that constitutes grounds for a hearing under Section 7.1-7 (a) - (l), the Chief of Staff shall give the Practitioner Special Notice of the adverse recommendation and of the right to request a hearing. The Governing Body may be informed of the recommendation, but shall take no action until the

Practitioner has either waived his or her right to a hearing or completed the hearing.

#### **7.1-7 INITIATION BY BOARD OF DIRECTORS**

If the Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Board of Directors may direct the Medical Executive Committee to initiate investigation or disciplinary action, but only after consultation with the Medical Executive Committee. The Governing Body's request for Medical Staff action shall be in writing and shall set forth the basis of the request. If the Medical Executive Committee fails to take action in response to that Board of Directors direction, the Board of Directors may initiate corrective action, but this corrective action must comply with Articles VII and VIII of these Medical Staff Bylaws. The Governing Body shall inform the Medical Executive Committee in writing of what it has done.

#### **7.2 SUMMARY RESTRICTION OR SUSPENSION**

##### **7.2-1 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, or a Member is placed under summary suspension or there is a limitation of Privileges at another hospital, the Chief of Staff, the Medical Executive Committee, or the head of the department or designee in which the Member holds Privileges may summarily restrict or suspend the Medical Staff membership or Clinical Privileges of such Member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the Member, the Board of Directors, the Medical Executive Committee and the Chief Executive Officer. 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 Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute Member.

#### **7.2-2 MEDICAL EXECUTIVE COMMITTEE ACTION**

In those cases where the Medical Executive Committee did not impose the initial summary action, a meeting of the Medical Executive Committee shall be convened within ten (10) calendar days 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 VIII, nor shall any procedural rules apply. In those cases where the Medical Executive Committee imposed the initial summary action, the Member may request a meeting with the Medical Executive Committee for the same purposes and on the same terms and conditions as described above. The Medical Executive Committee shall hold such meeting within ten (10) calendar days of receipt of the request. 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.

#### **7.2-3 PROCEDURAL RIGHTS**

Unless the Medical Executive Committee promptly terminates the summary restriction or suspension, the Member shall be entitled to the procedural rights afforded by Article VIII. The summary restriction or suspension shall remain in effect during the pendency and completion of the corrective process and of the hearing and appellate review process. When a summary action is continued, the affected Practitioner shall be entitled to the procedural rights afforded by Article VII, but the hearing may be consolidated with the hearing on any corrective action that is recommended so long as the hearing commences within sixty (60) days after the hearing on the summary action was requested.

#### **7.2-4 INITIATION BY BOARD OF DIRECTORS**

If the Chief of Staff, the Medical Executive Committee and the Department Chair(or the Vice Chair if the Chair is not available)

in which the Member holds Privileges are not available to summarily restrict or suspend the Member's membership or Clinical Privileges, the Board of Directors (or designee) may immediately suspend a Member's Privileges if a failure to summarily 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 Board of Directors (or designee) made reasonable attempts to contact the Chief of Staff, the Medical Executive Committee and the Department Chair (or Vice Chair if the Chair is unavailable) 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 provisions under Section 7.2 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.

#### **7.2-5 EFFECT OF ACTIONS TAKEN BY OTHER FACILITIES**

Whenever the Chief of Staff or Medical Executive Committee receives information about an action taken at another hospital and involving a Practitioner holding Privileges at the Hospital, the Chief of Staff or Medical Executive Committee shall independently assess the facts and circumstances to ascertain whether to take comparable action. However, when the Practitioner was summarily suspended or restricted at the other hospital, any person authorized under these Bylaws to impose a summary suspension or restriction is authorized to immediately impose a comparable summary suspension or restriction at the Hospital, subject to review by the Medical Executive Committee in accordance with the provisions of these Bylaws.

#### **7.3 AUTOMATIC SUSPENSION OR LIMITATION**

In the following instances, the Member's Privileges or membership may be suspended or limited as described, and a hearing, if requested, shall be limited to the question of whether the grounds for automatic suspension as set forth below, have occurred.

**7.3-1 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. Such Member shall not be entitled to the procedural rights afforded by Article VIII.
- (b) Restriction: Whenever a Member's license or other legal credential authorizing practice in this State is limited or restricted by the applicable licensing or certifying authority, any Clinical Privileges which the Member has been granted at the Hospital which are within the scope of said limitation or restriction shall be automatically limited 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, membership status and Clinical Privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

**7.3-2 EXCLUSIVE CONTRACTS**

The Privileges of a Practitioner who is a member of, a subcontractor of, or otherwise affiliated with, a Practitioner or group which holds an exclusive contract, shall be automatically terminated or restricted as to those Privileges covered by the exclusive contract if his or her membership in, subcontract with or affiliation with the exclusive contractor is terminated or if his or her Privileges with the group are restricted by the group.

**7.3-3 CONTROLLED SUBSTANCES**

- (a) Revocation and Suspension: Whenever a Member's 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.

#### **7.3-4 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT**

Failure of a Member without good cause to appear and satisfy the requirements of Section 12.6-2 shall result in the Member being automatically suspended from exercising all or such portion of Privileges as the Medical Executive Committee determines.

#### **7.3-5 MEDICAL RECORDS**

Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the Medical Executive Committee. A limited suspension in the form of withdrawal of admitting and other related Privileges until medical records are completed, shall be imposed by the Chief of Staff (or designee), after notice of delinquency for failure to complete medical records within such period. For the purpose of this Section, "related Privileges" means voluntary on call service for the emergency room, scheduling surgery, assisting in surgery, consulting on hospital cases, and providing professional services within 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 Chief of Staff (or designee) after receipt of notice from the records department that the necessary medical records have been completed and after payment of any monetary fines as determined by the Medical Executive Committee, or until termination of membership and Privileges in accordance with the Medical Staff Bylaws and/or Rules and Regulations.

#### **7.3-6 FAILURE TO PAY DUES/FINES/ASSESSMENTS**

Failure without good cause as determined by the Medical Executive Committee, to pay dues, fines or assessments, as required under

Section 14.2 or pursuant to other provisions of the Bylaws, Rules and Regulations or policies, shall be ground for automatic suspension of a Member's Clinical Privileges, and if within six (6) months after written warnings of the delinquency the Member does not pay the required dues or assessments, the Member's membership shall be automatically terminated.

**7.3-7 FAILURE TO MAINTAIN PROFESSIONAL LIABILITY INSURANCE**

Failure to maintain professional liability insurance 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.

**7.3-8 FAILURE TO RESUBMIT REAPPOINTMENT APPLICATION IN TIMELY MANNER**

Failure to submit the completed reappointment application in accordance with the provisions of these Bylaws shall constitute grounds for an automatic suspension of Privileges at the end of the Member's current appointment period.

**7.3-9 EXCLUSION FROM PARTICIPATION IN FEDERAL HEALTH CARE PROGRAM**

Whenever a Member is excluded from participation in Medicare, Medicaid, or any other federal health care program as a sanction for unlawful conduct, Medical Staff membership and Clinical Privileges shall be automatically and immediately suspended as of the effective date of the exclusion, pending final action by the Board of Directors, based upon recommendation of the Medical Executive Committee, which final action may included lifting the suspension following official reinstatement of eligibility to participate in the federal health care programs.

**7.3-10 EXECUTIVE COMMITTEE DELIBERATION**

As soon as practicable after action is taken or warranted as described in Sections 7.3-1(b) or (c), Sections 7.3-2, 7.3-3, 7.3-4, 7.3-5, 7.3-6, 7.3-7, 7.3-8 and 7.3-9 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 8.1-3.

## ARTICLE VIII

### HEARINGS AND APPELLATE REVIEWS

#### 8.1 GENERAL PROVISIONS

##### 8.1-1 EXHAUSTION OF REMEDIES

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

##### 8.1-2 INTRA-ORGANIZATIONAL REMEDIES

The hearing and appeal rights established in these Bylaws are strictly "judicial" rather than "legislative" in structure and function. The hearing committees have no authority to adopt or modify rules and standards or to decide questions about the merits or substantive validity of Bylaws, Rules or policies. However, the Medical Executive Committee, in conjunction with the Governing Body may, in its discretion, entertain challenges to the merits or substantive validity of Bylaws, Rules, or policies and decide those questions. If the only issue in a case is whether a Bylaw, Rule or policy is lawful or meritorious, the Practitioner is not entitled to a hearing or appellate review. In such cases, the Practitioner must submit his or her challenges first to the Governing Body and only thereafter may he or she seek judicial intervention.

##### 8.1-3 APPLICATION OF ARTICLE

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

##### 8.1-4 SUBSTANTIAL COMPLIANCE

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

## 8.1-5 FINAL ACTION

Recommended adverse action described in Section 7.1-7 shall become final only after the hearing and appellate rights set forth in these Bylaws have either been exhausted or waived, and only upon being adopted as final actions by the Governing Body.

## 8.2 GROUNDS FOR HEARING

In any case in which any Member of the Medical Staff, or any applicant for such membership, receives notice of a specific recommendation of the Medical Executive Committee to the Governing Body outlined in this Section 8.2 which recommendation, if approved by the Governing Body, would adversely affect Practitioner's exercise of Clinical Privileges ("adverse recommendation"), or if a Practitioner is otherwise entitled by these Bylaws to a hearing and review under these Bylaws, the Practitioner shall be entitled to a hearing before a Judicial Review Committee, and if the Judicial Review Committee also makes an adverse recommendation, to appellate review by the Governing Body prior to its final decision on the matter. 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 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 5.3);
- (l) Termination of contract between Hospital and Member of the Medical Staff for a medical disciplinary cause or reason as defined in Business and Professions Code Section 805 or its successor statute;
- (m) Denial, reduction, suspension or termination of temporary Privileges for a medical disciplinary cause or reason as defined in Business and Professions Code Section 805 or its successor statute;
- (n) Any other disciplinary action or recommendation that must be reported to the Medical Board of California or the Practitioner's appropriate licensing board.

### **8.3 REQUESTS FOR HEARING**

#### **8.3-1 NOTICE OF ACTION OR PROPOSED ACTION**

In all cases in which action has been taken or a recommendation made as set forth in Section 8.2, said person or body shall give the Member prompt written notice. This notice shall in all instances include the following information;

- (a) A description of the action or recommendation;
- (b) That the Practitioner has the right to request a hearing. Such hearing must be requested within thirty (30) days after receipt of the notice or the right to a hearing is waived;
- (c) A summary of the Practitioner's rights in the hearing;
- (d) A concise statement of the reasons for the action or recommendation; and
- (e) In the event the adverse action or recommendation is the type of action which will be reportable to Medical

Board of California pursuant to Section 805 of the Business and Professions Code, if adopted or implemented, then the notice should also explain that the action, if adopted or implemented, will be reportable to Medical Board of California pursuant to Business and Professions Code section 805.

**8.3-2 REQUEST FOR HEARING**

The Member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Medical Executive Committee with a copy to the Board of Directors. The Practitioner shall state, in writing, his or her intentions with respect to attorney representation at the time he or she files the request for a hearing. Notwithstanding the foregoing and regardless of whether the Practitioner elects to have attorney representation at the hearing, the parties shall have the right to consult with legal counsel to prepare for a hearing or an appellate review. In the event the Member does not request a hearing within the time and in the manner described, the Member shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

**8.3-3 TIME AND PLACE FOR HEARING**

Upon receipt of a request for hearing, the Medical Executive Committee shall schedule a hearing and, within thirty (30) 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 not less than thirty (30) days from the date of the notice, nor more than sixty (60) days after receipt by the Medical Executive Committee of the request for hearing; provided, however, that when the request is received from a Member who is under summary suspension the hearing shall be held as soon as the arrangements may reasonably be made.

**8.3-4 NOTICE OF CHARGES**

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 witness (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 8.4-1. The notice of hearing shall also include a list of the names and addresses of the individuals, so far as then reasonably known or anticipated, who are expected to give testimony or evidence in support of the Medical Executive Committee at the hearing. This list shall be updated, as necessary and appropriate, at least ten (10) days prior to the commencement of the hearing.

### **8.3-5 JUDICIAL REVIEW COMMITTEE**

When a hearing is requested, the Medical Executive Committee shall recommend a Judicial Review Committee to the Board of Directors for appointment. The Board of Directors shall be deemed to approve the selection unless it provides written notice to the Medical Executive Committee stating the reasons for its objection within five (5) days. The Judicial Review Committee shall be composed of not less than three (3) 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, initial decision-maker or otherwise and 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 a 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 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 M.D. or D.O. degrees.

**8.3-6 FAILURE TO APPEAR OR PROCEED**

Failure without good cause of the Member to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

**8.3-7 POSTPONEMENTS AND EXTENSIONS**

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted only upon agreement of the parties or by the Judicial Review Committee, or its Chair acting upon its behalf, within the discretion of the committee or its Chair on a showing of good cause.

**8.4 HEARING PROCEDURE**

**8.4-1 PREHEARING PROCEDURE**

- (a) If either side to the hearing requests in writing a list of witnesses, each party shall furnish to the other a written list of the names of the individuals, so far as is then reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. The list shall be provided within fifteen (15) days of receipt of such request, and in no event less than ten (10) days prior to the hearing. Failure of either party to do so shall constitute grounds for a continuance. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. The Member shall have the right to inspect and copy documents or other evidence upon which the charges are based as well as all other evidence relevant to the charges. The Member 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.

- (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 possess or controls 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 Member under review.
- (d) 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. The documents intended to be made available to the Judicial Review Committee must be exchanged at least ten (10) days prior to the hearing. A failure to comply with this rule shall constitute good cause for a continuance. Repeated failures to comply shall be good cause for the hearing officer to limit the introduction of any documents not provided to the other side in a timely manner.
- (e) The hearing officer shall consider and rule upon any disputed request for access to information and may impose any safeguards the protection of the peer review process and justice require. In so doing, the hearing officer shall consider, among other things, :
  - 1. Whether the information sought may be introduced to support or defend the charges;
  - 2. The exculpatory or inculpatory nature of the information sought, if any;
  - 3. The burden imposed on the party in possession of the information sought, if access is granted; and

4. Any previous requests for access to information submitted or resisted by the parties to the same proceeding.

(f) The Member shall be entitled to a reasonable opportunity to question and challenge the impartiality of Judicial Review Committee members and the hearing officer. The hearing officer shall establish the procedure by which this right may be exercised, which shall be intended to resolve all such questions prior to the hearing. Challenges to the impartiality of any Judicial Review Committee member or the hearing officer shall be ruled on by the hearing officer applying applicable legal principles defining standards of impartiality for hearing panels and hearing officers in proceedings of this type.

(g) 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 prehearing decisions may be succinctly made at the hearing.

#### **8.4-2 REPRESENTATION**

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

The Member shall be entitled to representation by legal counsel in any phase of the hearing, if the Member so chooses, and shall receive notice of the right to obtain representation by an attorney at law.

In the absence of legal counsel, the Member shall be entitled to be accompanied by and represented at the hearing only by a Practitioner licensed to practice in the state of California who is not also an attorney at law, and the Medical Executive Committee shall appoint a representative who is not an attorney

to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions. The Medical Executive Committee shall not be represented by an attorney at law if the Member is not so represented.

#### **8.4-3 THE HEARING OFFICER**

The Medical Executive Committee shall recommend a hearing officer to the Board of Directors to preside at the hearing. The Board of Directors 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 shall be an attorney at law qualified to preside over a quasi-judicial hearing, but an attorney from a firm regularly utilized by the Hospital, the Medical Staff or the involved Medical Staff Member or applicant for membership, for legal advice 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. The hearing officer shall assist in preparation of the Judicial Review Committee's report and recommendations. In the absence of the appointment of a hearing officer by the Medical Executive Committee, the Chairperson of the Judicial Review Committee shall serve as the presiding officer and all references to a "hearing officer" in these Bylaws will refer to such presiding officer.

#### **8.4-4 RECORD OF THE HEARING**

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

#### **8.4-5 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 refute evidence, and to submit a written statement at the close of the presentation of the 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/or Judicial Review Committee and examined as if under cross-examination.

#### **8.4-6 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.

#### **8.4-7 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 applicant's current qualifications for membership and Privileges. An applicant shall not be permitted to introduce information requested by the Medical Staff but 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 was reasonable and warranted.

#### **8.4-8 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.

#### **8.4-9 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 Board of Directors as the final action if it is supported by substantial evidence and has

followed these Medical Staff Bylaws or applicable law so as to extend a fair procedure.

#### **8.4-10 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 Chief Executive Officer, the Board of Directors, 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. 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 Board of Directors as the final action if it is supported by substantial evidence, following a fair procedure.

### **8.5 APPEAL**

#### **8.5-1 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 Chief of Staff, the Chief Executive Officer, and the other party in the hearing. If appellate review is not requested within such period, that action or recommendation shall be affirmed by the Board of Directors as the final action if it is supported by substantial evidence, following a fair procedure.

#### **8.5-2 GROUNDS FOR APPEAL**

A written request for an appeal shall include an identification of the grounds for appeal, and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be: (a) substantial non-compliance with the

procedures required by these Bylaws or applicable law which has created demonstrable prejudice; or (b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 8.5-5;.

#### **8.5-3 TIME, PLACE AND NOTICE**

If an appellate review is to be conducted, the appeal board shall, within thirty (30) days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The 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.

#### **8.5-4 APPEAL BOARD**

The Board of Directors 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 Board of Directors. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same 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 Board of Directors shall not be the attorney that represented either party at the hearing before the Judicial Review Committee.

#### **8.5-5 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 the appellant's 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 Board of Directors its written recommendations as to whether the Board of Directors should affirm, modify, or reverse the Judicial Review Committee decision, or remand the matter to the Judicial Review Committee for further review and decision.

#### **8.5-6 DECISION**

- (a) Except as provided in Section 8.5-6(b), within thirty (30) days after the conclusion of the appellate review proceedings, the Board of Directors 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 Board of Directors 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 Board of Directors. 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 Board of Directors and the Judicial Review Committee.

- (c) The decision shall be in writing, shall specify the reasons for the action taken, and provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and appeal (if any), and the decision reached, if such findings and conclusions differ from those of the Judicial Review Committee. The decision shall be forwarded to the Chief of Staff and the Medical Executive Committee the subject of the hearing.

#### **8.5-7 RIGHT TO ONE HEARING**

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

#### **8.5-8 CONFIDENTIALITY**

To maintain confidentiality in the performance of peer review, disciplinary and credentialing functions, participants in any stage of the hearing or appellate review process shall limit their discussion of the matters involved to the formal avenues provided in the Medical Staff Bylaws.

### **8.6 EXCEPTIONS TO HEARING RIGHTS**

#### **8.6-1 MEDICAL-ADMINISTRATIVE OFFICERS AND CONTRACT PHYSICIANS**

Any Member of the Medical Staff who has a contract with the Hospital which requires membership on the Medical Staff shall not have Medical Staff membership terminated or restricted for medical disciplinary cause or reason without the same rights of hearing and appeal as are available to all Members of the Medical Staff and the due process rights included herein may not be limited by any inconsistent provisions in a contract.

#### **8.6-2 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES**

- (a) No hearing is required when a Member's license or legal credential to practice has been revoked or suspended as set forth in Section 7.3-1(a). In other cases

described in Section 7.3-1 and 7.3-2, 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.

- (b) Practitioners whose Privileges are automatically suspended and/or who have resigned their Medical Staff membership for failing to satisfy a special appearance (Section 7.3-4), failing to complete medical records (Section 7.3-5), failing to timely file an application for reappointment (Section 7.3-8), failing to maintain malpractice insurance (Section 7.3-7), or failing to pay dues or fines (Section 7.3-6) are not entitled under Article VIII to any hearing or appellate review rights except when a suspension is required to be reported to the Medical Board of California.
- (c) A Practitioner who is automatically suspended pursuant to Section 7.3-9 shall be entitled to a hearing under Article VIII; however, the issues which may be considered at a hearing shall not include evidence designated to show that the determination by the government enforcement authorities was unwarranted. Rather the only issue considered at the hearing shall be whether the Practitioner may continue to practice in the Hospital while under the exclusion.

#### **8.6-3 EXCLUSIVE CONTRACTS**

- (a) The fair hearing rights of Article VIII do not apply to a Practitioner whose application for Privileges was denied, in whole or in part, on the basis that the Privileges sought are covered by an exclusive contract.
- (b) The fair hearing rights of Article VIII do not apply to a Practitioner whose Privileges are terminated, or suspended, or restricted following the decision to enter into an exclusive contract for the provision of the subject services.
- (c) The fair hearing requirements of Article VIII do not apply to a Practitioner whose Privileges are

terminated, suspended or restricted because he or she is terminated, suspended or restricted by, or he or she is no longer affiliated with, the physician or group holding the exclusive contract.

#### **8.6-4 FAILURE TO MEET MINIMUM ACTIVITY REQUIREMENTS**

Practitioners shall not be entitled to the hearing and appellate review rights if their membership or Privileges are denied, restricted, or terminated or their Medical Staff categories are changed or not changed because of a failure to meet any existing minimum activity requirements set forth in the Medical Staff Bylaws or Rules and Regulations. In such cases, the only review shall be provided by the Medical Executive Committee through a subcommittee consisting of at least three (3) Medical Executive Committee members. The subcommittee shall give the Practitioner notice of the reasons for the intended denial or change in membership, Privileges, and/or category and shall schedule an interview with the subcommittee to occur no less than thirty (30) days and no more than one hundred (100) days after the date the notice was given. At this interview, the Practitioner may present evidence concerning the reasons for the action, and thereafter the subcommittee shall render a written decision within forty-five (45) days after the interview. A copy of the decision shall be sent to the Practitioner, Medical Executive Committee and the Governing Body. The subcommittee decision shall be final unless it is reversed or modified by the Medical Executive Committee within forty-five (45) days after the decision was rendered or the Governing Body within ninety (90) days after the decision was rendered.

#### **8.7 EXPUNCTION OF DISCIPLINARY ACTION**

Upon petition, the Medical Executive Committee, in its sole discretion, may expunge previous disciplinary action upon a showing of good cause or rehabilitation.

#### **8.8 NATIONAL PRACTITIONER DATA BANK REPORTING**

##### **8.8-1 ADVERSE ACTIONS**

The authorized representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as final action. 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.

**8.8-2 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 Staff, 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 IX**

**OFFICERS**

**9.1 OFFICERS OF THE MEDICAL STAFF**

The Medical Staff's right of self-governance includes the right to select and remove Medical Staff Officers.

**9.1-1 IDENTIFICATION**

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

**9.1-2 QUALIFICATIONS**

Officers must be Members of the Active Medical Staff at the time of their nominations and election, and must remain Members in Good Standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

**9.1-3 NOMINATIONS**

- (a) The Medical Staff election year shall be each odd numbered Medical Staff year. A nominating committee shall be appointed by the Medical Executive Committee not later than one hundred twenty (120) days prior to the annual staff meeting to be held during the election year or at least forty five (45) days prior to any special election. The nominating committee shall consist of the current Chief of Staff (who shall serve as the Chair), the Vice-Chief of Staff, and one other member of the Medical Executive Committee, and two (2) members chosen by vote of the department chairs from among the active Medical Staff who are not then members of the Medical Executive Committee. The Nominating Committee shall nominate one or more nominees for each office. The nominations of the committee shall be reported to the Medical Executive Committee at least sixty (60) days prior to the annual meeting and shall be delivered or mailed to the voting Members of the Medical Staff at least forty (40) days prior to the election.
- (b) Further nominations may be made for any office by any voting Member of the Medical Staff, provided that the name of the candidate is submitted in writing to the Chair of the Nominating Committee, is endorsed by the signatures of at least ten percent (10%) of other Members who are eligible to vote, and bears the candidate's written consent. These nominations shall be delivered to the Chair of the Nominating Committee as soon as reasonably practicable, but at least forty (40) days prior to the date of election. If any nominations are made in this manner, the voting Members of the Medical Staff shall be advised by notice delivered or mailed at least ten (10) days prior to the meeting. Nominations from the floor will be recognized if the nominee is present and consents.

**9.1-4 ELECTIONS**

The Chief of Staff, Vice- Chief of Staff, and Secretary-Treasurer shall be elected at the annual meeting of the Medical Staff which falls during the election year. Voting shall be by secret

written ballot, and authenticated sealed mail ballots may be counted. Written ballots shall include handwritten signatures on the envelope for comparison with signatures on file, when necessary. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Medical Executive Committee shall decide the election by secret written ballot at its next meeting or a special meeting called for that purpose.

#### **9.1-5 TERM OF ELECTED OFFICE**

Each officer shall serve a two (2) year term, commencing on the first day of the Medical Staff year following the election. Each officer shall serve in each office until the end of that officer's term, or until a successor is elected, unless that officer shall sooner resign or be removed from office. At the end of that officer's term, the Chief of Staff shall automatically assume the office of Immediate Past Chief of Staff.

#### **9.1-6 RECALL OF OFFICERS**

Except as otherwise provided, recall of a Medical Staff officer may be initiated by the Medical Executive Committee or shall be initiated by a petition signed by at least one third (1/3) of the Members of the Medical Staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Grounds for recall shall include failure to be a Member in Good Standing (Article II.2-1) or for other good cause as articulated in Article 10.6-4. Recall shall require a two-thirds 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.

#### **9.1-7 VACANCIES IN ELECTED OFFICE**

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the Medical Staff. Vacancies, other than that of the Chief of Staff, shall be filled by appointment by the Medical Executive Committee until the next regular election. If there is

a vacancy in the office of Chief of Staff, the then Vice-Chief of Staff shall serve out that remaining term.

## **9.2 DUTIES OF OFFICERS**

### **9.2-1 CHIEF OF STAFF**

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

- (a) Enforcing the Medical Staff Bylaws and rules and regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated.
- (b) Calling, presiding at, and being responsible for the agenda of all general Medical Staff meetings.
- (c) Serving as Chair of the Medical Executive Committee and Nominating Committee.
- (d) Serving as an ex-officio member of all other staff committees (except hearing committees) without vote, unless the Chief of Staff's membership in a particular committee is required by these Bylaws.
- (e) Interacting with the Chief Executive Officer and Board of Directors in all matters of mutual concern within the Hospital.
- (f) Appointing, in consultation with the Medical Executive Committee, committee members for all standing and special Medical Staff, liaison, multi-disciplinary and ad hoc investigatory committees, except where otherwise provided by these Bylaws and, except where otherwise indicated, designating the Chair of these committees.
- (g) Representing the views and policies of the Medical Staff to the Board of Directors and to the Chief Executive Officer.

- (h) Being a spokesman for the Medical Staff in external professional and public relations.
- (i) Performing such other functions as may be assigned to him or her by these Bylaws, the Medical Staff, or by the Medical Executive Committee.
- (j) Serving on liaison committees with the Board of Directors and administration, as well as outside licensing or accreditation agencies.
- (k) In the interim between Medical Executive Committee meetings, performing those responsibilities of the Committee that, in his or her reasonable opinion, must be accomplished prior to the next regular or special meeting of the Medical Executive Committee;

**9.2-2 VICE-CHIEF OF STAFF**

The Vice-Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice-Chief of Staff shall be a member of the Medical Executive Committee of the Medical Staff and of the Joint Conference Committee, shall be the Chair of the Credentials Committee and the Chair of the Quality Committee. The Vice-Chief of Staff shall perform such other duties as may be assigned or as may be delegated by these Bylaws, or by the Medical Executive Committee.

**9.2-3 IMMEDIATE PAST CHIEF OF STAFF**

The Immediate Past Chief of Staff shall be a member of the Medical Executive Committee and shall perform such other duties as may be assigned or delegated by these Bylaws, or by the Medical Executive Committee.

**9.2-4 SECRETARY-TREASURER**

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

- (a) Maintaining a roster of members.

- (b) Keeping accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings.
- (c) Calling meetings on the order of the Chief of Staff or Medical Executive Committee.
- (d) Attending to all appropriate correspondence and notices on behalf of the Medical Staff.
- (e) Receiving and safeguarding all funds of the Medical Staff.
- (f) Excusing absences from meetings on behalf of the Medical Executive Committee.
- (g) Performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

## **ARTICLE X**

### **CLINICAL DEPARTMENTS AND DIVISIONS**

#### **10.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND DIVISIONS**

The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a Chair selected and entrusted with the authority, duties, and responsibilities specified in Section 10.6. A department may be further divided, as appropriate, into divisions which shall be directly responsible to the department within which it functions, and which shall have a Division Chief selected and entrusted with the authority, duties and responsibilities specified in Section 10.7. The Department may make recommendations for divisions to the Medical Executive Committee, which shall have the authority to approve such recommendations, subject to the ultimate approval of the Governing Body. The Medical Executive Committee may recommend to the Medical Staff the creation, elimination, modification, or combination of departments or divisions.

## 10.2 CURRENT DEPARTMENTS AND DIVISIONS

The current Departments are:

Department of Anesthesiology

Department of Emergency Medicine

Department of Radiology and Radiation Oncology

Department of Pathology and Laboratory Medicine

Department of Family Medicine

Department of Medicine

Department of Obstetrics and Gynecology

Department of Pediatrics

Department of Psychiatry

Department of Surgery

## 10.3 ASSIGNMENT TO DEPARTMENTS

Each Member shall be assigned membership in at least one (1) department, but may also be granted membership and/or Clinical Privileges in other departments consistent with practice Privileges granted.

## 10.4 FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

- (a) Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. The number of such reviews to be conducted during the year shall be as determined by the Medical Executive Committee in consultation with other appropriate committees. The Department shall routinely collect information about

important aspects of patient care provided in the department, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the Member whose work subject to such review is a Member of that department.

- (b) Recommending to the Medical Executive Committee guidelines for the granting of Clinical Privileges and the performance of specified services within the department.
- (c) Evaluating and making appropriate recommendations regarding the qualification of applicants seeking appointment or reappointment and Clinical Privileges within that department.
- (d) Conducting, participating and making recommendations regarding continuing education programs pertinent to departmental clinical practice.
- (e) Reviewing and evaluating departmental adherence to:  
(1) Medical Staff policies and procedures; (2) sound principles of clinical practice.
- (f) Coordinating patient care provided by the department's Members with nursing and ancillary patient care services.
- (g) Submitting written reports to the Medical Executive Committee concerning: (1) the department's review and evaluation activities, actions taken thereon, and the results of such action; and (2) recommendations for maintaining and improving the quality of care provided in the department and the Hospital.
- (h) Meeting at least twice a year for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other department and staff functions or otherwise create a mechanism (acceptable to the Medical Executive Committee) for the

performance of the functions and dissemination of the information.

- (i) Establishing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols.
- (j) Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified.
- (k) Accounting to the Medical Executive Committee for all professional and Medical Staff administrative activities within the department.
- (l) Appointing such committees as may be necessary or appropriate to conduct department functions.
- (m) Formulating recommendations for departmental Rules and Regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval of the Medical Executive Committee. Departmental Rules may specify additional credentials required for specific Privileges, e.g., ACLS, fluoroscopy, NRP, etc. and;
- (n) Assessing and recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the department or the organization.

#### **10.5 DEPARTMENT EXECUTIVE COMMITTEE**

The department may decide to create an Executive Committee of the department. The Executive Committee of the department shall be comprised of the officers of the department, division chiefs and specialty representatives at the discretion of the department chair. The Executive Committee shall function on behalf of the department in the interval between department meetings, including, but not limited to, performing peer review and quality management activities and conducting whatever business the department chair determines to be necessary to the efficient operation of the department.

## **10.6 FUNCTIONS OF DIVISIONS**

Subject to approval of the Medical Executive Committee, each division shall perform the functions assigned to it by the Department Chair. Such functions may include, without limitation, retrospective patient care reviews, evaluation of patient care practices, credentials review and Privileges delineation, and continuing education programs. The division shall transmit regular reports to the Department Chair on the conduct of its assigned functions.

## **10.7 DEPARTMENT CHAIRS**

### **10.7-1 QUALIFICATIONS**

Each department shall have a Chair and Vice Chair who shall be Members of the Active Medical Staff and shall be either certified by a specialty board in at least one (1) of the clinical areas covered by the department or demonstrate to the satisfaction of the Medical Executive Committee that the candidate possesses comparable expertise in at least one (1) of the clinical areas covered by the department. Where required by California licensure regulation, the department chair must be board certified or board eligible in his or her specialty.

### **10.7-2 SELECTION**

Department Chairs and Vice-Chairs shall be elected every two (2) years by those Members of the department who are eligible to vote for general officers of the Medical Staff. For the purpose of this election, each Department Chair shall appoint a nominating committee of three (3) members at least sixty (60) days prior to the meeting at which election is to take place.

The recommendations of the nominating committee of one or more nominees for Chair and Vice-Chair positions shall be circulated to the voting Members of each department at least twenty (20) days prior to the election. Election of department chairs and vice-chairs shall be subject to ratification by a majority vote of the Medical Executive Committee.

Vacancies due to any reason shall be filled for the unexpired term through special election by the respective department with such mechanisms as that department may adopt.

**10.7-3 TERM OF OFFICE**

Each Department Chair and Vice-Chair shall serve a two (2) year term which coincides with the Medical Staff year or until their successors are chosen, unless they shall sooner resign, be removed from office, or lose their Medical Staff membership or Clinical Privileges in that department. Department officers shall be eligible to succeed themselves.

**10.7-4 REMOVAL**

If a Department Chair ceases to be a Member in Good Standing of the Medical Staff, suffers a loss or significant limitation of practice Privileges, or if any other good cause exists (e.g. failure to fulfill the duties of the chair), that Member may be removed by the Medical Executive Committee and the Members of his department.

Removal of a Department Chair or Vice-Chair from office may occur by a two thirds (2/3) vote of the Medical Executive Committee and a two thirds (2/3) vote of the department Members eligible to vote on departmental matters who cast votes.

**10.7-5 DUTIES**

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

- (a) Act as presiding officer at Departmental meetings.
- (b) Report to the Medical Executive Committee and to the Chief of Staff regarding all professional and administrative activities within the department.
- (c) Continually assess and make recommendations regarding improving the quality of patient care and professional performance rendered by Members with Clinical Privileges in the department through a planned and systematic process; oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the department by the Medical Executive Committee; and take informal remedial or corrective

action, such as Practitioner counseling or issuing letters of warning to department Members and keep the Medical Executive Committee apprised of such actions.

- (d) Develop and implement departmental programs that guide and support the provision of services in the department, including policies and procedures for retrospective patient care review, ongoing monitoring of practice, credentials review and Privileges delineation, medical education, utilization review, and quality assurance.
- (e) Be a member of 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.
- (f) Transmit to the Medical Executive Committee the department's recommendations concerning Practitioner appointment and classification, reappointment, criteria for Clinical Privileges, monitoring of specified services, and corrective action with respect to persons with Clinical Privileges in the department.
- (g) Endeavor to enforce the Medical Staff Bylaws, rules, policies and regulations within the department.
- (h) Implement within the department appropriate actions taken by the Medical Executive Committee.
- (i) Participate in every phase of administration of the department, including cooperation with the nursing service and the Hospital administration in matters such as personnel, supplies, special regulations, standing orders and techniques.
- (j) Establishing, together with the Medical Staff and Hospital Administration, the type and scope of services required to meet the needs of the patients and the Hospital, including recommendations for space and other resources needed by the department and assessing and recommending to the Hospital off-site sources for needed patient care, treatment and services not provided by the department or the Hospital;

- (k) Participate in the orientation and continuing education of all persons in the department;
- (l) Assist in the preparation of such annual reports, including budgetary planning, pertaining to the department as may be required by the Medical Executive Committee.
- (m) Recommend delineated Clinical Privileges for each Member of the department.
- (n) Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff or the Medical Executive Committee.

## **10.7 DIVISION CHIEFS**

### **10.7-1 QUALIFICATIONS**

Each division shall have a chief who shall be a Member of the Active Medical Staff and a Member of the division, and shall be qualified by training, experience, and demonstrated current ability in the clinical area covered by the division.

### **10.7-2 SELECTION**

Each Division Chief shall be selected or elected with such mechanism as the clinical department may adopt. Vacancies due to any reason shall be filled for the unexpired term by the Department Chair. Selection of division chiefs shall be subject to the majority approval of the Medical Executive Committee.

### **10.7-3 TERM OF OFFICE**

Each Division Chief shall serve a two (2) year term which coincides with the Medical Staff year or until a successor is chosen, unless the Chief shall sooner resign, or be removed from office, or lose membership or Clinical Privileges in that division. Division chiefs shall be eligible to succeed themselves.

### **10.7-4 REMOVAL**

If a Division Chief ceases to be a Member in good standing of the Medical Staff as described in Article II.1-1, suffers a loss or

significant limitation of practice Privileges, or if any other good cause exists, that Chief may be removed by a two-thirds (2/3) vote of the Medical Executive Committee.

#### **10.7-5 DUTIES**

Each Division Chief shall:

- (a) Act as presiding officer at Division meetings.
- (b) Assist in the development and implementation, in cooperation with the Department Chair, of programs to carry out the quality review, and evaluation and monitoring functions assigned to the Division.
- (c) Evaluate the clinical work performed in the Division.
- (d) Conduct investigations and submit reports and recommendations to the Department Chair regarding the Clinical Privileges to be exercised within the Division by Members of or applicants to the Medical Staff.
- (e) Attend Department Executive Committee meetings; and
- (f) Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Department Chair, the Chief of Staff, or the Medical Executive Committee.

### **ARTICLE XI**

#### **COMMITTEES**

##### **11.1 DESIGNATION**

Medical Staff committees shall include but not be limited to, the Medical Staff meeting as a committee of the whole, meetings of departments and divisions, meetings of committees established under this Article, and meetings of special or ad hoc committees created by the Medical Executive Committee or by departments. The committees described in this Article and the Rules & Regulations shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by any standing committee to perform

specified tasks. Any committee, whether Medical Staff-wide or department or other clinical unit, or standing or ad hoc, that is carrying out all or any portion of a function or activity required by these Bylaws, is deemed a duly appointed and authorized committee of the Medical Staff. Unless otherwise specified, the new Chair and members of all committees shall be recommended by the Committee Chair, subject to appointment or removal by the Chief of Staff, subject to consultation with and approval by the Medical Executive Committee. Medical Staff committees shall be responsible to the Medical Executive Committee. Each Medical Staff Member who serves on a committee participates with vote unless the statement of committee composition designates the person as non-voting.

## **11.2 GENERAL PROVISIONS**

### **11.2-1 TERMS OF COMMITTEE MEMBERS**

Unless otherwise specified, committee members shall be appointed for a term of two (2) years, and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee.

### **11.2-2 REMOVAL**

If a member of a committee ceases to be a Member in good standing of the Medical Staff as described in Article II.2-1, suffers a loss or significant limitation of practice Privileges, or if any other good cause exists, that member may be removed by a majority vote of the Medical Executive Committee, or by the Chief of Staff, subject to a majority vote of approval by the members of the Medical Executive Committee.

### **11.2-3 VACANCIES**

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

### **11.2-4 EX OFFICIO MEMBERS**

The Chief of Staff is an ex officio member of all standing and

special committees of the Medical Staff (except hearing committees) and shall serve without vote unless provided otherwise in the provision or resolution creating the committee. The Hospital Chief Executive Officer, or his or her designee, attends each Medical Executive Committee meeting as an ex-officio member without vote.

#### **11.2-5 ACTION THROUGH SUBCOMMITTEES**

Any standing committee may use subcommittees to help carry out its duties. The Medical Executive Committee shall be informed when a subcommittee is appointed. The committee chair may appoint individuals in addition to, or other than, members of the standing committee, to the subcommittee after consulting with the Chief of Staff regarding Medical Staff Members, and the Hospital Chief Executive Officer regarding the Hospital administrative staff.

### **11.3 MEDICAL EXECUTIVE COMMITTEE**

#### **11.3-1 COMPOSITION**

The Medical Executive Committee shall consist of the following persons:

- (a) The officers of the Medical Staff.
- (b) The Department Chairs;
- (c) Two (2) at-large physician Members of the Active Medical Staff who shall be nominated and elected for a two (2) year term in the same manner and at the same time as provided in Sections 9.1-4 through 9.1-5 for the nomination and election of officers.
- (d) Other Members as may be required to comply with the state licensing regulations and/or The Joint Commission (or equivalent) accreditation standards or the standards of comparable accreditation agencies. The majority of the voting members of the Medical Executive Committee must be licensed physicians actively practicing in the Hospital. All Members of the organized Medical Staff, of any discipline or

specialty, are eligible for membership on the Medical Executive Committee.

The Chief Executive Officer is permitted to attend, but not to vote, at meetings of this Committee. Their presence may be excused if the Medical Executive Committee determines that it is appropriate for the Committee to meet in executive session.

### **11.3-2 DUTIES**

The duties of the Medical Executive Committee shall include, but not be limited to the following. Further, it is the responsibility of this Committee to make final recommendations concerning all such matters to the Board of Directors of the Hospital.

- (a) Representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws.
- (b) Coordinating and implementing the professional and organizational activities and policies of the Medical Staff.
- (c) Receiving and acting upon reports and recommendations from Medical Staff Departments, Divisions, committees, and assigned activity groups.
- (d) Recommending action to the Board of Directors on matters of a medical-administrative nature, to include appointment to medical administrative positions, and Medical Staff participation in organizational performance improvement activities.
- (e) Establishing the structure of the Medical Staff, the mechanism to review credentials and delineate individual Clinical Privileges, the granting of individual staff memberships and Privileges, the organization of quality assurance activities and mechanisms of the Medical Staff to conduct, evaluate and revise such activities, termination of Medical Staff membership and fair hearing procedures, changes

to Medical Staff Bylaws and Rules and Regulations as well as other matters relevant to the operation of an organized Medical Staff.

- (f) Evaluating the medical care rendered to patients in the Hospital. Such evaluation shall include, but not be limited to, participation in the review of the following functions: infection surveillance and control, medical record review, blood usage, drug usage, case management review of physicians and allied health professionals, and other activities necessary to assess and improve the quality of care provided at Marin General Hospital. Further, it is the responsibility of this Committee to ensure that there is adequate physician participation in the review of these functions
- (g) Participating in the development of all Medical Staff and Hospital policy, practice, and planning, including effective communication with the Board and Administration via the Chief of Staff, Committee Chairs, and Department Chairs.
- (h) Reviewing the qualifications, credentials, performance and professional competence and character of applicants and Staff Members and making recommendations to the Board of Directors regarding staff appointments and reappointments, assignments to departments, Clinical Privileges, and corrective action.
- (i) Taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all Members including the initiation of and participation in Medical Staff corrective or review measures when warranted including but not limited to, taking informal corrective action such as counseling a Practitioner or issuing letters of warning or reprimand to a Practitioner.

- (j) Taking reasonable steps to develop continuing education activities and programs for the Medical Staff.
- (k) Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the Chief of Staff.
- (l) Reporting to the Medical Staff at regular staff meetings.
- (m) Assisting in the obtaining and maintaining of accreditation.
- (n) Developing and maintaining of methods for the protection and care of patients and others in the event of internal or external disaster.
- (o) Appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff.
- (p) Reviewing the quality and appropriateness of services provided by contract physicians and services.
- (q) Reviewing and acting on requests for deletions of materials from staff credentialing files as set forth in 14.9-3.
- (r) Reviewing and approving the designation of the Hospital's authorized representative for National Practitioner Data Bank purposes.
- (s) Establishing a mechanism for dispute resolution between Medical Staff Members (including limited license practitioners) involving the care of a patient;
- (t) Issuing such directives as appropriate to assure effective performance of all Medical Staff functions and following up to assure implementation of all directives;

- (u) With the assistance of the Chief of Staff, supervise the Medical Staff's compliance with the Medical Staff Bylaws, Rules and Regulations and policies; the Hospital's Bylaws, Rules and policies; state and federal laws and regulations and The Joint Commission (or equivalent) accreditation requirements;

### **11.3-3 MEETINGS**

The Medical Executive Committee shall meet as often as necessary, but at least ten (10) times yearly and shall maintain a record of its proceedings and actions.

## **11.4 BYLAWS COMMITTEE**

### **11.4-1 COMPOSITION**

The Bylaws Committee shall consist of at least five (5) Members of the Medical Staff, including at least the Vice-Chief of Staff and Immediate Past Chief of Staff.

### **11.4-2 DUTIES**

The duties of the Bylaws Committee shall include:

- (a) Conducting a review, at least annually and more frequently as necessary, of the Medical Staff Bylaws, as well as the Rules and Regulations and forms promulgated by the Medical Staff, its Departments and Divisions.
- (b) Receiving and evaluating suggestions for the modification of the items specified in subparagraph (a).
- (c) Submitting recommendations to the Medical Executive Committee of necessary changes in the Bylaws to reflect current Medical Staff practices.

### **11.4-3 MEETINGS**

The Bylaws Committee shall meet as often as necessary at the call of its Chair, but at least annually. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

## **11.5 CREDENTIALS COMMITTEE**

### **11.5-1 COMPOSITION**

The Credentials Committee shall consist of not less than seven (7) Members of the Active staff selected on a basis that will ensure insofar as feasible, representation of major clinical specialties and each of the staff Departments. When an application or matter regarding a health care professional other than a physician is to be considered, a Staff Member representing that discipline may be invited to be present.

### **11.5-2 DUTIES**

The Credentials Committee shall:

- (a) Review and evaluate the qualifications of each Practitioner applying for initial appointment, reappointment, or modification of and for Clinical Privileges, and, in connection therewith, obtain and consider the recommendations of the appropriate Departments.
- (b) Submit required reports and information on the qualifications of each Practitioner applying for membership or particular Clinical Privileges including recommendations with respect to appointment, membership category, Department affiliation, Clinical Privileges and special conditions.
- (c) Investigate, review and report on matters referred by the Chief of Staff or the Medical Executive Committee regarding the qualifications, conduct, professional character or competence of any applicant or Medical Staff Member.
- (d) Submit periodic reports to the Medical Executive Committee on its activities and the status of pending applications.
- (e) If a contracted credentials verification organization (CVO) is used, the Credentials Committee will use an

established quality control process to periodically evaluate the CVO's effectiveness at least annually.

### **11.5-3 MEETINGS**

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

## **11.6 JOINT CONFERENCE COMMITTEE**

### **11.6-1 COMPOSITION**

The Joint Conference Committee shall be composed of an equal number of members of the Board of Directors and of the Medical Executive Committee, but the Medical Staff Members shall at least include the Chief of Staff, the Vice Chief of Staff, and the Immediate Past Chief of Staff. The Administrator shall be a non-voting ex-officio member. The Chairship of the committee shall alternate yearly between the Board of Directors and the Medical Staff.

### **11.6-2 DUTIES**

The Joint Conference Committee shall constitute a forum for the discussion of matters of Hospital and Medical Staff policy, practice, and planning, and a forum for interaction between the Board of Directors and the Medical Staff on such matters as may be referred by the Medical Executive Committee or the Board of Directors including, but not limited to, disputes regarding Medical Staff self governance rights. The Joint Conference Committee shall exercise any other responsibilities set forth in these Bylaws.

### **11.6-3 MEETINGS**

The Joint Conference Committee shall meet as often as necessary to conduct business and shall transmit written reports of its activities to the Medical Executive Committee and the Board of Directors.

## **11.7 PHYSICIAN WELL-BEING COMMITTEE**

### **11.7-1 COMPOSITION**

The Physician Well-Being Committee shall consist of at least five (5) Members of the Medical Staff, a majority of whom, including the Chair, shall hold Active Staff membership. To maintain the expertise of its Members, duration of committee appointment shall not be subject to limitation. (See 11.2-1) Appointments to and continued service on this committee shall be at the discretion of the Committee Chair and Chief of Staff. Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assessment committees while serving on this committee.

### **11.7-2 DUTIES**

The Physician Well-Being Committee may receive reports related to the health, well-being, or impairment of Medical Staff Members and, as it deems appropriate, may investigate such reports. With respect to matters involving individual Medical Staff Members, the committee may, when it deems appropriate, provide advice, counseling, or referral information to the Staff Member in question. Such activities shall be confidential. However, in the event information received by the committee clearly demonstrates that the health or known impairment of a Medical Staff Member poses an unreasonable risk of harm to hospitalized patients, or others within the Hospital, the committee shall provide such information to the Staff Member's Department Chair and to the Chief of Staff.

The committee shall also consider general matters related to the health and well-being of the Medical Staff and, with the approval of the executive committee, develop educational programs or related activities.

### **11.7-3 MEETINGS**

The committee shall meet as often as necessary, but at least quarterly. It shall maintain only such record of its proceedings as it deems advisable, but shall report on its activities on a routine basis to the Medical Executive Committee.

## ARTICLE XII

### MEETINGS

#### 12.1 MEETINGS

##### 12.1-1 MEETINGS

There shall be two (2) meetings of the Medical Staff per year. The Chief of Staff, or such other officers, Department or Division heads, or committee Chairs the or Medical Executive Committee may designate, shall present reports on actions taken during the preceding year and on other matters of interest and importance to the Members. The date, place and time of the regular meetings shall be determined by the Medical Executive Committee. Notice of this meeting shall be given to the Members at least 15 days prior to the meeting.

##### 12.1-2 AGENDA

The order of business at a meeting of the Medical Staff shall be determined by the Chief of Staff and the Medical Executive Committee. The agenda shall be posted on line, e-mailed or mailed to each Active Staff Member and posted conspicuously in the Hospital at least fifteen (15) days before each meeting. The agenda shall include, insofar as feasible:

- (a) Acceptance of the minutes of the last meeting.
- (b) Administrative reports from the Chief of Staff, Departments, and Committees, and the Chief Executive Officer.
- (c) Election of officers when required by these Bylaws.
- (d) Reports by responsible officers, Committees and Departments on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the staff, and on the fulfillment of other required staff functions.
- (e) Old and new business.

### **12.1-3 SPECIAL MEETINGS**

Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the Medical Executive Committee, or shall be called upon the written request of ten percent (10%) of the Members of the Active Medical Staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the Medical Executive Committee within thirty (30) days after receipt of such request. No later than ten (10) days prior to the meeting, notice shall be mailed or delivered to the Members of the 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.

## **12.2 COMMITTEE AND DEPARTMENT MEETINGS**

### **12.2-1 REGULAR MEETINGS**

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

### **12.2-2 SPECIAL MEETINGS**

A special meeting of any Medical Staff committee, Department or Division may be called by the Chair thereof, the Medical Executive Committee, or the Chief of Staff, and shall be called by written request of one-third (1/3) of the current members, eligible to vote, but not less than five (5) members.

## **12.3 QUORUM**

### **12.3-1 STAFF MEETINGS**

The concurrence of a majority of Active Staff Members present is necessary for the transaction of business, including amending these Bylaws, Rules and Regulations, or for the election or removal of Medical Staff officers, unless otherwise provided in these Bylaws.

## **12.3-2 DEPARTMENT AND COMMITTEE MEETINGS**

A quorum of fifty (50) percent (50%) of the voting members shall be required for Medical Executive and Credentials Committee meetings. For other committees, Departments and Divisions a quorum shall consist of fifty percent (50%) of the voting members of a committee but no less than two (2) voting members. [For Department and Division meetings the concurrence of a majority of eligible Active Staff Members is necessary for the transaction of business, including amendment of department rules and regulations and the election or removal of officers.

## **12.4 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 committee if it is acknowledged by a writing setting forth the action so taken which is signed by at least two thirds (2/3) of the members entitled to vote.

## **12.5 MINUTES**

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters. A copy of the minutes shall be signed by the presiding officer of the meeting and forwarded to the Medical Executive Committee.

## **12.6 ATTENDANCE REQUIREMENTS**

### **12.6-1 REGULAR ATTENDANCE**

Attendance at Medical Staff department and general staff meetings is encouraged but not required, except that each Member must

attend one (1) general Medical Staff meeting per year. Consequently, attendance will not be tracked and utilized at the time of reappraisal to determine a physician's reappointment staff category. Any Department may establish reasonable attendance requirement in their departmental rules. Attendance at committees or task forces shall also be credited toward members' attendance levels.

#### **12.6-2 SPECIAL ATTENDANCE**

At the discretion of the Chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular Department, Division, or committee meeting, the Member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a Member to appear at any meeting with respect to which he was given such notice, unless excused by the Medical Executive Committee upon a show of good cause, shall be a basis for corrective action.

#### **12.7 CONDUCT OF MEETINGS**

Unless otherwise specified, meetings shall be conducted according to Sturgis Standard Code of Parliamentary Procedure; however, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

#### **12.8 EXECUTIVE SESSION**

Executive session is a meeting of a Medical Staff committee which only voting Medical Staff committee members may attend unless others are expressly requested by the committee to attend. Executive session may be called by the presiding officer at the request of any Medical Staff committee member, and shall be called by the presiding officer pursuant to a duly adopted motion. Executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality.

## ARTICLE XIII

### CONFIDENTIALITY, IMMUNITY AND RELEASES

#### 13.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising Clinical Privileges within this Hospital, an applicant:

- (a) Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications.
- (b) Authorizes persons and organizations to provide information concerning such Practitioner to the Medical Staff.
- (c) Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative 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.

#### 13.2 CONFIDENTIALITY OF INFORMATION

##### 13.2-1 GENERAL

Records and proceedings of all Medical Staff committees having the responsibility of evaluation and improvement of quality of care rendered in this Hospital, including, but not limited to common meetings of the Medical Staff meeting as a committee of the whole, meetings of departments and divisions, meetings of committees established under Section XI, and meetings of special or ad hoc committees created by the Medical Executive Committee (pursuant to Section 11.1) or by departments (pursuant to Section 10.4 (i) and (l)) and including information regarding any Member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential. Dissemination of such information and records shall only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff or,

where no officially adopted policy exists, only with the express approval of the Medical Executive Committee or its designee.

### **13.2-2 BREACH OF CONFIDENTIALITY**

Inasmuch as effective peer review and consideration of the qualifications of Medical Staff Members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff Departments, Divisions, or Committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff, violates the Medical Staff Bylaws and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate, including termination of Medical Staff membership and Clinical Privileges.

### **13.2-3 PRESERVATION OF CONFIDENTIALITY**

Members of the Medical Staff shall respect and preserve the confidentiality of all communications and information generated in connection with credentialing, peer review and quality management activities as is specifically authorized by these Bylaws, the Medical Staff Rules and Regulations, or by the Medical Executive Committee. Members pledge to invoke the protection of all applicable laws, including California Evidence Code Section 1157 as applicable in legal proceedings, in order to preserve the confidentiality of this information.

### **13.2-4 PARTICIPATION BY NON-MEDICAL STAFF MEMBERS**

Individuals who are permitted to attend Medical Staff committee meetings, but who are neither Members of the Medical Staff nor ex-officio Members, such as members of Administration and members of the Nursing Staff, may be required to sign the sign-in sheets which shall include pledges of confidentiality consistent with the requirements of these Bylaws. Failure to respect such pledge shall constitute grounds for immediate termination of the individual's right to continue to participate on such committees, and may also constitute grounds for disciplinary action, including, but not limited to, termination of employment, as determined by Administration.

### **13.3 INDEMNIFICATION AND IMMUNITY FROM LIABILITY**

#### **13.3-1 INDEMNIFICATION**

To the fullest extent covered under the Hospital's insurance program applicable to a claim under this paragraph, the Hospital shall indemnify, defend and hold harmless the Medical Staff and its individual Members from and against losses and expenses (including attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation or other dispute relating or pertaining to any alleged act or failure to act while 1) serving as a member of any duly constituted Medical Staff or Board committee, the activities of which in whole or in part relate directly to the review of surveillance of the quality of medical care, patient care, Hospital utilization, safety, medical-legal responsibility, credentialing, professional review, formal accreditation, or any other activity affecting in whole or in part any of the above, 2) executing directives of any such committee, or 3) performing or failing to perform, services while acting as a person who is responsible for the care, supervision or surveillance of any department, division, activity or other area of involvement of the Hospital.

#### **13.3-2 ACTIVITIES AND INFORMATION COVERED**

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

- (a) Applications for appointment, reappointment, or Clinical Privileges.
- (b) Corrective action.
- (c) Hearings 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) National Practitioner Data Bank queries and reports, peer review organizations, Medical Board of California and similar reports.

**13.3-3 FOR ACTION TAKEN**

Each representative of the Medical Staff and the Hospital shall be immune to the fullest extent permitted by law, from liability to an applicant or Member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or the Hospital.

**13.3-4 FOR PROVIDING INFORMATION**

Each representative of the Medical Staff and the Hospital and all third parties shall be immune, to the fullest extent permitted by law, from liability to an applicant or Member for damages or other relief by reason of providing information to a representative of the Medical Staff or the Hospital concerning such person who is, or has been, an applicant to, or Member of, the Staff, or who did, or does, exercise Clinical Privileges or provide services at the Hospital.

**13.4 RELEASES**

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

## ARTICLE XIV

### GENERAL PROVISIONS

#### 14.1 RULES AND REGULATIONS

The Medical Staff shall initiate and adopt such Rules and Regulations as it may deem necessary for the proper conduct of its work and shall periodically review and revise its Rules and Regulations to comply with current Medical Staff practice. Recommended changes to the Rules and Regulations shall be submitted to the Medical Executive Committee for review and evaluation prior to presentation for consideration by the Medical Staff as a whole, under such review or approval mechanism as the Medical Staff shall establish. If there is a conflict between either a general Rule or a Departmental Rule and the Bylaws, the Bylaws shall prevail.

Following adoption, such Rules and Regulations shall become effective following approval of the Board of Directors, which approval shall not be withheld unreasonably, or automatically in ninety (90) days if no action is taken or withheld by the Board of Directors. 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 Rules and Regulations, the Bylaws shall prevail. The mechanisms described in Article 15.1 and herein shall be the sole methods for the initiation, adoption, amendment, or repeal of the Medical Staff Rules and Regulations.

The Rules and Regulations may be amended at any regular or special meeting of the Medical Staff provided that such amendments have been reviewed and approved by the Bylaws and Medical Executive Committees and at least one (1) month written notice of changes has been given to the Active Staff Members. A Rules and Regulations amendment shall be considered approved if a supporting vote of at least 51% of Active Staff Members present is achieved.

#### 14.2 DUES OR ASSESSMENTS

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

#### **14.3 MEDICAL STAFF LEGAL COUNSEL**

The Medical Staff shall have the right to retain and be represented by independent legal counsel at the expense of the Medical Staff.

#### **14.4 CLINICAL DEPARTMENT RULES AND POLICIES AND PROCEDURES**

Departmental Rules policies and procedures may be formulated by each clinical department for the conduct of its affairs and the discharge of its responsibilities. The departmental Rules policies and procedures shall be consistent with the Medical Staff Bylaws, Rules and Regulations. Departmental Rules policies and procedures shall be approved or revised by the affected department and the Medical Executive Committee.

#### **14.5 CONSTRUCTION OF TERMS AND HEADINGS**

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

#### **14.6 AUTHORITY TO ACT**

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

#### **14.7 DIVISION OF FEES**

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

#### **14.8 NOTICES**

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

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

Addressee name and proper title, if known or applicable;  
Department, division, or committee name  
c/o Manager, Medical Staff Services  
Marin General Hospital  
Post Office Box 8010  
San Rafael, California, 94901-8010

Mailed notices to a Member, applicant or other party, shall be to the addressee at the address as it last appears in the official records of the Medical Staff or the Hospital. Mailed notice shall be deemed received seven days after mailing. All other notices shall be deemed effective on the actual date received.

#### **14.9 DISCLOSURE OF INTEREST**

Medical Staff Members who occupy Medical Staff offices, such as Medical Staff Officers, department and committee chairships and Members of the Medical Executive Committee, carry with them a requirement of loyalty and fidelity and must discharge their duties diligently and honestly, exercising their best care, skill and judgment for the sole benefit of the Medical Staff. Accordingly, it is the responsibility of each Medical Staff Member who occupies a Medical Staff office, all Medical Staff Officers, department and committee chairs, and members of the Medical Executive Committee to make full disclosure of any duality of interest that might result in a possible conflict on his or her part. The subject Medical Staff Member shall refrain from voting on any matter about which he or she has a duality or conflict of interest, and shall be excused from the room while the vote on the matter is taken. All nominees for election or appointment to Medical Staff offices, Department Chairs, or the Medical Executive Committee shall, at least 20 days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. Any nominee from the floor shall disclose any such affiliations or relationships at the time of such nomination.

**14.10 NOMINATION OF MEDICAL STAFF REPRESENTATIVES**

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

**14.11 MEDICAL STAFF CREDENTIALS FILES**

**14.11-1 INSERTION OF ADVERSE INFORMATION**

This section applies to actions relating to requests for insertion of adverse information into the Medical Staff Member's credentials file. For the purposes of this section, "adverse information" is considered to be unfavorable information about a Medical Staff Member which is submitted to the Medical Staff, but which was not solicited or requested by the Medical Staff. Accordingly, information obtained through routine credentialing, peer review and quality management activities is not considered "adverse information" for the purposes of this section.:

- (a) As stated previously, in Section 7.1-1, any person may provide information to the Medical Staff about the conduct, performance or competence of its Members.
- (b) When a request is made for insertion of adverse information into the Medical Staff Member's credentials file, the respective Department Chair shall review such a request.
- (c) After such review a decision will be made by the respective Department Chair and Chief of Staff to:
  - (1) Not insert the information;
  - (2) Notify the Member of the adverse information by a written summary and offer him or her the opportunity to review and/or refute this information before it is entered into his or her file; or
  - (3) Insert the information along with a notation that a request has been made to the Medical Executive

Committee for an investigation as outlined in Section 7.1-2 of these Bylaws.

- (d) This decision shall be reported to the Medical Executive Committee. The Medical Executive Committee, when so informed, may either ratify or initiate contrary actions to this decision by a majority vote.
- (e) A Practitioner shall be entitled to submit a rebuttal to any letter of counseling, warning or reprimand placed in his/her credentials file by the department or Medical Executive Committee.
- (f) There shall be only one (1) credentials file for each Staff Member. Information placed in this file shall be limited to that reasonably related to quality of care concerns as determined by the Medical Staff.

**14.11-2 REVIEW OF ADVERSE INFORMATION AT THE TIME OF REAPPRAISAL AND REAPPOINTMENT**

The following applies to the review of adverse information in the Medical Staff Member's credentials file at the time of reappraisal and reappointment:

- (a) Prior to recommendation on reappointment, the department Chair or Division Chief, and the Credentials Committee, as part of the reappraisal function, shall review any adverse information in the credentials file pertaining to a Member.
- (b) Following this review, the Credentials Committee shall determine whether documentation in the file warrants further action.
- (c) With respect to such adverse information, if it does not appear that an investigation and/or adverse action on reappointment is warranted, the Credentials Committee shall so inform the Medical Executive Committee.
- (d) However, if an investigation and/or adverse action on reappointment is warranted, the Credentials Committee shall so inform the Medical Executive Committee.

**14.11-3 DELETION OF INFORMATION FROM CREDENTIALS FILES**

- (a) Request for Removal. At the time a Member applies for reappointment, the Member may request that selected information in the credentials file be removed from the file and destroyed. All such requests must be reviewed by the Credentials Committee which shall make a recommendation to the Medical Executive Committee supporting or disagreeing with the Member's request.
  
- (b) Medical Executive Committee Review.
  - (1) Basis for review. The Medical Executive Committee shall review the request and the recommendation of the Credentials Committee and shall evaluate whether the material should be retained or discarded. In reviewing this issue, the Medical Executive Committee shall consider whether the materials might be relevant to future inquiries and whether, after evaluation, the materials have been found to be accurate or significant.
  
  - (2) Denial of request. If the Medical Executive Committee determines the materials should be retained in the Member's file, the review process is concluded and the materials shall be retained. The Member may renew the request for removal of the materials at the next time for reappointment.
  
  - (3) Approval of request. If the Medical Executive Committee concludes that the materials should be removed from the file and destroyed, it shall so recommend in writing to counsel for the Hospital, setting forth the reasons for the recommendation for removal.
  
- (c) Hospital Counsel. If Hospital counsel concurs in the recommendation for removal, the materials shall be removed and destroyed. If Hospital counsel concludes that the materials should be retained, the Medical Executive Committee's written recommendation for removal shall be attached to the materials and retained

with them so long as they are retained. The Member may renew the request for the removal of the materials at the next time for reappointment.

#### **14.11-4 CONFIDENTIALITY**

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

- (a) The records of the Medical Staff and its committees responsible for the evaluation and improvement of the quality of patient care rendered in the Hospital shall be maintained as confidential.
- (b) Access to such records shall be limited to duly appointed officers and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.
- (c) Information which is disclosed to the governing body of the Hospital or its appointed representatives -- in order that the governing body may discharge its lawful obligations and responsibilities -- shall be maintained by that body as confidential.
- (d) Information contained in the credentials file of any Member may be disclosed with that Member's consent to any Medical Staff or professional licensing board, or as required by these Bylaws. However, any disclosure outside of the Medical Staff shall require the written authorization of the Chief of Staff and the concerned department Chair -- and notification to the Member. Copies of these notices and authorizations must be inserted in the Member's credentials file.
- (e) A Medical Staff Member shall be granted access to his or her own credentials file, subject to the following provisions:
  - (1) Timely notice of such shall be made by the Member to the Chief of Staff (or designee);

(2) The Member may review, and receive a copy of, only those documents provided by or addressed personally to the Member. A summary of all other information -- including peer review committee findings, letters of reference, proctoring reports, complaints, etc. -- shall be provided to the Member, in writing, by the designated officer of the Medical Staff, at the time the Member reviews the credentials file, or within a reasonable time afterwards as determined by the Medical Executive Committee. Such summary shall disclose the substance, but not the source, of the information summarized and shall not be removed from the review site.

(3) The review shall take place in the Medical Staff office, during normal work hours, with a Medical Staff officer or designee present.

(f) In the event a Notice of Charges is filed against a Member, access to the Member's own credentials file shall be governed by Section 8.4-1.

**14.11-5 MEMBER'S OPPORTUNITY TO REQUEST CORRECTION/DELETION OF AND TO MAKE ADDITION TO INFORMATION IN FILE**

(a) When a Member has reviewed the file as provided under Section 14.9-3(e) the member may address to the Chief of Staff a written request for correction or deletion of information in the credentials file. Such request shall include a statement of the basis for the action requested.

(b) The Chief of Staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Committee, after such review, whether or not to make the correction or deletion requested. The Medical Executive Committee, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote.

(c) The Member shall be notified promptly, in writing, of the decision of the Medical Executive Committee.

- (d) In any case, a Member shall have the right to add to the Member's own credentials file, upon written request to the Medical Executive Committee, a statement responding to any information contained in the file.

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

The Hospital shall confer with the Medical Executive Committee regarding exclusive contracts in each of the following situations: (a) the decision to execute an exclusive contract in a previously open department or service; (b) the decision to review or modify an exclusive contract in a particular department or service; (c) the decision to open a department or service that was previously closed; (d) the decision to change the contracting group in a department or service already subject to an exclusive contract. With regard to each of the above situations, the Medical Executive Committee shall consult with the Medical Staff departments and sections and shall evaluate the proposed action on quality of care considerations exclusively, and shall advise the Hospital in writing, regarding those issues. As part of its evaluation process, the Medical Executive Committee shall extend at least one opportunity at which time interested Members of the Hospital and Medical Staff may offer opinions on quality of care issues on the proposed action. Advance notice by the Medical Executive Committee of at least two (2) weeks shall be promulgated. In taking any of the actions noted in (a) through (d) above, the Hospital shall accept and act in conformance with the recommendation of the Medical Executive Committee, if any, unless the Hospital makes specific written findings to the effect that the recommendation was not reasonable or not rationally related to issues of quality of care.

Quality of care issues as used herein shall pertain to the clinical provision of patient care services. These issues shall include but are not necessarily limited to the competency, qualifications and timeliness of the service providers. The Hospital shall proceed in a timely manner, providing the Medical Executive Committee at least ninety (90) days prior notice of those actions described in (a) through (d) above. The Medical Executive Committee must respond in writing, if at all, no later than thirty (30) days prior to the contemplated action. If the Hospital has provided the Medical Executive Committee with timely notice of a proposed action as defined herein and the Medical Executive Committee does not provide the Hospital with its recommendation in a timely manner as defined herein, the Hospital may act without regard to a recommendation from the Medical Executive Committee. Nothing herein is intended to prevent

the Hospital from taking immediate action to terminate an exclusive contract for compelling cause.

## **ARTICLE XV**

### **ADOPTION AND AMENDMENT OF BYLAWS**

#### **15.1 PROCEDURE**

Upon the request of (1) the Medical Executive Committee, or the Chief of Staff, or the Bylaws Committee after approval by the Medical Executive Committee, or (2) upon timely written petition signed by at least 10% of the Members of the Active Medical Staff entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these Bylaws. Such action shall be taken by mail ballot, or at a regular or special meeting provided (1) written notice of the proposed change was sent to all voting Members, or at the last meeting of the Medical Staff a notice of such changes was offered, or (2) notice of the meeting at which action is to be taken included notice that a Bylaw change would be considered. Notices shall include the exact wording of the existing Bylaw language, if any, and the proposed change(s).

#### **15.2 ACTION ON BYLAW CHANGE**

Such action to change these Bylaws shall be taken by authenticated written ballot. Written notice of the proposed Bylaws change(s) shall be sent to all Members at least thirty (30) days prior to the date set for submission of the ballots. Approval of changes shall require an affirmative vote of fifty-one percent (51%) of the Members voting by written ballot.

#### **15.3 APPROVAL**

Bylaw changes adopted by the Medical Staff shall become effective following approval by the Board of Directors, which approval shall not be withheld unreasonably, or automatically within ninety (90) days if no action is taken by the Board of Directors. If approval is withheld, the reasons for doing so shall be specified by the Board of Directors in writing, and shall be forwarded to the Chief of Staff, the Medical Executive and the Bylaws Committees.

#### **15.4 AMENDMENT TO BYLAWS**

The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws, Rules and Regulations as are, in its judgment, technical modifications or clarifications, reorganization or renumbering of sections, grammatical or punctuation errors, inaccurate cross-reference, or such amendments necessary to respond to specific rules and requirements of governmental agencies. The Medical Executive Committee shall advise the Medical Staff of such amendments in writing and provide an opportunity for questions or challenges.

Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board within ninety (90) days of adoption by the Medical Executive Committee. The action to amend may be taken by motion 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 Board.

Except as noted above, the mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws, Rules and Regulations.

#### **15.5 EXCLUSIVITY**

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws. Neither the Medical Staff nor the Governing Body may unilaterally amend the Medical Staff Bylaws.

#### **15.6 AMENDMENTS TO GOVERNING BODY BYLAWS**

The Board of Directors shall inform the Medical Staff of changes to the governing body Bylaws so that the content of the Medical Staff Bylaws, Rules and Regulations, or policies and procedures and the governing body Bylaws will not be in conflict.

#### **15.7 SUCCESSOR IN TRUST**

These Bylaws, the Medical Staff Rules and Regulations, and the rights and Privileges accorded to individual Medical Staff Members as specified therein, will be binding upon the Medical Staff and the Board of Directors of any successor in interest in this Hospital. In the event the staffs are being combined, the Medical Staffs shall work

together to develop new bylaws. Until such time as new bylaws are approved, these existing Medical Staff bylaws will remain in effect.

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

ADOPTED by the Medical Staff (by vote)

**APPROVED by the Board of Directors on July 12, 2007**

**Current Review dates: September, 2003; April, 2004; August, 2006**

Original Bylaws approved by the Marin General Hospital Board in 1952.  
Major revisions approved March 1, 1990.  
Replaces revisions dated: October, 1997; October, 1998; October 1999; November, 2000;  
August, 2002; April, 2004; January, 2005