S196830

IN THE SUPREME COURT OF CALIFORNIA

OSAMAH EL-ATTAR,
Plaintiff and Appellant,

v.

HOLLYWOOD PRESBYTERIAN MEDICAL CENTER,
Defendant and Respondent.

AFTER A DECISION BY THE COURT OF APPEAL, SECOND APPELLATE DISTRICT, DIVISION FOUR
CASE NO. B209056

MOTION FOR JUDICIAL NOTICE; DECLARATION OF ANNA M. SUDA; [PROPOSED] ORDER GRANTING JUDICIAL NOTICE

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MOTION FOR JUDICIAL NOTICE

Defendant and respondent Hollywood Presbyterian Medical Center (Hospital) moves under Evidence Code sections 452, subdivision (h), 453, and 459, and rules 8.252(a) and 8.520(g) of the California Rules of Court, for this court to take judicial notice of the California Hospital Association (CHA) Model Medical Staff Bylaws 2011, attached as Exhibit A to the declaration of Anna M. Suda supporting this motion.

This request for judicial notice is being filed concurrently with the Hospital's opening brief on the merits. It is supported by the attached declaration of Anna M. Suda, the attached memorandum of points and authorities, and all the files, records, and briefs in this case.

February 24, 2012

HORVITZ & LEVY LLP
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By: 
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MEMORANDUM OF POINTS AND AUTHORITIES

THIS COURT SHOULD TAKE JUDICIAL NOTICE OF THE 2011 CHA MODEL MEDICAL STAFF BYLAWS BECAUSE THEY ARE NOT REASONABLY SUBJECT TO DISPUTE AND ARE RELEVANT TO THE ISSUE PRESENTED IN THIS CASE.

A. Reviewing courts have authority and a duty to take judicial notice.

Evidence Code section 452, subdivision (h), allows courts to take judicial notice of "[f]acts and propositions that are not reasonably subject to dispute and are capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy."

Under Evidence Code section 453, such judicial notice is compulsory if "a party requests it and [¶] (a) [g]ives each adverse party sufficient notice of the request, through the pleadings or otherwise, to enable such adverse party to prepare to meet the request; and [¶] (b) [f]urnishes the court with sufficient information to enable it to take judicial notice of the matter."

Under Evidence Code section 459, appellate courts have the same right, power, and duty to take judicial notice as do the trial courts.

B. The 2011 CHA Model Medical Staff Bylaws may be judicially noticed because they are not reasonably subject to dispute.

The CHA Model Medical Staff Bylaws 2011 are the type of documents that courts may judicially notice because they are "not reasonably subject to dispute and are capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy." (Evid. Code, § 452, subd. (h).) A true and correct copy of the CHA model bylaws has been secured by the Hospital's counsel and is attached as Exhibit A to the supporting declaration of Anna M. Suda. These model bylaws are also available at the CHA's official web site: California Hospital Association, Model Medical Staff Bylaws & Rules (2011) <http://www.calhospital.org/ medical-staff-bylaws> (as of Feb. 23, 2012).

In *Anton v. San Antonio Community Hosp.* (1977) 19 Cal.3d 802, 819, this court took judicial notice, under Evidence Code section 452, subdivision (h), of the 1971 model medical staff bylaws, which at that time were jointly adopted and approved by the California Medical Association (CMA) and the California Hospital Association (CHA). Similarly, in both *Anton,* at pages 818-819, and *Miller v. Eisenhower Medical Center* (1980) 27 Cal.3d 614, 628, fn. 15, this court took judicial notice of the model bylaws of the Joint Commission on Accreditation of Hospitals, which contain provisions regarding medical staff eligibility. Other courts have taken judicial

notice of model medical staff bylaws as well. [1] (See *Matchett v. Superior Court* (1974) 40 Cal.App.3d 623, 627 ["We avail ourselves of Evidence Code section 452, subdivision (h), to take judicial notice of nationwide, generally accepted standards describing the organization and functions of medical staffs and medical staff committees in accredited hospitals"]; see also *El-Attar v. Hollywood Presbyterian Medical Center* (2011) 198 Cal.App.4th 664, 676-677, typed opn., 14 [discussing the California Medical Association's Model Medical Staff Bylaws, but without specifying whether the court took judicial notice of them].)

C. This court should take judicial notice of the CHA Model Medical Staff Bylaws because they are relevant to the issue pending before this court.

As explained more fully in the Hospital's concurrently filed opening brief on the merits (OBOM), the CHA Model Medical Staff Bylaws 2011 are relevant to the issue pending before this court

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[1] Courts have likewise taken judicial notice of bylaws governing other types of administrative proceedings. (See *Masters v. San Bernardino County Employees Retirement Assn.* (1995) 32 Cal.App.4th 30, 35, fn. 1 ["[p]ursuant to Evidence Code sections 452 and 459, the court takes judicial notice of the bylaws of the San Bernardino County Employees Retirement Association" in an action seeking damages for alleged delay in award of disability retirement benefits]; see also *Coffin v. Alcoholic Beverage Control Appeals Bd.* (2006) 139 Cal.App.4th 471, 479, fn. 6 [taking judicial notice on the court's own motion of instructions given by Department of Alcoholic Beverage Control in a hearing regarding an applicant's petition for a liquor license].)

concerning the Hospital governing board's authority to appoint the hearing officer and judicial review committee panel members for Dr. El-Attar's peer review proceeding.

Dr. El-Attar's peer review followed the governing board's denial of his application for readmission to the Hospital's medical staff—an action that the Medical Executive Committee (MEC) of the Hospital's medical staff did not endorse. (OBOM 11-14.) Accordingly, although the Hospital's medical staff bylaws specified that the MEC shall appoint the hearing officer and physician members of the judicial review committee adjudicating the soundness of the board's action, the MEC resolved that the Hospital's governing board should make those appointments because the peer review proceeding concerned the board's recommended action. (*Ibid.*)

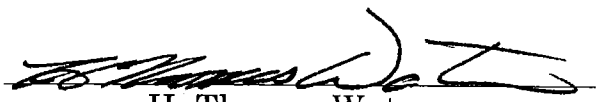
The CHA model bylaws provide that, if a peer review hearing is based upon an adverse action by the hospital's governing board, the chair of the governing board shall fulfill the functions otherwise assigned to the chief of the medical staff, and the hospital's governing board shall assume the role of the medical staff's MEC with respect to the peer review proceedings. (CHA Model Medical Staff Bylaws 2011, ¶ 14.6-1; see *id.* ¶¶ 14.1-5, 14.6-4, 14.6-5.) As explained in the Hospital's opening brief, the CHA Model Medical Staff Bylaws are relevant because they demonstrate that Dr. El-Attar's fair procedure rights were not infringed and show that the Court of Appeal's decision would undermine the medical staff bylaws of every California hospital that has adopted the CHA Model Medical Staff Bylaws. (OBOM 40, 44-46.)

CONCLUSION

For all the foregoing reasons, the Hospital respectfully requests that this court take judicial notice of the CHA Model Medical Staff Bylaws 2011.

February 24, 2012

HORVITZ & LEVY LLP
DAVID S. ETTINGER
H. THOMAS WATSON
CHRISTENSEN & AUER
JAY D. CHRISTENSEN
ANNA M. SUDA

By: 
H. Thomas Watson

Attorneys for Defendant and Respondent
HOLLYWOOD PRESBYTERIAN MEDICAL CENTER

DECLARATION OF ANNA M. SUDA

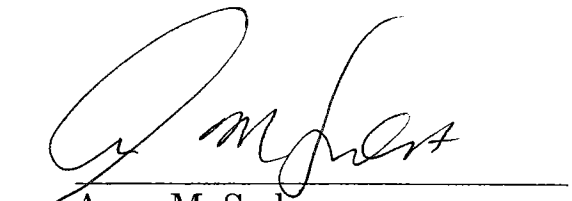
I, Anna M. Suda, declare as follows:

1. I am an attorney duly admitted to practice before this Court. I am a Senior Associate at Christensen & Auer, counsel of record for defendant and respondent Hollywood Presbyterian Medical Center in the action styled *El-Attar v. Hollywood Presbyterian Medical Center*, Supreme Court Case No. S196830. I have personal knowledge of the facts set forth herein. If called as a witness, I could and would competently testify to the matters stated herein.

2. Attached hereto as Exhibit A is a true and correct copy of the CHA Model Medical Staff Bylaws 2011, which I secured from the California Hospital Association.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed this 22nd day of February, 2012, at Pasadena, California.



Anna M. Suda

S196830

IN THE SUPREME COURT OF CALIFORNIA

OSAMAH EL-ATTAR,
Plaintiff and Appellant,

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HOLLYWOOD PRESBYTERIAN MEDICAL CENTER,
Defendant and Respondent.

[PROPOSED] ORDER GRANTING JUDICIAL NOTICE

Good cause appearing in *El-Attar v. Hollywood Presbyterian Medical Center* (Case No. S196830), judicial notice is taken of the California Hospital Association (CHA) Model Medical Staff Bylaws 2011, attached as Exhibit A to the declaration of Anna M. Suda supporting the motion for judicial notice filed by Hollywood Presbyterian Medical Center.

Dated: _____

_____

CHIEF JUSTICE

CHA

MODEL MEDICAL

STAFF BYLAWS 2011

Model Medical Staff Bylaws Introduction

The Model Medical Staff Bylaws are designed to comply with California and federal law, and the applicable standards of The Joint Commission (TJC).

The 2008 edition of the Model Medical Staff Bylaws was published amidst uncertainty as to TJC's medical staff bylaws standard (then known as MS 1.20), which called into question the CHA Model Medical Staff Bylaws format of addressing major issues in the Bylaws, and including implementing details in the Rules.

The controversy surrounding MS 1.20 caused TJC to suspend its implementation, and instead convene a Task Force to review the standard. In the meantime, TJC also implemented a new numbering scheme, and MS 1.20 was renumbered as MS.01.01.01.

In March 2010, TJC announced acceptance of the Task Force's recommended revisions to MS.01.01.01, which are effective March 2011. While these revisions do impact some of CHA's Model Medical Staff Bylaws, they leave intact the fundamental structure of the CHA Model Medical Staff Bylaws – namely allowing major issues to be addressed in the Bylaws, and additional details to be included in the Rules.

In August 2010, CHA published an Interim Edition of the Model Medical Staff Bylaws addressing the changes necessitated by the new MS.01.01.01 Standard and the Centers for Medicare & Medicaid Services (CMS) Medicare Conditions of Participation.

This 2011 Edition presents some further refinements to those Interim changes, as well as other changes to address recent legal developments. Refinements to the MS.01.01.01 revisions (i.e., MS.01.01.01-related changes that did not appear in the Interim amendments) are highlighted with a *.

Throughout the Bylaws, there are optional provisions and alternative selections the Medical Staff can use to prepare Bylaws that meet its needs and practices. Explanatory comments are called out, while options are italicized, bracketed and blue. For example, in the Preamble, the name of your hospital should be inserted instead of "*[insert name of hospital]*." Revisions to this edition are shown in red: additions are underlined, deletions are stricken over. Please note that when a section has been added or deleted, the subsequent numbers have changed.

Model Medical Staff Bylaws

Preamble

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

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

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

COMMENT: The above Preamble summarizes the intent of the Bylaws, capturing not only the statutory provisions of Business & Professions Code Section 2282.5, but also the legislative intent articulated in the enacting legislation (SB 1325, enacted in 2004). CHA believes these are important provisions to include in the Bylaws, especially as they state the interdependency and reciprocal commitments of the Medical Staff and the Governing Body.

Definitions

COMMENT: Definitions may be added to or deleted; however, they should be placed in alphabetical order to facilitate ease of reference.

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

COMMENT: Not all hospitals allow clinical psychologists to become Medical Staff members. See the Comment accompanying definition 11.

2. **Chief Executive Officer** means the person appointed by the Governing Body to serve in an administrative capacity or his or her designee.
3. *[Chief Medical Officer (CMO)] means a practitioner appointed by the Governing Body to serve as a liaison between the Medical Staff and the administration.]*

COMMENT: Some hospitals have Chief Medical Officers who help the Medical Staff fulfill its functions and who often take very active roles in quality improvement and peer review. If a different title is used for the CMO, such as Vice President for Medical Affairs, that title may be used in lieu of CMO, or the definition can be revised to refer to the title. Hospitals that do not have CMOs should delete the italicized references and provisions throughout the Bylaws pertaining to the CMO. Note, in prior editions of the CHA Model Bylaws, we used the term Medical Director to describe this position. However, in many hospitals, there are service-specific Medical Directors whose roles are more limited than that contemplated for the CMO. Accordingly, we have shifted the terminology to correlate with the broader role typically assigned to this position.Throughout the Bylaws, references to "Medical Director" have been changed to Chief Medical Officer.Also, note, to maintain the alphabetical order of the definitions, this description has been moved, and affects the numbering of subsequent definitions.

4. **Chief of Staff** means the chief officer of the Medical Staff elected by the Medical Staff.
5. **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 72 hours after the notice, special notice, or communication was deposited, postage prepaid, in the United States mail. (See also, the definitions of **Notice** and **Special Notice.**)
6. **Days** means calendar days unless otherwise specified.
7. **Ex Officio** means service by virtue of office or position held. An ex officio appointment is with vote unless specified otherwise.
8. **Governing Body** means the *[board of directors], [board of trustees], [district board].* As appropriate to the context and consistent with the hospital's Bylaws, it may also mean any Governing Body committee or individual authorized to act on behalf of the Governing Body.

9. **Hospital** means *[insert name of hospital]*, and includes all inpatient and outpatient locations and services operated under the auspices of the hospital's license.

10. **Medical Executive Committee** or **Executive Committee** means the executive committee of the Medical Staff.

11. **Medical Staff** means the organizational component of the hospital that includes all physicians (M.D. or D.O.), dentists, *[clinical psychologists]*, and podiatrists who have been granted recognition as members pursuant to these Bylaws.

COMMENT: Some hospitals allow clinical psychologists to join the Medical Staff; others do not. Throughout these Bylaws, references to clinical psychologists are italicized so the Medical Staff can easily revise them depending on whether clinical psychologists are members of the Medical Staff or the AHP staff.However, a health care facility owned or operated by the State that offers care or services within a clinical psychologist's scope of practice must establish Rules, regulations and procedures for consideration of an application for Medical Staff membership and clinical privileges submitted by a clinical psychologist.

12. **Medical Staff Year** means the period from *[January 1 through December 31]*.

13. **Member** means any practitioner who has been appointed to the Medical Staff.

14. **Notice** means a written communication delivered personally to the addressee or sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the Medical Staff or the hospital. (See also, the definitions of **Date of Receipt** and **Special Notice.**)

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

16. **Practitioner** means, unless otherwise expressly limited, any currently licensed physician (M.D. or D.O.), dentist, *[clinical psychologist]* or podiatrist.

17. **Privileges** or **Clinical Privileges** means the permission granted to a Medical Staff member or AHP to render specific patient services.

18. **Rules** refers to the Medical Staff *[and/or department]* Rules adopted in accordance with these Bylaws unless specified otherwise.

19. **Special Notice** means a notice sent by certified or registered mail, return receipt requested. (See also, the definitions of **Date of Receipt** and **Notice** above.)

20. *[**System** means the [insert name of health system].]*

21. *[**System Member** 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.]*

COMMENT: System should be defined for hospitals that are part of a health system and desire to develop and implement cooperative credentialing and peer review among the health system entities. Throughout these Bylaws, enabling language authorizes such cooperative arrangements. Hospitals that are not part of a health system, or that do not wish to participate in such cooperative arrangements, should drop the italicized references throughout the Bylaws to the system-oriented provisions.

22. **Telemedicine** is the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video or data communications.

Article 1 Name and Purposes

1.1 Name

The name of this organization shall be the Medical Staff of *[insert name of hospital]*.

1.2 Description

1.2-1 The Medical Staff organization is structured as follows: The members of the Medical Staff are assigned to a Staff category depending upon nature and tenure of practice at the hospital. All new members are assigned to the Provisional Staff. Upon satisfactory completion of the provisional period, the members are assigned to one of the Staff categories described in Bylaws, Article 3, Categories of the Medical Staff.

1.2-2 *[Members are also assigned to departments, depending upon their specialties, as follows: [Insert list of departments – this will be the same as the list for your hospital at Bylaws, Section 10.2-1]. Each department is organized to perform certain functions on behalf of the department, such as credentials review and peer review.]*

1.2-3 There are also Medical Staff committees, which perform staff-wide responsibilities, and which oversee related activities being performed by the *[departments]/[department committees]*.

1.2-4 Overseeing all of this is the Medical Executive Committee, comprised of the elected officials of the Medical Staff, *[the department chairpersons,]* representatives elected at large, and *[insert other members of your hospital's Medical Executive Committee]*.

1.3 Purposes and Responsibilities

1.3-1 The Medical Staff's purposes are:

a. To assure that all patients admitted or treated in any of the hospital services receive a uniform standard of quality patient care, treatment and efficiency consistent with generally accepted standards attainable within the hospital's means and circumstances.

b. To provide for a level of professional performance that is consistent with generally accepted standards attainable within the hospital's means and circumstances.

c. To organize and support professional education and community health education and support services.

d. To initiate and maintain Rules for the Medical Staff to carry out its responsibilities for the professional work performed in the hospital.

e. To provide a means for the Medical Staff, Governing Body and administration to discuss issues of mutual concern and to implement education and changes intended to continuously improve the quality of patient care.

f. To provide for accountability of the Medical Staff to the Governing Body.

g. To exercise its rights and responsibilities in a manner that does not jeopardize the hospital's license, Medicare and Medi-Cal provider status, accreditation, *[or tax exempt status.]*

1.3-2 The Medical Staff's responsibilities are:

a. To provide quality patient care.

b. To account to the Governing Body for the quality of patient care provided by all members authorized to practice in the hospital through the following measures:

1. Review and evaluation of the quality of patient care provided through valid and reliable patient care evaluation procedures;

2. An organizational structure and mechanisms that allow on-going monitoring of patient care practices;

3. A credentials program, including mechanisms of appointment, reappointment and the matching of clinical privileges to be exercised or specified services to be performed with the verified credentials and current demonstrated performance of the Medical Staff applicant or member;

4. A continuing education program based at least in part on needs demonstrated through the medical care evaluation program;

5. A utilization review program to provide for the appropriate use of all medical services.

c. To recommend to the Governing Body action with respect to appointments, reappointments, staff category *[and department assignments]*, clinical privileges and corrective action.

d. To establish and enforce, subject to the Governing Body approval, professional standards related to the delivery of health care within the hospital.

e. To account to the Governing Body for the quality of patient care through regular reports and recommendations concerning the implementation, operation, and results of the quality review and evaluation activities.

f. To initiate and pursue corrective action with respect to members where warranted.

g. To provide a framework for cooperation with other community health facilities and/or educational institutions or efforts.

h. To establish and amend from time to time as needed Medical Staff Bylaws, Rules and policies for the effective performance of Medical Staff responsibilities, as further described in these Bylaws.

i. To select and remove Medical Staff officers.

j. To assess Medical Staff dues and utilize Medical Staff dues as appropriate for the purposes of the Medical Staff.

1.4 [Health System Affiliation]

COMMENT: These are optional provisions for facilities desiring to develop and implement cooperative appointment, reappointment, and peer review procedures with other system members. Such cooperative processes are generally advisable only where the system members are located in the same geographic area and the involved practitioner seeks membership at more than one facility or entity in that area. (This could include geographically proximate acute care hospitals, surgery centers, medical foundations, etc.) These cooperative provisions are especially useful in effectively implementing and managing telemedicine programs operated among system affiliates.

[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, corrective action, and procedural rights are hereby authorized, in accordance with the guidelines in these Bylaws.]

1.4-1 ***[Credentialing]***

[The Medical Staff may enter into arrangements with other system members to assist it in credentialing activities. This may include, without limitation, relying on information in other system members' credentials and peer review files in evaluating applications for appointment and reappointment, and utilizing the other system members' medical or professional staff support resources to process or assist in processing applications for appointment and reappointment.]

1.4-2 ***[Peer Review]***

[The Medical Staff may enter into arrangements with other system members to assist it in peer review activities. This may include, without limitation, relying on information in other system members' credentials and peer review files, and utilizing the other system members' medical or professional staff support resources to conduct or assist in conducting peer review activities.]

1.4-3 ***[Corrective Action]***

[The Medical Staff may work cooperatively with any other system member at which a Medical Staff member holds privileges to develop and impose coordinated, cooperative, or joint corrective 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 corrective actions imposed and/or reciprocal effectiveness of such corrective actions as provided in the Bylaws, Section 13.6.]

1.4-4 ***[Joint Hearings and Appeals]***

[The Medical Staff and Governing Body are authorized to participate in joint hearings and appeals provided the applicable procedures are substantially comparable to those set forth in the Bylaws, Article 14, Hearings and Appellate Reviews.]

Article 2 Medical Staff Membership

2.1 Nature of Medical Staff Membership

Medical Staff membership and/or privileges may be extended to and maintained by only those professionally competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and the Rules. A practitioner, including one who has a contract with the hospital to provide medical-administrative services, may admit or provide services to patients in the hospital only if the practitioner is a member of the Medical Staff or has been granted temporary privileges in accordance with these Bylaws and the Rules. Appointment to the Medical Staff shall confer only such privileges and prerogatives as have been established by the Medical Staff and granted by the Governing Body in accordance with these Bylaws.

2.2 Qualifications for Membership

2.2-1 General Qualifications

Membership on the Medical Staff and privileges shall be extended only to practitioners who are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws and Rules. Medical Staff membership (except honorary Medical Staff) shall be limited to practitioners who are currently licensed or qualified to practice medicine, podiatry, *[clinical psychology]* or dentistry in California.

2.2-2 Basic Qualifications

COMMENT: All Medical Staffs have basic standards every member must meet. It is helpful to identify those standards as the minimum necessary to have an application reviewed. In this way, the Medical Staff can avoid investigating and reviewing an applicant who fails to meet basic qualifications.Whether the applicant meets basic qualifications can be determined either by reviewing the application that is submitted or by using a two-step application process (often referred to as pre-application screening) in which applicants must fill out forms demonstrating they meet the basic criteria before they can receive the complete Medical Staff application form. Medical Staffs may want to avoid the two-step process, which builds in more paperwork and delays, in favor of informing applicants that their applications will not be processed if they fail to meet specified basic criteria. These Bylaws use the latter approach.Each hospital may set its own basic standards. The examples listed below in Section 2.2-2 are relatively elevated standards that will not be realistic for some hospitals. This list can be augmented or scaled down depending upon the hospital's needs and constraints. All basic standards should, however, be capable of objective determination.

A practitioner must demonstrate compliance with all basic standards set forth in this Section in order to have an application for Medical Staff membership accepted for review. The practitioner must:

a. Qualify under California law to practice with an out-of-state license or be licensed as follows:

   1. Physicians must be licensed to practice medicine by the Medical Board of California or the Board of Osteopathic Examiners of the State of California;
   2. Telemedicine providers who are not licensed in California must be registered as a telemedicine provider with the Medical Board of California.

COMMENT: Traditionally physicians were required to maintain licenses in the state in which the care was provided to a patient. With the onset of telemedicine, California and other states have had to address licensing issues with respect to how an out-of-state physician can provide services and/or consultation when they are not licensed in the state where the patient is located.California has enacted two laws specifically relating to the practice of medicine across state lines. Business & Professions Code Section 2052.5 establishes a registration program to permit out-of-state physicians to register to practice medicine in California. Business & Professions Code Section 2060 exempts practitioners located outside this state from the Medical Practice Act when **consulting** with an in-state physician; however, this exemption is not sufficient to enable the out-of-state physician to be a Telemedicine Provider of services directly to a patient.

3. Dentists must be licensed to practice dentistry by the California Board of Dental Examiners;
4. Podiatrists must be licensed to practice podiatry by the California Board of Podiatric Medicine;
5. *[Clinical psychologists must be licensed to practice clinical psychology by the California Board of Psychology and Division of Allied Health Professions of the Medical Board of California.]*

b. If practicing clinical medicine, dentistry, or podiatry, have a federal Drug Enforcement Administration number.

COMMENT: Some hospitals no longer require practitioners to maintain Drug Enforcement Administration (DEA) certificates if they will not have privileges to prescribe scheduled drugs. If a DEA certificate will not be required for all applicants, this subsection should be eliminated from the basic requirements.

c. Be certified by or currently qualify to take the board certification examination of a board recognized by the American Board of Medical Specialties, the American Board of Podiatric Surgery, the American Board of Orthopedic Podiatric Medicine, or a board or association with equivalent requirements approved by the Medical Board of California in the specialty that the practitioner will practice at the hospital, or have completed a residency approved by the Accreditation Council for Graduate Medical Education that provided complete training in the specialty or subspecialty that the practitioner will practice at the hospital. This section shall not apply to dentists *[or clinical psychologists]*.

d. *[Be eligible to receive payments from the federal Medicare and state Medicaid (Medi-Cal) programs.]*

COMMENT: Medicare and Medi-Cal eligibility are important considerations, especially as relates to call-coverage requirements and excluded providers. While it is arguably not necessary to make this a pre-condition to Medical Staff membership, in most cases participation in these programs is essential. Need for exceptions can be dealt with via Section 2.2-4, Waiver of Qualifications, below.

e. Have liability insurance or equivalent coverage meeting the standards specified *[in the Rules] [by the Governing Body]*.

COMMENT: Some hospitals include the insurance requirements in the Medical Staff Rules; others prefer the requirements be established by the Governing Body.

f. Have actively practiced for an average of at least 20 hours per week in the specialty he or she will practice at the hospital for 12 of the previous 24 months (or have completed a residency within the previous 18 months).

g. Be located close enough (office and residence) to the hospital to provide continuous care to his or her patients. The distance to the hospital may vary depending upon the Medical Staff category and privileges that are involved and the feasibility of arranging alternative coverage, and may be defined in the Rules.

COMMENT: Some hospitals establish proximity by using mileage parameters; others prefer to use an average travel time. Using a travel time is more difficult to monitor due to traffic delays. It's important to relate proximity to both home and office because of emergency call responsibilities.

h. Pledge to provide continuous care to his or her patients.

i. If requesting privileges only in *[departments] [services]* operated under an exclusive contract, be a member, employee or subcontractor of the group or person that holds the contract.

A practitioner who does not meet these basic standards is ineligible to apply for Medical Staff membership, and the application shall not be accepted for review, except that applicants for the honorary Medical Staff do not need to comply with any of the basic standards *[and applicants for the affiliate Medical Staff need not comply with paragraphs (c), (d) and (f), and applicants for the Telemedicine Staff need not comply with paragraph (g) of this Section 2.2-2].* If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in these Bylaws, but may submit comments and a request for reconsideration of the specific standards which adversely affected such practitioner. Those comments and requests shall be reviewed by the Medical Executive Committee and the Governing Body, which shall have sole discretion to decide whether to consider any changes in the basic standards or to grant a waiver as allowed by Bylaws, Section 2.2-4, below.

2.2-3 Additional Qualifications for Membership

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

a. Document his or her:

1. Adequate experience, education, and training in the requested privileges;
2. Current professional competence;
3. Good judgment; and
4. Adequate physical and mental health status (subject to any necessary reasonable accommodation) to demonstrate to the satisfaction of the Medical Staff that he or she is sufficiently healthy and professionally and ethically competent so that patients can reasonably expect to receive the generally recognized professional level of quality and safety of care for this community. Without limiting the foregoing, with respect to communicable diseases, practitioners are expected to know their own health status, to take such precautionary measures as may be warranted under the circumstances to protect patients and others present in the hospital, and to comply with all reasonable precautions established by hospital

and/or Medical Staff policy respecting safe provision of care and services in the hospital.

COMMENT: This provision is recommended to proactively address immunizations and communicable diseases. This Bylaws provision stops short of requiring immunization, but provides an avenue for each hospital to develop its own policies addressing these issues.

b. Be determined to:

1. Adhere to the lawful ethics of his or her profession;
2. Be able to work cooperatively with others in the hospital setting so as not to adversely affect patient care or hospital operations; and
3. Be willing to participate in and properly discharge Medical Staff responsibilities.

2.2-4 Waiver of Qualifications

Insofar as is consistent with applicable laws, the Governing Body has the discretion to deem a practitioner to have satisfied a qualification, after consulting with 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.

2.3 Effect of Other Affiliations

No practitioner shall be entitled to Medical Staff membership 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 he or she had, or presently has, staff membership or privileges at another health care facility.

2.4 Nondiscrimination

Medical Staff membership or particular privileges shall not be denied on the basis of age, religion, race, creed, color, national origin, or any physical or mental impairment if, after any necessary reasonable accommodation, the applicant complies with the Bylaws or Rules of the Medical Staff or the hospital.

2.5 Administrative and Contract Practitioners

2.5-1 Contractors with No Clinical Duties

A practitioner employed by or contracting with the hospital in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of the hospital and to the terms of his or her contract or other conditions of employment and need not be a member of the Medical Staff.

2.5-2 Contractors Who Have Clinical Duties

COMMENT: Some Medical Staffs also terminate membership, as well as privileges, when an exclusive arrangement is terminated and the practitioner has no other privileges. If that is done, this Section and Section 2.5-3, Subcontractors, should be modified.

a. A practitioner with whom the hospital contracts to provide services which involve clinical duties or privileges must be a member of the Medical Staff, achieving his or her status by the procedures described in these Bylaws. Unless a written contract or agreement, executed after this provision is adopted, specifically provides otherwise, or unless otherwise required by law, those privileges made exclusive or semi-exclusive pursuant to a closed-staff or limited-staff specialty policy will automatically terminate, without the right of access to the review, hearing, and appeal procedures of the Bylaws, Article 14, Hearings and Appellate Reviews, upon termination or expiration of such practitioner's contract or agreement with the hospital.

b. Contracts between practitioners and the hospital shall prevail over these Bylaws and the Rules, except that the contracts may not reduce any hearing rights granted when an action will be taken that must be reported to the Medical Board of California or the federal National Practitioner Data Bank.

2.5-3 Subcontractors

Practitioners who subcontract with practitioners or entities who contract with the hospital may lose privileges granted pursuant to an exclusive or semi-exclusive arrangement (but not their Medical Staff membership) if their relationship with the contracting practitioner or entity is terminated, or the hospital and the contracting practitioner's or entity's agreement or exclusive relationship is terminated. The hospital may enforce such an automatic termination even if the subcontractor's agreement fails to recognize this right.

2.6 Basic Responsibilities of Medical Staff Membership

Except for honorary members *(see Rule 1, Appendix 1E Honorary and Retired Staff)*, each Medical Staff member and each practitioner exercising temporary privileges shall continuously meet all of the following responsibilities:

2.6-1 Provide his or her patients with care that is generally recognized professional level of quality and efficiency.

2.6-2 Abide by the Medical Staff Bylaws and Rules and all other lawful standards, policies and Rules of the Medical Staff and the hospital.

2.6-3 Abide by all applicable laws and regulations of governmental agencies and comply with applicable standards of The Joint Commission.

2.6-4 Discharge such Medical Staff, *[department, section,]* committee and service functions for which he or she is responsible by appointment, election or otherwise.

2.6-5 Abide by all applicable requirements for timely completion and recording of a physical examination and medical history, as further described at Section 5.4-3.*

COMMENT: *The timing requirements for the H&P have been moved to a new Section 5.4-3, and consolidated with provisions regarding who can perform H&Ps.

2.6-6 Acquire a patient's informed consent for all procedures and treatments identified in the Bylaws, Section 15.1-5, and abide by the procedures for obtaining such informed consent.

COMMENT: CMS Interpretive Guidelines to 42 CFR Section 482.13(b)(2) require that a list of all procedures requiring informed consent be included in the Bylaws.

2.6-7 Prepare and complete, in a timely and accurate manner, the medical and other required records for all patients to whom the practitioner in any way provides services in the hospital, *[including compliance with such electronic health record (EHR) policies and protocols as have been implemented by the hospital].*

2.6-8 Abide by the ethical principles of his or her profession.

2.6-9 Refrain from unlawful fee splitting or unlawful inducements relating to patient referral.

2.6-10 Refrain from any unlawful harassment or discrimination against any person (including any patient, hospital employee, hospital independent contractor, Medical Staff member, volunteer, or visitor) based upon the person's age, sex, religion, race, creed, color, national origin, health status, ability to pay, or source of payment.

2.6-11 Refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a practitioner or Allied Health Professional who is not qualified to undertake this responsibility or who is not adequately supervised.

2.6-12 Coordinate individual patients' care, treatment and services with other practitioners and hospital personnel, including, but not limited to, seeking consultation whenever warranted by the patient's condition or when required by the Rules or policies and procedures of the Medical Staff *[or applicable department].*

2.6-13 Actively participate in and regularly cooperate with the Medical Staff in assisting the hospital to fulfill its obligations related to patient care, including, but not limited to, continuous organization-wide quality measurement, assessment, and improvement, peer review, utilization management, quality evaluation, ongoing and Focused Professional Practice Evaluations and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time.

COMMENT: Revised to accommodate The Joint Commission Standards MS.05.01.01.

2.6-14 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.

2.6-15 Recognize the importance of communicating with appropriate *[department officers and/or]* Medical Staff Officers when he or she obtains credible information indicating that a fellow Medical Staff member may have engaged in unprofessional or unethical conduct or may have a health condition which poses a significant risk to the well-being or care of patients and then cooperate as reasonably necessary toward the appropriate resolution of any such matter.

2.6-16 Accept responsibility for participating in Medical Staff proctoring in accordance with the Rules and polices and procedures of the Medical Staff.

2.6-17 Complete continuing medical education that meets all licensing requirements and is appropriate to the practitioner's specialty.

2.6-18 Adhere to the Medical Staff Standards of Conduct (as further described in Section 2.7, below), so as not to adversely affect patient care or hospital operations.

2.6-19 Participate in emergency service coverage and consultation panels as allowed and as required by the Rules.

COMMENT: The model Rules that accompany these Bylaws suggest which categories of staff should have emergency room call responsibilities. However, they do not contain an elaborate description of these responsibilities, because such responsibilities vary significantly from hospital to hospital. It is imperative that each hospital develop such provisions, and it is strongly recommended that they be included in the Rules. Failure to address emergency room call responsibilities in the Bylaws or Rules can impair the Medical Staff's ability to take corrective action when a staff member disregards emergency room call obligations.

2.6-20 Cooperate with the Medical Staff in assisting the hospital to meet its uncompensated or partially compensated patient care obligations.

2.6-21 Participate in patient and family education activities, as determined by the *[department or]* Medical Staff Rules, or the Medical Executive Committee.

2.6-22 Notify the Medical Staff office in writing promptly, and no later than 14 calendar days, following any action taken regarding the member's license, Drug Enforcement Administration registration, privileges at other facilities, changes in liability insurance coverage, any report filed with the National Practitioner Data Bank, or any other action or change in circumstances that could affect his/her qualifications for Medical Staff membership and/or clinical privileges at the hospital.

COMMENT: The above changes are recommended so the Medical Executive Committee (MEC) remains apprised of all pertinent changes in a members' current qualifications for membership and privileges.

2.6-23 Continuously meet the qualifications for and perform the responsibilities of membership as set forth in these Bylaws. A member may be required to demonstrate continuing satisfaction of any of the requirements of these Bylaws upon the reasonable request of the Medical Executive Committee. This shall include, but is not limited to, mandatory health or psychiatric evaluation and mandatory drug and/or alcohol testing, the results of which shall be reportable to the Medical Executive Committee, the Well-Being Committee*[, and/or the Professional Conduct Committee]*.

COMMENT: The above changes are recommended to clarify mandatory testing rights and disclosure of results. See new Rule Appendix 4J, regarding the Professional Conduct Committee.

2.6-24 Discharge such other staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Committee.

2.7 Standards of Conduct

COMMENT: These provisions, as well as corresponding provisions in the Rules, are designed to give the Medical Staff effective tools for dealing with disruptive behavior.

Members of the Medical Staff are expected to adhere to the Medical Staff Standards of Conduct including, but not limited to, the following:

2.7-1 General

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

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

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

2.7-2 Conduct Guidelines

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

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

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

d. Complaints and disagreements shall be aired constructively, in a nondemeaning manner, and through official channels.

e. Cooperation and adherence to the reasonable Rules of the hospital and the Medical Staff is required.

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

2.7-3 Adoption of Rules

The Medical Executive Committee may promulgate Rules further illustrating and implementing the purposes of this Section including, but not limited to, procedures for

investigating and addressing incidents of perceived misconduct, and, where appropriate, progressive or other remedial measures. These measures may include *[establishing a Professional Conduct Committee to oversee practitioner conduct issues,]* alternative avenues for medical or administrative disciplinary action, which in turn may include but are not limited to conditional appointments and reappointments, requirements for behavioral contracts, mandatory counseling, practice restrictions, and/or suspension or revocation of Medical Staff membership and/or privileges.*

COMMENT: *The above changes further clarify the authority of the MEC to promulgate Rules that include specific disciplinary actions. These changes are recommended in light of MS.01.01.01, EPs 29 and 30, requiring the Medical Staff Bylaws to address the indications for disciplinary actions. This revised Section clarifies that behavioral misconduct is an indication for such actions, and also clarifies that not all remedial measures need be progressive (e.g., in particularly egregious circumstances immediate and severe action may be warranted).Additionally, the change accommodates and correlates with new provisions that have been added to the Rules, providing an alternative avenue for processing certain behavioral issues through administrative channels, rather than medical disciplinary channels, and establishing a Professional Conduct Committee. See additional comments accompanying changes to Bylaws, Section 14.8 and to Rules Section 2.3 and Appendix 4J.

Article 3 Categories of the Medical Staff

3.1 Categories

Each Medical Staff member shall be assigned to a Medical Staff category based upon the qualifications defined in the Rules *(see Rule 1, Categories of Membership)*. The members of each Medical Staff category shall have the prerogatives and carry out the duties defined in the Bylaws and Rules. Action may be initiated to change the Medical Staff category or terminate the membership of any member who fails to meet the qualifications or fulfill the duties described in the Bylaws or Rules. Changes in Medical Staff category shall not be grounds for a hearing unless they adversely affect the member's privileges.

3.2 General Exceptions to Prerogatives

Regardless of the category of membership in the Medical Staff, podiatrists, *[clinical psychologists,]* dentists, and limited license members:

3.2-1 May not hold any general Medical Staff office.

COMMENT: The Joint Commission requires that no Medical Staff member actively practicing in the hospital shall be ineligible for membership on the Medical Executive Committee (MEC) solely because of his or her professional discipline or specialty. Therefore, hospitals may need to create one or more at-large positions on the MEC in order to meet this requirement.

3.2-2 Shall have the right to vote only on matters within the scope of their licensure. Any disputes over voting rights shall be determined by the chair of the meeting, subject to final decision by the Medical Executive Committee.

3.2-3 Shall exercise privileges only within the scope of their licensure and as limited by the Medical Staff Bylaws and Rules.

3.3 Summary of Prerogatives and Responsibilities of the Medical Staff

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COMMENT: The Joint Commission MS.01.01.01, EP 15, requires that the Medical Staff Bylaws include a description of the roles and responsibilities of each category of practitioner on the Medical Staff. The following summary (replicated from the CHA Model Medical Staff Rules), fulfills this requirement.

MEDICAL STAFF CATEGORIES

	PROVISIONAL	ACTIVE	CONSULTING	COURTESY	HONORARY & RETIRED	AFFILIATE	HOUSE OFFICERS	LOCUM TENENS AFFILIATE	TELEMEDICINE
PREROGATIVES									
Admits, consults and refers inpatients and outpatients	Yes	Yes (regulary)[1]	Yes (consults only)[2]	Yes (w/limits)[3]	No	Yes (w/linits)[4]	No	Yes (w/ limits)[5]	Yes (w/limits)[6]
Eligible for clinical privileges	Yes	Yes	Yes	Yes	No	Yes (limited)	Yes (covers)	Yes (covers)	Yes
Vote	No	Yes	No	No	No	No	No	No	No
Hold Office	No	Yes	No	No	No	No	No	No	No
Serve as Committee Chair	No	Yes	No	No	No	No	No	No	No
Serve on Committees	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
RESPONSIBILITIES									
Medical Staff Functions	Yes	Yes	Yes	Yes	No	No	No	No	Yes
Consulting	Yes	Yes	Yes	Yes	No	No	No	No	Yes
ER Call	Yes	Yes	Yes	*[Yes/No]*	No	No	No	No	No
Attend Meetings	Yes	Yes	No	No	No	No	No	No	No
Pay Application Fee	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Pay Dues	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes
ADDITIONAL PARTICULAR QUALIFICATIONS									
Must first complete provisional	1.1 N/A	1.2 Yes	*[Yes/No]*	Yes	No	Yes	No	No	No
Malpractice Insurance	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
File application and apply for reappointment	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

[1] Regularly means at least *[eight]*; *[five]* for the following specialties: allergy, dentistry, dermatology and psychiatry/psychology.
[2] No admissions.
[3] Fewer than *[eight]* but at least *[three]*.
[4] Co-admit, assist in surgery and write progress notes.
[5] Patients of member being covered.
[6] Medical Executive Committee shall define limits pertinent to each telemedicine service.

Article 4 Procedures for Appointment and Reappointment

4.1 General

The Medical Staff shall consider each application for appointment, reappointment and privileges, and each request for modification of Medical Staff category using the procedure and the criteria and standards for membership and clinical privileges set forth in the Bylaws and the Rules. The Medical Staff shall perform this function also for practitioners who seek temporary privileges and for Allied Health Professionals. The Medical Staff shall investigate each applicant for appointment or reappointment and make an objective, evidence-based decision based upon assessment of the applicant vis-à-vis the hospital's "general competencies," (as further described at Bylaws, Section 5.2, before recommending action to the Governing Body. The Governing Body shall ultimately be responsible for granting membership and privileges (provided, however, that these functions may be delegated to the Chief of Staff and Chief Executive Officer with respect to requests for temporary privileges). By applying to the Medical Staff for appointment or reappointment (or by accepting honorary Medical Staff appointment), the applicant agrees that regardless of whether he or she is appointed or granted the requested privileges, he or she will comply with the responsibilities of Medical Staff membership and with the Medical Staff Bylaws and Rules as they exist and as they may be modified from time to time.

4.2 Overview of the Process

The following chart depicts the basic steps of the appointment, reappointment, and temporary privileges processes. Details of each step are described in Rules 2.2 through 2.9.

COMMENT: The Joint Commission (TJC) Standard MS.01.01.01, EPs 14, 15, 26, and 27, require that the Medical Staff Bylaws must include the basic steps of the credentialing, recredentialing, privileging, reprivileging, and appointment, reappointment processes. The summary below (replicated from the CHA Model Medical Rules) fulfills this requirement.

APPOINTMENT AND REAPPOINTMENT		
Person or Body	**Function**	**Report to**
Medical Staff Coordinator	Verify application information	*[Department (See Rule 2.5)]*
[Department]	*[Review applicant's qualifications vis-à-vis standards developed by department; recommend appointment and privileges]*	*[Credentials Committee (See Rule 2.7-1)]*
[Credentials Committee]	*[Review department's recommendation; review applicant's qualifications vis-à-*	*[Medical Executive Committee (See Rule 2.7-2)]*

	vis Medical Staff Bylaws general standards; recommend appointment and privileges]	
Medical Executive Committee	*[Review recommendations of department and Credentials Committee;]* recommend appointment and privileges	Governing Body (See Rule 2.7-3)
Governing Body	Review recommendations of the Medical Executive Committee; make decision	Final Action (See Rule 2.7-4)

REAPPOINTMENT AND PRIVILEGES		
Person or Body	**Function**	**Report to**
Medical Staff Coordinator	Verify reappointment information	*[Department (See Rule 2.9-3)]*
[Department]	*[Review applicant's performance vis-à-vis standards developed by department; recommend appointment and privileges]*	*[Medical Executive Committee (See Rule 2.9-4) or Credentials Committee (See Optional Rule 2.9-4)]*
[Other Review Committees]	*[Report on any performance problems within scope of committee review]*	*[Credentials Committee (See Optional Rule 2.9-4)]*
[Credentials Committee]	*[Review department's recommendation; review committee reports; review applicant's performance vis-à-vis Medical Staff bylaws general standards; recommend appointment and privileges]*	*[Medical Executive Committee (See Optional Rule 2.9-5)]*
Medical Executive Committee	*[Review recommendations of department and Credentials Committee;]* recommend appointment and privileges	Governing Body (See Rule 2.9-5) or (See Optional Rule 2.9-5)
Governing Body	Review recommendations of the Medical Executive Committee; make decision	Final Action (See Rule 2.9-6)

TEMPORARY PRIVILEGES		
Person or Body	**Function**	**Report to**

Medical Staff Coordinator	Verify key information	*[Department (See Rule 2.5 and Bylaws Section 5.5-2)]*
[Department Chief]	*[Review applicant's qualifications vis-à-vis standards developed by department; recommend temporary privileges]*	*[Chief of Staff (See Bylaws Section 5.5-2d.)]*
Chief of Staff	*[Review recommendations of Department Chair;]* recommend temporary privileges	Chief Executive Officer (See Bylaws Section 5.5-2d.)
Chief Executive Officer	Make decision	Final action (See Bylaws Section 5.5-2d.)

Article 5 Privileges

5.1 Exercise of Privileges

Except as otherwise provided in these Bylaws or the Rules, every practitioner or Allied Health Professional providing direct clinical services at this hospital shall be entitled to exercise only those setting-specific privileges granted to him or her. Practitioners who wish to participate in the delivery of telemedicine services (whether to patients of this hospital, or to patients of another facility that this hospital is assisting via telemedicine technology) must apply for and be granted setting and procedure-specific telemedicine privileges. (Additionally, practitioners who are not otherwise members of this hospital's Medical Staff who wish to provide services via telemedicine technology must apply for and be granted membership and privileges as part of the Telemedicine Staff (per Rule 1, Categories of Membership, Appendix 1I Telemedicine Staff) in order to provide services to patients of this hospital.)

5.2 Criteria for Privileges/General Competencies

5.2-1 Criteria for Privileges

Subject to the approval of the Medical Executive Committee and Governing Body, *[each department] [the Medical Staff]* will be responsible for developing criteria for granting setting-specific privileges (including, but not limited to, identifying and developing criteria for any privileges that may be appropriately performed via telemedicine). These criteria shall address the hospital's general competencies (as described below) and assure uniform quality of patient care, treatment, and services. Insofar as feasible, affected categories of Allied Health Professionals shall participate in developing the criteria for privileges to be exercised by Allied Health Professionals. Such criteria shall not be inconsistent with the Medical Staff Bylaws, Rules or policies. *[Each department's approved criteria for granting privileges shall be included in the department's rules.]*

5.2-2 General Competencies

The Medical Staff shall assess all practitioners' current proficiency in the hospital's general competencies, which shall be established by the *[departments] [Medical Staff]* and shall include assessment of *[patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice]. [Each department] [The Medical Staff]* shall define how to measure these general competencies as applicable to the privileges requested, and shall use them to regularly monitor and assess each practitioner's current proficiency.

COMMENT: The Joint Commission's (TJC) revised standards relating to credentialing and privileging require the hospital to establish "general competencies" that will serve as the basis for evaluating practitioner's qualifications for appointment, reappointment, and privileges. TJC suggests, but does not require, the general competencies developed by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties, as reflected in the above Bylaws language.

5.3 Delineation of Privileges in General

5.3-1 Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific privileges desired by the applicant. A request for a modification of privileges must be supported by documentation of training and/or experience supportive of the request. The basic steps for processing requests for privileges are described at Bylaws, Section 4.2.

COMMENT: Added to comply with TJC Standard MS.01.01.01, EPs 3 and 14.

5.3-2 Basis for Privilege Determinations

Requests for privileges shall be evaluated on the basis of the hospital's needs and ability to support the requested privileges and assessment of the applicant's general competencies with respect to the requested privileges, as evidenced by the applicant's license, education, training, experience, demonstrated professional competence, judgment and clinical performance, (as confirmed by peers knowledgeable of the applicant's professional performance), health status, the documented results of patient care and other quality improvement review and monitoring, performance of a sufficient number of procedures each year to develop and maintain the applicant's skills and knowledge, and compliance with any specific criteria applicable to the privileges requested. Privilege determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where an applicant exercises privileges.

5.3-3 Telemedicine Privileges

a. The initial appointment of telemedicine privileges may be based upon:

1. The practitioner's full compliance with this hospital's privileging standards;
2. By using this hospital's standards but relying on information provided by the hospital(s) at which the practitioner routinely practices; or
3. If the hospital where the practitioner routinely practices is accredited by The Joint Commission and agrees to provide a comprehensive report of the practitioner's qualifications, by relying entirely on the privileging of that other hospital.

COMMENT: The above Section was narrowed to address just privileging decisions. Corollary provisions relating to credentialing of a telemedicine practitioner appear at Bylaws, Section 5.3-3(b) below.

b. Reappointment of a Telemedicine Staff member's privileges may be based upon performance at this hospital, and, if insufficient information is available, upon information from the hospital(s) where the practitioner routinely practices.

5.4 Admissions; Responsibility for Care; History and Physical Requirements; and Other General Restrictions on Exercise of Privileges by Limited License Practitioners

COMMENT: The below changes reorganize and reconcile the myriad requirements imposed by California hospital licensing regulations, CMS Conditions of Participation, and TJC. These include:

• 22 CCR 70717(c) — requiring that patients shall be admitted only upon the order and under the care of a member of the medical staff.

• 22 CCR 70701(a)(1)(E) — stating that membership on the medical staff shall be restricted to physicians, dentists, podiatrists, and clinical psychologists.

• 42 CFR 482.12(c) — requiring (in pertinent part) that all Medicare patients must be under the care of a MD, DO, DDS, or DMD, DPM, or clinical psychologists; and that patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the state to admit patients to a hospital; that if a Medicare patient is admitted by a practitioner not specified (in the Medicare definition of a "physician," that patient is under the care of a MD or DO; and that a MD or DO is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization and is not specifically within the scope of practice of a DDS or DMD. DPM or clinical psychologist as defined by state law (while Medicare also permits other practitioners to be members of the medical staff, this is not permitted by California hospital licensing regulations so these provisions have been tailored in the model Bylaws to reconcile with state law).

• 22 CCR 70717(c) — requiring that the patient's condition and provisional diagnosis shall be established at time of admission by the member of the medical staff who admits the patient.

• 22 CCR 70717(c)(1) — requiring that patients admitted for podiatric services shall receive the same basic medical appraisal as patients admitted for other services; including the performance and recordings of the findings in the heath record of an admission H&P exam which shall be performed by persons lawfully authorized to do so by their respective practice acts.

• 22 CCR 70717(d) — requiring a complete H&P within 24 hours after admission, or immediately before (if the condition of the patient permits).

• 22 CCR 70223 — requiring that prior to commencing surgery the person responsible for administering anesthesia, or the surgeon if a general anesthetic is not to be administered, shall ascertain that the patient's medical record includes an interval medical history and physical examination performed and recorded within the previous 24 hours.

• 42 CFR 482.22(c)(5) — requiring that the Bylaws include a requirement that a medical history and physical exam must be completed no more than 30 days before or 24 hours after admission by a physician [as defined by Medicare this includes MD, DO, DDS, DPM, DC, or Clinical PhD], or an oromaxillofacial surgeon or other qualified individual in accordance with state law and hospital policy; that the H&P be placed in the medical record within 24 hours after admission; and that when the H&P are completed within 30 days before admission, there must be an updated medical record entry documenting an examination for any changes in the patient's condition is completed and documented in the record within 24 hours after admission; and 482.51(b)(1) — requiring a complete H&P in the chart prior to surgery [an exception for emergencies is permitted if appropriately documented, but this is not required to be in the Bylaws; most hospitals include this level of detail in the rules along with other hospital-specific requirements for performing and documenting the H&P].

• TJC Standard MS.01.01.01 EP 16 — requiring that the Bylaws include requirements for completing an H&P; and PC.01.02.03 EPs 4 & 5 — requiring a H&P no more than 30 days prior or within 24 hours after admission, but prior to surgery or a procedure requiring anesthesia; and an update documenting any changes within 24 hours after registration and prior to a surgery or procedure requiring anesthesia.

COMMENT: Moved to New Sections, Section 5.4-2(c) and Section 5.4-3(b).

5.4-1 Admitting Privileges

[Option 1]

a. *[Only Medical Staff members with admitting privileges may independently admit patients to the hospital. The following categories of licensees are eligible to independently admit patients to the hospital:]*

1. *[Physicians (MDs or DOs);]*

2. *[Dentists;]*

3. *[Podiatrists;]*

4. *[Clinical Psychologists.]*

[Option 2]

a. *[The following categories of licensees are eligible to independently admit patients to the hospital:]*

1. *[Physicians (MDs or DOs).]*

b. *[The following categories of licensees are eligible to co-admit patients to the hospital:]*

1. *[Dentists;]*

2. *[Podiatrists;]*

3. *[Clinical Psychologists.]*

COMMENT: While Option 1 and Option 2 are both legally permitted, some hospitals require co-admitting by dentists, podiatrists, and clinical psychologists to assure compliance with the requirement, at Bylaws, Section 5.4-2(b), below, that a physician member of the Medical Staff must assume responsibility for care of medical or psychiatric conditions that are present upon or that arise after admission.Note: CMS surveyors are reviewing Bylaws to see who may admit patients. While federal law permits a broader range of practitioners to have admitting privileges, California hospital licensing regulations are not as permissive [22 CCR 70701(a)(1)(E), see comment above].

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c. *[Additionally, AHPs with admitting privileges may admit patients upon order of a member of the Medical Staff who has admitting privileges and who maintains responsibility for the overall care of the patient:]*

1. *[Physician Assistants;]*

2. *[Nurse Practitioners;]*

3. *[Certified Nurse Midwives.]*

COMMENT: Note, it is within the discretion of the hospital to extend admitting privileges to these additional categories (and subject to the stated conditions, i.e., a member must order and be responsible for overall care); but it is not required. If these categories are allowed to admit on behalf of their supervising physician, it should be described in the Bylaws or the Rules.

5.4-2 Responsibility for Care of Patients

a. All patients admitted to the hospital must be under care of a member of the Medical Staff.

b. The admitting member of the Medical Staff shall establish, at the time of admission, the patient's condition and provisional diagnosis.

c. For patients admitted by or upon order of a dentist, oral surgeon, *[clinical psychologist]* or podiatrist members, a physican member must assume responsibility for the care of the patient's medical or psychiatric problems that are present at the time of

admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice or clinical privileges.

COMMENT: Moved to Section 5.4-4.

5.4-3 History and Physicals and Medical Appraisals

a. Members of the Medical Staff, with appropriate privileges, may perform history and physical examinations.

b. When evidence of appropriate training and experience is documented, a limited license practitioner may perform the history or physical on his or her own patient. Otherwise, a physician member must conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry, *[clinical psychology]* or podiatry).

c. All patients admitted for care in a hospital by a dentist, oral surgeon, *[clinical psychologist]* or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and a physician member or a limited license practitioner with appropriate privileges shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the *[appropriate department(s)] [Chief of Staff]*.

COMMENT: Note, although Title 22 only requires the above physician oversight for patients admitted by a podiatrist, the above provision extends this requirement to apply to patients admitted by any of these limited license practitioners. This provision can be modified to the scope of the regulation.

d. The admitting or referring member of the Medical Staff shall assure the completion of a physical examination and medical history on all patients within 24 hours after admission (or registration for a surgery or procedure requiring anesthesia or moderate or deep sedation), or immediately before. This requirement may be satisfied by a complete history and physical that has been performed within the 30 days prior to admission or registration (the results of which are recorded in the hospital's medical record) so long as an examination for any changes in the patient's condition is completed and documented in the hospital's medical record within 24 hours after admission or registration.

e. Additionally, the history and physical must be updated within 24 hours prior to any surgical procedure or other procedure requiring general anesthesia or moderate or deep sedation. The practitioner responsible for administering anesthesia may, if granted clinical privileges, perform this updating history and physical.

COMMENT: Moved from Section 2.6-5, and modified to address outpatient H&P requirements as well.

5.4-4 Surgery and High Risk Interventions by Limited License Practitioners

a. Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the *[Chair of the designated department or the Chair's designee]*.

b. Additionally, the findings, conclusions, and assessment of risk must be confirmed or endorsed by a physician member with appropriate privileges, prior to major high-risk (as defined by the *[responsible department] [Medical Staff]*) diagnostic or therapeutic interventions.

5.5 Temporary Privileges

5.5-1 Circumstances

a. Temporary privileges may be granted after appropriate application:

1. For *[30]*-day periods, subject to renewal during the pendency of an application, not to exceed a total of 120 days;
2. For the care of up to *[4]* specific patients each consecutive *[12]* months;
3. For practitioners who will serve as locum tenens for a Medical Staff member for up to *[30]* days at a time, subject to renewal to a total of *[120]* days in any consecutive *[12]* months (if a locum tenens serves more than *[4]* times in a calendar year, or for greater than *[120]* days in a calendar year, he or she shall be required to apply for regular Medical Staff membership if he or she desires to exercise privileges at the hospital); or
4. As otherwise necessary to fulfill an important patient care need.

b. Temporary members of the Medical Staff who are granted temporary membership for purposes of serving on standing or Ad Hoc Committees for investigation proceedings, are not, by virtue of such membership, granted temporary clinical privileges.

COMMENT: The Bylaws must establish a time limit on temporary privileges to meet an important patient care need (which is the category generally applicable to temporary locum tenens appointments) (see TJC standard MS.06.01.13, EP 1); and TJC limits temporary privileges for new members to a total of 120 consecutive days (see MS.06.01.13, EP 6).Note: If a hospital does not anticipate an ongoing need for telemedicine services, temporary privileging may be an appropriate way to accommodate the occasional need for such services.

5.5-2 Application and Review

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

1. There must first be verification of:
   i. Current licensure;
   ii. Relevant training or experience;
   iii. Current competence;
   iv. Ability to perform the privileges requested.
2. The results of the National Practitioner Data Bank and Medical Board of California queries have been obtained and evaluated.
3. The applicant has:
   i. Filed a complete application with the Medical Staff office;

ii. No current or previously successful challenge to licensure or registration;
iii. Not been subject to involuntary termination of Medical Staff membership at another organization; and
iv. Not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.

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

c. 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.

COMMENT: The decision to grant temporary privileges should be deferred if there is unfavorable information or reasonable doubts as to an applicant's suitability for the Medical Staff. Under California law, the denial or termination of temporary privileges for a medical disciplinary cause or reason must be reported to the Medical Board of California. This action entitles the practitioner to a hearing, whereas a deferral may not require a hearing.

d. Temporary privileges may be granted by the Chief Executive Officer (or his or her designee) on the recommendation of the Chief of Staff *[or the Department Chair where the privileges will be exercised, or either's designee].*

e. 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.

5.5-3 General Conditions and Termination

a. Members granted temporary privileges shall be subject to the proctoring and supervision in accordance with the Focused Professional Practice Evaluation requirements specified in the Rules.

b. Temporary privileges shall automatically terminate at the end of the designated period, unless affirmatively renewed as provided at Bylaws, Section 5.5-1(a), page 41, or earlier terminated as provided at Bylaws, Section Section 5.5-3(c), below.

c. Temporary privileges may be terminated with or without cause at any time by the Chief of Staff, *[the responsible Department Chair,]* or the Chief Executive Officer after conferring with the Chief of Staff *[or the responsible Department Chair].* A person shall be entitled to the procedural rights afforded by the Bylaws, Article 14, Hearings and Appellate Reviews, only if a request for temporary privileges is refused based upon, or if all or any portion of temporary privileges are terminated or suspended for, a medical disciplinary cause or reason. In all other cases (including a deferral in acting on a request for temporary privileges), the affected practitioner shall not be entitled to any procedural rights based upon any adverse action involving temporary privileges.

d. Whenever temporary privileges are terminated, *[the appropriate Department Chair or, in the Chair's absence,]* the Chief of Staff shall assign a member to assume responsibility for the care of the affected practitioner's patient(s). The wishes of the patient and affected practitioner shall be considered in the choice of a replacement member.

e. All persons requesting or receiving temporary privileges shall be bound by the Bylaws and Rules.

5.6 Disaster and Emergency Privileges

5.6-1 Disaster privileges may be granted when the hospital's disaster plan has been activated and the organization is unable to handle the immediate patient needs. The following provisions apply:

a. Disaster privileges may be granted on a case-by-case basis by the Chief Executive Officer, based upon recommendation of the Chief of Staff, *[or in his or her absence, the recommendation of the responsible Department Chair,]* upon presentation of a valid government-issued photo identification issued by a state or federal agency **and** any of the following:

1. A current picture hospital identification card;
2. A current license to practice and primary source verification of the license;
3. Identification indicating that the practitioner is a member of a Disaster Medical Assistance Team;
4. Identification indicating that the practitioner has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity;
5. Presentation by current hospital or Medical Staff member(s) with personal knowledge regarding the practitioner's identity.

b. Persons granted disaster privileges shall wear identification badges denoting their status as a Disaster Medical Assistance Team member.

c. The Medical Staff office shall begin the process of verification of credentials and privileges as soon as the immediate situation is under control, using a process identical to that described in Bylaws, Section 5.5-2, above (except that the individual is permitted to begin rendering services immediately, as needed).

d. The *[responsible Department Chair] [Chief of Staff]* shall arrange for appropriate concurrent or retrospective monitoring of the activities of practitioners granted disaster privileges.

5.6-2 In the event of an emergency, any member of the Medical Staff or credentialed Allied Health Professional shall be permitted to do everything reasonably possible, within the scope of their licensure, to save the life of a patient or to save a patient from serious harm. The member or Allied Health Professional shall promptly yield such care to a qualified member when one becomes available. *[If additional practitioners are needed and available, the emergency credentialing procedure described in the Rules shall be used to grant credentials to the practitioner.]*

5.7 Transport and Organ Harvest Teams

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

COMMENT: TJC permits practitioners who are not members of the Medical Staff and who have not undergone Medical Staff credentialing to provide patient care services as members of a transport or organ harvest team.Under California

law, such a team member must hold a current California license to practice medicine. An exception to the licensure requirement would be in the case of an emergency (Business & Professions Code Section 2060).Also, the Medicare Conditions of Participation require that hospitals performing certain organ transplants must be a member of the Organ Procurement and Transplantation Network established under Section 372 of the Public Health Services Act and must abide by its Rules and requirements. (This applies to the following transplants: human kidney, liver, heart, lung or pancreas.)

COMMENT: The proctoring provisions have been moved to follow the Allied Health Professional article, as these provisions apply to members of the Medical Staff and Allied Health Professionals. More significantly, proctoring has been incorporated into the overall scheme of Focused Professional Practice Evaluations, required by TJC, as described in the Bylaws, Article 7, Performance Evaluation and Monitoring.

5.8 Dissemination of Privileges List

Documentation of current privileges (granted, modified, or rescinded) shall be disseminated to the hospital admissions/registration office and such other scheduling and health information services personnel as necessary to maintain an up-to-date listing of privileges for purposes of scheduling and monitoring to assure that practitioners are appropriately privileged to perform all services rendered.

COMMENT: Added to comply with TJC Standard MS.06.01.09, EP 4.

Article 6 Allied Health Professionals

COMMENT: These credentialing provisions for Allied Health Professionals (AHPs) envision that an Interdisciplinary Practice Committee will serve as the credentialing committee. (See additional comments at Appendix 4I Interdisciplinary Practice Committee).

6.1 Qualifications of Allied Health Professionals

Allied Health Professionals (AHPs) are not eligible for Medical Staff membership. They may be granted practice privileges if they hold a license, certificate or other credentials in a category of AHPs that the Governing Body (after securing Medical Executive Committee comments) has identified as eligible to apply for practice privileges, and only if the AHPs are professionally competent and continuously meet the qualifications, standards and requirements set forth in the Medical Staff Bylaws and Rules.

6.2 Categories

The Governing Body shall determine, based upon comments of the Medical Executive Committee and such other information as it has before it, those categories of AHPs that shall be eligible to exercise privileges in the hospital. Such AHPs shall be subject to the supervision requirements developed *[in each department]* and approved by the Interdisciplinary Practice Committee, the Medical Executive Committee, and the Governing Body.

6.3 Privileges [and Department Assignment]

6.3-1 AHPs may exercise only those setting-specific privileges granted to them by the Governing Body. The range of privileges for which each AHP may apply, and any special limitations or conditions to the exercise of such privileges, shall be based on recommendations of the Interdisciplinary Practice Committee, subject to approval by the Medical Executive Committee and the Governing Body.

6.3-2 An AHP must apply and qualify for practice privileges, and practitioners who desire to supervise or direct AHPs who provide dependent services must apply and qualify for privileges to supervise approved AHPs. Applications for initial granting of practice privileges and biennial renewal thereof shall be submitted and processed in a similar manner to that provided for practitioners, unless otherwise specified in the Rules.

6.3-3 Each AHP shall be *[assigned to the department or departments appropriate to his or her occupational or professional training and, unless otherwise specified in these Bylaws or the Rules, shall be]* subject to terms and conditions similar to those specified for practitioners as they may logically be applied to AHPs and appropriately tailored to the particular AHP.

6.4 Prerogatives

The prerogatives which may be extended to an AHP shall be defined in the Rules and/or hospital policies. Such prerogatives may include:

6.4-1 Provision of specified patient care services; which services may be provided independently or under the supervision or direction of a Medical Staff member and consistent with the practice privileges granted to the AHP and within the scope of the AHP's licensure or certification, as specified in the Rules.

COMMENT: This clarification correlates with the fact that certain AHP services may be provided independently (if permitted by the Governing Body).

6.4-2 Service on the Medical Staff, *[department]* and hospital committees.

6.4-3 Attendance at *[the meetings of the department to which the AHP is assigned, as permitted by the department rules, and attendance at]* hospital education programs in the AHP's field of practice.

6.5 Responsibilities

Each AHP shall:

6.5-1 Meet those responsibilities required by the Rules and as specified for practitioners in Bylaws, Section 2.6, as they may be logically applied to reflect the more limited practice of the AHP.

6.5-2 Retain appropriate responsibility within the AHP's area of professional competence for the care and supervision of each patient in the hospital for whom the AHP is providing services.

6.5-3 Participate in peer review and quality improvement and in discharging such other functions as may be required from time to time.

6.6 Procedural Rights of Allied Health Professionals

COMMENT: The Joint Commission requires there to be a mechanism, including a fair hearing and appeal process, for addressing adverse decisions for AHP's holding clinical privileges (i.e., adverse decisions regarding renewal, revocation, or revision of clinical privileges). The procedures may, but need not be, the same for AHPs and Medical Staff members. Three alternative procedures are listed below. Some hospitals prefer to afford AHPs the same hearing and appeal rights as are afforded members of the Medical Staff (per Option 1, below); others prefer a more abbreviated process (such as the provisions described in Options 2 and 3, below). Option 2 assumes the hospital has decided to extend to AHPs already holding clinical privileges, the same hearing and appeal rights as are afforded members of the Medical Staff (but AHP applicants would be afforded a more abbreviated hearing and appeal process). Option 3 assumes the hospital prefers a more abbreviated fair hearing and appeal process for all AHPs (other than clinical psychologists, who under California law must be given the same hearing and appeal rights as afforded to members of the Medical Staff). The rationale for distinguishing between the categories is generally that state and federal law mandate extensive hearing rights for physicians, podiatrists, dentists and clinical psychologists, marriage and family therapists, and clinical social workers, but not for AHPs (other than clinical psychologists, marriage and family therapists, and clinical social workers). Also, state and federal law require reporting to the Medical Board of California and the National Practitioner Data Bank whenever a medical disciplinary action has been taken against a practitioner; whereas there is no such reporting requirement for AHPs. Given these differences in the law, and given the cost and difficulty of conducting the statutorily

mandated hearings and appeals, some hospitals opt for a simplified procedure wherever possible. As yet, the California statutes and cases have not specifically addressed fair hearing rights for AHPs. Medical Staffs are encouraged to discuss these considerations with their own legal counsel prior to adopting procedural rights affecting AHPs.

[Option 1]

6.6-1 ***[Fair Hearing and Appeal]***

[Denial, revocation, or modification of AHPs' privileges shall be the prerogative of the Interdisciplinary Practices Subcommittee, subject to approval by the Credentials Committee, the Medical Executive Committee, and the Governing Body. The procedural rights described at Bylaws, Article 14, Hearings and Appellate Reviews, shall apply.]

[OR]

[Option 2]

6.6-1 ***[Fair Hearing and Appeal]***

a. *[Clinical psychologists, marriage and family therapists, and clinical social workers shall be entitled to the procedural rights set forth at Bylaws, Article 14, Hearings and Appellate Reviews.]*

b. *[[Except as provided at Section 6.6-1(a), with respect to clinical psychologists, marriage and family therapists, and clinical social workers] there shall be no formal hearing and appeal rights with respect to decisions to deny initial applications for AHP clinical privileges. However, an AHP applicant shall have the right to challenge any such action by filing a written grievance with the Medical Executive Committee within 15 days of such action. Upon receipt of such a grievance, the Medical Executive Committee or its designee shall conduct a review that shall afford the AHP an opportunity for an interview concerning the grievance. Any such interview shall not constitute a hearing as established by Bylaws, Article 14, Hearings and Appellate Reviews, and shall not be conducted according to the procedural Rules applicable to such hearings. Before the interview, the AHP shall be informed of the general nature and circumstances giving rise to the action, and the AHP may present information relevant thereto at the interview. A record of the interview shall be made. The Medical Executive Committee or its designee shall make a decision based on the interview and all other information available to it.]*

c. *[Whenever an AHP holding clinical privileges is subject to an action that would constitute grounds for a hearing under Bylaws, Section 14.2-2 through 14.2-6, the AHP shall be entitled to the procedural rights set forth at Bylaws, Article 14, Hearings and Appellate Reviews.]*

COMMENT: Revised to reflect changes in law requiring B&P 805 reports, and consequent Article 14 hearing rights for marriage and family therapists and clinical social workers. The bracketed language pertaining to clinical psychologists in subparagraphs (a) and (b) above, and in subparagraph (a) below, would be included only if clinical psychologists are part of the AHP staff rather than the Medical Staff.

[OR]

[Option 3]

6.6-1 ***[Fair Hearing and Appeal]***

[AHPs shall be entitled to certain fair hearing and appeal rights, as described below:]

a. *[Clinical psychologists, marriage and family therapists, and clinical social workers shall be entitled to the procedural rights set forth at Bylaws, Article 14, Hearings and Appellate Reviews.]*

b. *[[Other] AHP applicants shall have the right to challenge a recommendation of the Interdisciplinary Practice Committee to deny or restrict requested privileges by filing a written grievance with the Medical Executive Committee within 15 days of such action. Upon receipt of such a grievance, the*

Medical Executive Committee or its designee shall conduct a review that shall afford the AHP an opportunity for an interview concerning the grievance. Any such interview shall not constitute a hearing as established by Bylaws, Article 14, Hearings and Appellate Reviews, and shall not be conducted according to the procedural Rules applicable to such hearings. Before the interview, the AHP shall be informed of the general nature and circumstances giving rise to the action, and the AHP may present information relevant thereto at the interview. A record of the interview shall be made. The Medical Executive Committee or its designee shall make a decision based on the interview and all other information available to it.]

c. *[An AHP [other than a clinical psychologist, marriage and family therapist, or clinical social worker] holding clinical privileges who is subject to a recommendation of the Interdisciplinary Practice Committee to revoke, restrict or not renew any or all of such AHP's privileges shall be entitled to the rights set forth below.]*

1. *[The affected AHP shall be given written notice of the recommended action.]*
2. *[The affected AHP shall have 10 days within which to request a Medical Executive Committee review hearing of the action.]*
3. *[If a review is requested, the affected AHP shall be given written notice of the general reasons for the action, and the date, time and place that the Medical Executive Committee review hearing is scheduled. Such date shall afford the AHP at least 14 calendar days' notice.]*
4. *[The affected AHP and the Interdisciplinary Practice Committee, through its designated representative, shall each have 10 days to submit written information and argument in support of their positions.]*
5. *[The affected AHP shall have a right to appear at the Medical Executive Committee hearing, to hear such evidence as the Interdisciplinary Practice Committee representative may present in support of the committee's recommended action, and to present evidence in support of the AHP's challenge to that recommendation. Neither party shall be represented by legal counsel in the hearing.]*
6. *[The Medical Executive Committee may then, at a time convenient to itself, deliberate outside the presence of the parties.]*
7. *[The Medical Executive Committee decision following such a hearing shall be effective immediately, but shall be subject to appeal to the Governing Body (or, in the discretion of the Governing Body, to an Appeal Board appointed by the Governing Body).]*
8. *[The affected AHP shall be promptly informed, in writing, of the Medical Executive Committee's decision, and of his or her right to appeal the decision.]*
9. *[The affected AHP shall have 10 days to request an appeal hearing. The request for appeal shall state, with specificity, the basis for the appeal.]*
10. *[The appeal hearing shall be conducted within 30 days. The parties to the appeal shall be the Medical Executive Committee (which shall be represented by a member of the Medical Staff, who may, but need not be a member of the Medical Executive Committee or the Interdisciplinary Practice Committee).]*
11. *[Each party shall have the right to present a written statement in support of his, her or its position on appeal. The Governing Body (or Appeal Board, if applicable) Chair may establish reasonable time frames for the appealing party to submit a written statement and for the responding party to respond. Each party has the right to personally appear and make oral argument. The Governing Body (or Appeal Board, if applicable) may then, at a time convenient to itself, deliberate outside the presence of the parties]*
12. *[The Governing Body (or Appeal Board, if applicable) shall issue a final decision, in writing.]*

COMMENT: Additional comments regarding Option 3:The optional language pertaining to clinical psychologists (in subparagraphs (a) and (c) above), and the word "other" (at the beginning of subparagraph (b) above) would be included only if clinical psychologists are part of the AHP staff rather than the Medical Staff. The above provision makes the Medical Executive Committee the hearing body. This is appropriate only if the Interdisciplinary Practice Subcommittee or the Credentials Committee participates in the credentialing process and is in a position to issue an adverse recommendation. Some hospitals may prefer to reserve to the Medical Executive Committee the authority to make the adverse recommendation that gives rise to the hearing (as is done with adverse recommendations as to applicants or members of the Medical Staff), but if they do that, then an ad hoc hearing committee (rather than the Medical Executive Committee) would need to be the hearing body. This is because The Joint Commission requires that the hearing be conducted by a body that was not involved in making the adverse recommendation that would be at issue in the hearing.

6.6-2 Automatic Termination

Notwithstanding the provisions of Bylaws, Section 6.6-1, page 49, an AHP's privileges shall automatically terminate, without review pursuant to Bylaws, Section 6.6-1 or any other Section of the Medical Staff Bylaws, in the event:

a. The Medical Staff membership of the supervising practitioner is terminated, whether such termination is voluntary or involuntary;

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

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

Where the AHP's privileges are automatically terminated for reasons specified in Section 6.6-2(a), above, the AHP may apply for reinstatement as soon as the AHP has found another supervising practitioner who agrees to supervise the AHP and receives privileges to do so. In this case, the Medical Executive Committee may, in its discretion, expedite the reapplication process.

COMMENT: This clarification can help assure no gap in service in cases where the supervising physician's departure is unexpected. CMS surveyors, in particular, are carefully scrutinizing that AHP privileges are consistent with the Bylaws and Rules.

6.6-3 Review of Category Decisions

The rights afforded by this Section shall not apply to any decision regarding whether a category of AHP shall or shall not be eligible for practice privileges and the terms, prerogatives, or conditions of such decision. Those questions shall be submitted for consideration to the Governing Body, which has the discretion to decline to review the request or to review it using any procedure the Governing Body deems appropriate.

Article 7 Performance Evaluation and Monitoring

COMMENT: This Article incorporates The Joint Commission's (TJC) Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) standards. As described below, the proctoring provisions, formerly described in Bylaws, Article 5, Privileges, have been moved to this Article 7, as a subset of FPPE.

7.1 General Overview of Performance Evaluation and Monitoring Activities

The credentialing and privileging processes described in Bylaws, Article 4, Procedures for Appointment and Reappointment, and Article 5, Privileges, require that the Medical Staff develop ongoing performance evaluation and monitoring activities to ensure that decisions regarding appointment to membership on the Medical Staff and granting or renewing of privileges are, among other things, detailed, current, accurate, objective and evidence-based. Additionally, performance evaluation and monitoring activities help assure timely identification of problems that may arise in the ongoing provision of services in the hospital. Problems identified through performance evaluation and monitoring activities are addressed via the appropriate performance improvement and/or remedial actions as described in Bylaws, Article 13, Performance Improvement and Corrective Action.

7.2 Performance Monitoring Generally

7.2-1 Except as otherwise determined by the Medical Executive Committee and Governing Body, the Medical Staff shall regularly monitor all members' privileges in accordance with the provisions set forth in these Bylaws and such performance monitoring policies as may be developed by the Medical Staff and approved by the Medical Executive Committee and the Governing Body.

7.2-2 Performance monitoring is not viewed as a disciplinary measure, but rather is an information-gathering activity. Performance monitoring does not give rise to the procedural rights described in Bylaws, Article 14, Hearings and Appellate Reviews (unless the form of monitoring is Level III proctoring and its imposition becomes a restriction of privileges because procedures cannot be done unless a proctor is present and proctors are not available after reasonable attempts to secure a proctor).

7.2-3 The Medical Staff shall clearly define how information gathered during performance monitoring shall be shared in order to effectuate change and additional action, if determined necessary.

7.2-4 Performance monitoring activities and reports shall be integrated into other quality improvement activities.

7.2-5 The results of any practitioner-specific performance monitoring shall be considered when granting, renewing, revising or revoking clinical privileges of that practitioner.

7.3 Ongoing Professional Performance Evaluations

7.3-1 *[Each department] [The Medical Staff]* shall recommend, for Medical Executive Committee and Governing Body approval, the criteria to be used in the conduct of Ongoing Professional Performance Evaluations for its practitioners.

COMMENT: For example, TJC suggests the following criteria Ongoing Professional Performance Evaluation (OPPE): review of operative and other clinical procedure(s) performed and their outcomes, pattern of blood and pharmaceutical usage, requests for tests and procedures, length of stay patterns, morbidity and mortality data, practitioner's use of consultants. See commentary to TJC Standard MS.08.01.03.

7.3-2 Methods that may be used to gather information for Ongoing Professional Performance Evaluations include, but are not limited to:

a. Periodic chart review;

b. Direct observation;

c. Monitoring of diagnostic and treatment techniques;

d. Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing and administrative personnel.

7.3-3 Ongoing performance reviews shall be factored into the decision to maintain, revise or revoke a practitioner's existing privilege(s).

7.4 Focused Professional Practice Evaluation

COMMENT: According to TJC, Focused Professional Practice Evaluation (FPPE) includes proctoring. Therefore, we have modified the Bylaws provisions regarding proctoring, incorporating proctoring as a subset of FPPE. In addition, we have replaced the general proctoring requirement (customarily implemented to review new members of the staff or new requests for privileges) with a more generic FPPE requirement, which may include proctoring. Finally, we have refined the proctoring provisions to create three levels of proctoring: • Level I proctoring applies to all initially requested privileges and infrequently used privileges whereas Level II or Level III proctoring is appropriate when a question arises regarding a practitioner's competency. • The difference between Level II and Level III is that the latter results in a restriction on the practitioner's privilege(s) that automatically triggers procedural rights. (Levels I and II are not practice restrictions, and do not trigger such rights).These changes are recommendations only. Before they become part of the Bylaws and Rules, these concepts must be checked for consistency with any other hospital policies and procedures that have been created to accommodate OPPE and FPPE in general. The hospital's policies and procedures must address the elements of performance at TJC Standard MS.08.01.01, which include: • The Medical Staff develops criteria to be used for evaluating the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified. • The performance monitoring process is clearly defined, including criteria for conducting performance monitoring, method for establishing a monitoring plan specific to the requested privileges, method for determining the duration of performance monitoring, and the circumstances when an external source is required for monitoring. • The triggers that indicate a need for performance monitoring and criteria for what type of monitoring.For more on FPPE, see TJC Standard MS.08.01.01.

7.4-1 The Medical Staff is responsible for developing a focused professional practice evaluation process that will be used in predetermined situations to evaluate, for a time-limited period, a practitioner's competency in performing specific privilege(s). The Medical Staff may supplement these Bylaws with policies, for approval by the Medical Executive Committee and the Governing Body, that will clearly define the circumstances when a focused evaluation will occur, what criteria and methods should be used for conducting the focused evaluation, the duration of the evaluation period, requirements for extending the evaluation period, and how the information gathered during the evaluation process will be analyzed and communicated.

COMMENT: The above Section is a general statement summarizing the detail that should be included in any supplemental FPPE policies.

7.4-2 Information for a focused evaluation process may be gathered through a variety of measures including, but not limited to:

a. Retrospective or concurrent chart review;

b. Monitoring clinical practice patterns;

c. Simulation;

d. External peer review;

e. Discussion with other individuals involved in the care of each patient;

f. Proctoring, as more fully described at Bylaws, Section 7.4-4, below.

7.4-3 A Focused Professional Practice Evaluation shall be used in at least the following situations:

a. All initial appointees to the Medical Staff and all members granted new privileges shall be subject to a period of focused professional practice evaluation in accordance with these Bylaws *[and the Rules of the department in which the applicant or member will be exercising those privileges]*. Such focused evaluation will generally include a period of Level I proctoring in accordance with Bylaws, Section 7.4-4(a), below, unless additional circumstances appear to warrant a higher level of proctoring, as described below.

b. In special instances, focused evaluation will be imposed 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 competency in that area). Such evaluation will generally consist of Level I proctoring in accordance with Bylaws, Section Section 7.4-4(a)(1) below, unless additional circumstances appear to warrant a higher proctoring level, as described below.

c. When questions arise regarding a practitioner's competency in performing specific privilege(s) at the hospital as a result of specific concerns or circumstances, a focused evaluation may be imposed. Such evaluations may include either Level II or III proctoring, in accordance with these Bylaws, Sections Section 7.4-4(a)(1) or (2).

d. As otherwise defined in these Bylaws or applicable Focused Professional Practice Evaluation policies.

e. Nothing in the foregoing precludes the use of other Focused Professional Practice Evaluation tools, in addition to or in lieu of proctoring, as deemed warranted by the circumstances.

COMMENT: The hospital policy regarding FPPE's will likely include more detail as to the types of situations that may trigger FPPE. These may include unexpected deaths, unexpected complications, severe drug reactions, severe transfusion reactions, sentinel events, certain compensable events identified by the risk manager, all cases in which a letter of intent has been filed, written patient complaints concerning members or AHPs, staff reports of concern, utilization issues, etc. The policy should provide that whenever FPPE is imposed as a result of a discretionary decision, that decision must be made by an officer or committee of the Medical Staff.

7.4-4 Proctoring

a. **Overview of Proctoring Levels**

1. Level I proctoring shall be considered routine and is generally implemented as a means to review initially requested privileges in accordance with Bylaws, Section 7.4-3(a), above, and for review of infrequently used privileges in accordance with Bylaws, Section 7.4-3(b), above.
2. Level II proctoring is appropriate in situations where a practitioner's competency or performance is called into question, in accordance with Bylaws, Section 7.4-3(c), above, but where the circumstances do not involve a "medical disciplinary" cause or reason or where the proctoring does not constitute a restriction on the practitioner's privilege(s) (i.e., the practitioner is required to participate in proctoring, and to notify either the proctor or other designated individual(s) prior to providing services, but is permitted to proceed without the proctor if one is not available).
3. Level III proctoring is appropriate in situations where a practitioner's competency or performance is called into question due to a "medical disciplinary" cause or reason in accordance with Bylaws, Section 7.4-3(c), above, and where the form of proctoring is a restriction on the practitioner's privilege(s) (because the practitioner may not perform a procedure or provide care in the absence of the proctor). Upon imposition of Level III proctoring, that practitioner is afforded such procedural rights as provided at Bylaws, Article 14, Hearings and Appellate Reviews.

b. **Overview of Proctoring Procedures**

1. Whenever proctoring is imposed, the number (or duration) and types of procedures to be proctored shall be delineated.
2. During the proctoring, the practitioners must demonstrate they are qualified to exercise the privileges that were granted and are carrying out the duties of their Medical Staff category.
3. In the event that the new applicant has privileges at a neighboring hospital where members of this hospital's Medical Staff are familiar with the member to be proctored, and familiar with that neighboring hospital's peer review standards, privileging and proctoring information from the neighboring hospital may, at the discretion of *[the appropriate Department Chair]*, be acceptable to satisfy a portion of the focused professional practice evaluation required for this hospital.

c. **Proctor: Scope of Responsibility**

1. All members who act as proctors of new appointees and/or members of the Medical Staff are acting at the direction of and as an agent for *[the department]*, the Medical Executive Committee and the Governing Body. When possible, no business relationship shall exist between proctor and proctoree.
2. The intervention of a proctor shall be governed by the following guidelines:

    i. A member who is serving as a proctor does not act as a supervisor of the member or practitioner he or she is observing. His or her role is to observe and record the performance of the member or

practitioner being proctored, and report his or her evaluation to the *[department and/or the Credentials Committee].*

ii. A proctor is not mandated to intervene when he or she observes what could be construed as deficient performance on the part of the practitioner or member being proctored.

iii. In an emergency situation, a proctor may intervene, even though he or she has no legal obligation to do so.

d. **Completion of Proctoring**

The member shall remain subject to such proctoring until the Medical Executive Committee has been furnished with:

1. A report signed by *[the Chair of the department to which the member is assigned]* describing the types and numbers of cases observed and the evaluation of the member's performance, a statement that the member appears to meet all of the qualifications for unsupervised practice in the hospital, has discharged all of the responsibilities of Medical Staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made; and
2. *[A report signed by the Chair of such other department(s) in which the member may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the member's performance and a statement that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments.]*

e. **Effect of Failure to Complete Proctoring**

1. **Failure to Complete Necessary Volume.** Any practitioner or member undergoing Level I or Level II proctoring 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 Bylaws, Article 14, Hearings and Appellate Reviews. However, *[the department] [other responsible official or committee]* 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 Bylaws, Article 14, Hearings and Appellate Reviews.
2. **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 Bylaws, Article 14, Hearings and Appellate Reviews. A recent case, *Bode v. Los Angeles Metropolitan Medical Center*, 174 Cal. App. 4th 1224 (2009), held that once privileges have been granted, even if subject to proctoring, the individual is no longer deemed an applicant.

COMMENT: Recommended clarification of procedural rights for those who have not successfully completed proctoring.

3. **Effect on Advancement.** The failure to complete proctoring for any specific privilege shall not, by itself, preclude advancement from provisional staff. If advancement is approved prior to completion of proctoring, the proctoring will

continue for the specified privileges. The specific privileges may be voluntarily relinquished or terminated, pursuant to Bylaws, Section 7.4-4(e)(1) or (2), if proctoring is not completed thereafter within a reasonable time.

Article 8 Medical Staff Officers (and Medical Director)

8.1 Medical Staff Officers — General Provisions

8.1-1 Identification

a. There shall be the following general officers of the Medical Staff:

1. Chief of Staff
2. Vice Chief of Staff
3. Secretary-Treasurer

b. In addition, the Medical Staff's *[department and section]* officers and Committee Chairs shall be deemed Medical Staff officers within the meaning of California law.

8.1-2 Qualifications

All Medical Staff officers shall:

a. Understand the purposes and functions of the Medical Staff and demonstrate willingness to assure that patient welfare always takes precedence over other concerns;

b. Understand and be willing to work toward attaining the hospital's lawful and reasonable policies and requirements;

c. Have administrative ability as applicable to the respective office;

d. Be able to work with and motivate others to achieve the objectives of the Medical Staff and hospital;

e. Demonstrate clinical competence in his or her field of practice;

f. Be an active Medical Staff member (and remain in good standing as an active Medical Staff member while in office); and

g. Not have any significant conflict of interest.

8.1-3 Disclosure of Conflict of Interest

a. All nominees for election or appointment to Medical Staff offices (including those nominated by petition of the Medical Staff pursuant to Bylaws, Section 8.2-3) 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 that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. Generally, a conflict of interest arises when there is a divergence between an individual's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by those private interests. A conflict of interest depends on the situation and not on the character of the individual. The fact that an individual practices in the same specialty as a practitioner who is being reviewed does not by itself create a conflict of interest. The evaluation of whether a

conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. The Medical Executive Committee shall evaluate the significance of such disclosures and discuss any significant conflicts with the nominee. If a nominee with a significant conflict remains on the ballot, the nature of his or her conflict shall be disclosed in writing and circulated with the ballot.

b. *[A person nominated from the floor shall be asked to verbally disclose conflicts to those in attendance at the meeting, and the Medical Executive Committee or its representative shall have an opportunity to comment thereon, prior to the vote.]*

COMMENT: Recommended clarification of conflict of interest parameters. This is an important disclosure since conflicts of interest can sway decision making and, in some instances (e.g., when the officer automatically becomes a Governing Body member), may result in disqualification from voting on issues before the body. Significant or pervasive conflicts can impair an officer's effectiveness. Include Section 8.1-3(b), Disclosure of Conflict of Interest, if nominations are permitted from the floor.

8.2 Method of Selection — General Officers

COMMENT: Two options are presented: Vice Chief of Staff becoming Chief of Staff, and direct election of the Chief of Staff. Accession of the Vice Chief helps to assure better continuity and preparation for the responsibilities of the position, but it requires a longer commitment.

[Option 1]

8.2-1 ***[Succession of Vice Chief of Staff to Chief of Staff]***

[The Vice Chief of Staff shall accede to the position of Chief of Staff upon the Chief of Staff's completion of his or her term.]

8.2-2 ***[Nominating Committee]***

[An ad hoc nominating committee composed of the Chief of Staff, two staff members elected by the Medical Executive Committee, and two staff members appointed by the Chief of Staff shall develop a slate of candidates meeting the qualifications of office, as described in Bylaws, Section 8.1-2, above. This slate shall be developed at least 45 days prior to the scheduled election. At least one candidate shall be nominated for each of the following positions:]

a. *[Vice Chief of Staff and]*

b. *[Secretary-Treasurer]*

[Option 2]

8.2-1 ***[Nominating Committee]***

[An ad hoc nominating committee composed of the Chief of Staff, two staff members elected by the Medical Executive Committee, and two staff members appointed by the Chief of Staff shall develop a slate of candidates meeting the qualifications of office, as described in Bylaws, Section 8.1-2, above. This slate shall be developed at least 45 days prior to the scheduled election. At least one candidate shall be nominated for each of the following positions:]

a. *[Chief of Staff,]*

b. *[Vice Chief of Staff, and]*

c. *[Secretary-Treasurer]*

COMMENT: If Option 2 is selected, Section 8.2-3 through 8.2-6 must be renumbered.

8.2-3 Nomination by Petition

The Medical Staff may nominate candidates for office by a petition signed by at least ten members who are eligible to vote and a statement from the candidate signifying willingness to run. Such nominations must be received by the Chief of Staff at least 30 days prior to the scheduled elections.

8.2-4 ***[Governing Body Review]***

COMMENT: Some hospitals provide for Governing Body input into the selection process. This approach is based upon the premise that Medical Staff officers play critical roles in the smooth functioning of the hospital, and the Governing Body should therefore have input into this key selection process. However, with the adoption of Business & Professions Code Section 2282.5, this provision was modified to provide for Governing Body review and comment, rather than approval. If the Governing Body will not be commenting on the selection of candidates, then Bylaws, Section 8.2-4, Governing Body Review, should be eliminated, and Bylaws, Section 8.2-5, Election, should be renumbered.

[The slate of candidates (including those nominated by petition), together with the disclosure information provided pursuant to Bylaws, Section 8.1-3, will be presented to the Governing Body for its review and comment. The Governing Body may issue written comments about any or all candidates, which comments must be communicated to all voting Medical Staff prior to the election.]

8.2-5 Election

The election shall be by mail ballot, and the outcome shall be determined by a majority of the votes cast by mail ballots that are returned to the Medical Staff office within 15 days after the ballots were mailed to the voting Medical Staff members.

8.2-6 Term of Office

a. Officers shall be elected in the fall of odd-numbered years and shall take office the following January.

b. The term of office shall be two years. No officer shall serve consecutive terms in the same position.

COMMENT: Two-year terms are recommended to build skills and continuity of leadership.

8.3 Recall of Officers

A general Medical Staff Officer may be recalled from office for any valid cause including, but not limited to, failure to carry out the duties of his or her office. Except as otherwise provided, recall of a general Medical Staff Officer may be initiated by the Medical Executive Committee or by a petition signed by at least 33-1/3 percent of the Medical Staff members eligible to vote for officers; but recall itself shall require a 66-2/3 percent vote of the Medical Executive Committee or 66-2/3 percent vote of the Medical Staff members eligible to vote for general Medical Staff Officers.

8.4 Filling Vacancies

Vacancies created by resignation, removal, death, or disability shall be filled as follows:

8.4-1 A vacancy in the office of Chief of Staff shall be filled by the Vice Chief of Staff.

8.4-2 A vacancy in the office of Vice Chief of Staff shall be filled by special election held in general accordance with Bylaws, Section 8.2, page 64.

8.4-3 A vacancy in the office of secretary-treasurer shall be filled by appointment by the Medical Executive Committee.

8.5 Duties of Officers

8.5-1 Chief of Staff

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

a. Enforcing the Medical Staff Bylaws and Rules, promoting quality of care, implementing sanctions when indicated, and promoting compliance with procedural safeguards when corrective action has been requested or initiated;

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

c. Serving as Chair of the Medical Executive Committee, and in that capacity shall be deemed the individual responsible for the organization and conduct of the Medical Staff;

COMMENT: Medicare Conditions of Participation, Section 482.22(b)(3) require that the responsibility for organization and conduct of the Medical Staff must be assigned only to an individual doctor of medicine or osteopathy.

d. Serving as an ex officio member of all other Staff committees without vote, unless his or her membership in a particular committee is required by these Bylaws;

e. Appointing, in consultation with the Medical Executive Committee, committee members for all standing, ad hoc, and special Medical Staff, liaison, or multi-disciplinary committees except where otherwise provided by these Bylaws and, except where otherwise indicated, designating the Chairs of these committees;

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

g. Serving on liaison committees with the Governing Body and administration, as well as outside licensing or accreditation agencies;

h. Appointing members of the Medical Staff to participate, as a Medical Staff liaison, in the development of hospital policies;

COMMENT: Added to assure compliance with 22 California Code of Regulations 70701(a)(9).

i. Regularly reporting to the Governing Body on the performance of Medical Staff functions and communicating to the Medical Staff any concerns expressed by the Governing Body;

j. In the interim between Medical Executive Committee meetings, performing those responsibilities of the committee that, in his or her reasonable opinion, must be accomplished prior to the next regular or special meeting of the committee;

k. Interacting with the Chief Executive Officer and Governing Body in all matters of mutual concern within the hospital;

l. Representing the views and policies of the Medical Staff to the Governing Body and to the Chief Executive Officer and serving as an ex-officio member of the Governing Body;

m. Serving on the Joint Conference Committee;

n. Being accountable to the Governing Body, in conjunction with the Medical Executive Committee, for the effective performance, by the Medical Staff, of its responsibilities with respect to quality and efficiency of clinical services within the hospital and for the effectiveness of the quality assurance and utilization review programs; and

o. Performing such other functions as may be assigned to him or her by these Bylaws, the Medical Staff or the Medical Executive Committee.

8.5-2 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 and of the Joint Conference Committee, and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws or the Medical Executive Committee.

8.5-3 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 correspondence and notices on behalf of the Medical Staff;

e. Receiving and safeguarding all funds of the Medical Staff;

f. Excusing absences from meetings on behalf of the Medical Executive Committee; and

g. Performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

8.6 [Chief Medical Officer]

COMMENT: This section should be included if the hospital has a Chief Medical Officer.

8.6-1 ***[Appointment]***

[The Chief Medical Officer shall be appointed by the Governing Body and approved by the Medical Executive Committee.]

8.6-2 ***[Responsibilities]***

a. *[The Chief Medical Officer's duties shall be delineated by the Governing Body in keeping with the general provisions set forth in subparagraph (b) below. The Medical Executive Committee approval shall be required for any Chief Medical Officer duties that relate to authority to perform*

functions on behalf of the Medical Staff or directly affect the performance or activities of the Medical Staff.]

b. *[In keeping with the foregoing, the Chief Medical Officer shall:]*

1. *[Serve as administrative liaison among hospital administration, the Governing Body, outside agencies and the Medical Staff;]*

2. *[Assist the Medical Staff in performing its assigned functions and coordinating such functions with the responsibilities and programs of the hospital; and]*

3. *[In cooperation and close consultation with the Chief of Staff and the Medical Executive Committee, supervise the day-to-day performance of the Medical Staff office and the hospital's quality improvement personnel.]*

8.6-3 *[Participation in Medical Staff Committees]*

[The Chief Medical Officer:]

a. *[Shall be an ex officio member—without vote—of all Medical Staff Committees, except the Joint Conference Committee (which the Chief Medical Officer shall attend as a resource person) and any hearing committee.]*

b. *[May attend any meeting of any department or section.]*

Article 9 Committees

COMMENT: There are a variety of ways to organize Medical Staff committees. Smaller hospitals have traditionally minimized the number of committees — sometimes assigning many, if not all, responsibilities to the Medical Executive Committee (MEC). Larger hospitals, on the other hand, have traditionally had many committees, with each assigned responsibility to perform distinct functions of the Medical Staff. Nondepartmentalized hospitals necessarily need a different structure. A trend is emerging to consolidate committee functions to achieve better efficiency and integration. These Bylaws and the Rules present one such approach — namely assigning most responsibility for peer review to the departments, reducing the number of Medical Staff-wide committees, and consolidating most performance improvement committee activities under the auspices of a Medical Staff-wide Quality Improvement Committee. The most important consideration when designing committee structure is assuring that all required Medical Staff functions are assigned to one or more committees. The Bylaws or Rules must specify for each committee the committee's composition, minimum meeting frequency and the voting rights of all members, keeping in mind that ex officio members are presumed to have voting rights unless otherwise specified. These Bylaws and Rules are consistent with the growing trend toward encouraging greater flexibility in the committee structure by having only the MEC and Joint Conference Committee described in the Bylaws and all other committees described in the Rules. General provisions applicable to all committees are described in the Bylaws.

9.1 General

9.1-1 Designation

The Medical Executive Committee and the other committees described in these Bylaws and the Rules shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee *[or a department]* to perform specified tasks. 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.

9.1-2 Appointment of Members

a. Unless otherwise specified, the Chair and members of all committees shall be appointed by, and may be removed 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.

b. A Medical Staff committee created in these Bylaws is composed as stated in the description of the committee in these Bylaws or the Rules. Except as otherwise provided in the Bylaws, committees established to perform Medical Staff functions required by these Bylaws may include any category of Medical Staff members; Allied Health Professionals; representatives from hospital departments such as administration, nursing services, or health information services; representatives of the community; and persons with special expertise, depending upon the functions to be discharged. Each Medical Staff member who serves on a committee participates with votes unless the statement of committee composition designates the position as nonvoting.

c. The Chief Executive Officer, or his or her designee, in consultation with the Chief of Staff, shall appoint any non-Medical Staff members who serve in non-ex officio capacities.

d. The Committee Chair, after consulting with the Chief of Staff and Chief Executive Officer, may call on outside consultants or special advisors.

e. Each Committee Chair shall appoint a Vice Chair to fulfill the duties of the Chair in his or her absence and to assist as requested by the Chair. Each Committee Chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

9.1-3 Representation on Hospital Committees and Participation in Hospital Deliberations

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

9.1-4 Ex Officio Members

The Chief of Staff and the Chief Executive Officer, or their respective designees *[and the Medical Director]* are ex officio members of all standing and special committees of the Medical Staff and shall serve with vote unless provided otherwise in the provision or resolution creating the committee.

9.1-5 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 Chief Executive Officer regarding hospital staff.

9.1-6 Terms and Removal of Committee Members

Unless otherwise specified, a committee member shall be appointed for a term of *[one year; two years]*, subject to unlimited renewal, and shall serve until the end of this period and until his or her successor is appointed, unless he or she shall sooner resign or be removed from the committee. Any committee member who is appointed by the Chief of Staff may be removed by a majority vote of the Medical Executive Committee. *[Any committee member who is appointed by the Department Chair may be removed by a majority vote of his or her Department Committee or the Medical Executive Committee.]* The removal of any committee member who is automatically assigned to a committee because he or she is a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official.

9.1-7 Vacancies

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

9.1-8 Conduct and Records of Meetings

Committee meetings shall be conducted and documented in the manner specified for such meeting in Bylaws, Article 11, Meetings.

9.1-9 Attendance of Nonmembers

Any Medical Staff member who is in good standing may ask the Chair of any committee for permission to attend a portion of that committee's meeting dealing with a matter of importance to that practitioner. The Committee Chair shall have the discretion to grant or deny the request and shall grant the request only if the member's attendance will reasonably aid the committee to perform its function. If the request is granted, the invited member shall abide by all Bylaws and Rules applicable to that committee.

9.1-10 Conflict of Interest

a. In any instance where a Medical Staff member has or reasonably could be perceived to have a conflict of interest, as defined below, such individual shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual with a conflict may be asked, and may answer, any questions concerning the matter before leaving. Any dispute over the existence of a conflict of interest shall be resolved by the chairperson of the committee, or, if it cannot be resolved at that level, by the Chief of Staff.

b. A conflict of interest arises when there is a divergence between an individual's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by those private interests. A conflict of interest depends on the situation and not on the character of the individual. The fact that an individual practices in the same specialty as a practitioner who is being reviewed does not by itself create a conflict of interest. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

COMMENT: Recommended to address conflict issues generally. (This is in addition to the conflict of interest disclosures required of candidates for Medical Staff office, per Section 8.1-3.)

9.1-11 Accountability

All committees shall be accountable to the Medical Executive Committee.

9.2 Joint Conference Committee

COMMENT: The Joint Commission (TJC) no longer requires a Joint Conference Committee, and it is not required by California or federal laws or regulations. However, many hospitals maintain the committee since it can help fulfill TJC requirement for a mechanism to assure effective communication among the Medical Staff, hospital administration and the Governing Body, and it fits well with TJC's Shared Vision – New Pathways philosophy. Additionally, the Joint Conference Committee represents an effective forum for operationalizing the interdependence of the Medical Staff and Governing Body, and may also be an appropriate forum for the meet and confer provisions required by Business & Professions Code Section 2282.5 (see additional comment at Bylaws, Section 9.2-2, below). District hospitals and hospitals governed by the Brown Act should consider whether this committee will be subject to the Brown Act and revise this Section as needed to accommodate these considerations.

9.2-1 Composition

The Joint Conference Committee shall be composed of *[eight]* members: *[the Chief of Staff, the Vice Chief of Staff, the immediate-past Chief of Staff, the Secretary-Treasurer, three*

members of the hospital's Governing Body, and the Chief Executive Officer]. All members are voting members. The person serving as the Joint Conference Committee Chair shall alternate annually between the *[Chief of Staff]* and one of the Governing Body representatives.

9.2-2 Duties and Meeting Frequency

a. This committee shall serve as a focal point for furthering an understanding of the roles, relationships, and responsibilities of the Governing Body, administration, and the Medical Staff. It may also serve as a forum for discussing any hospital matters regarding the provision of patient care. It shall meet at least quarterly or as often as necessary to fulfill its responsibilities. Any member of the committee shall have the authority to place matters on the agenda for consideration by the committee.

b. The committee *[shall/may]* also serve as the initial forum for exercise of the meet and confer provisions contemplated by Bylaws, Section 15.7; provided, however, that upon request of at least four committee members (which four must be comprised of at least three Medical Staff representatives and one Governing Body representative, or of at least three Governing Body representatives and one Medical Staff representative), a neutral mediator, acceptable to both contingents, shall be engaged to assist in dispute resolution.

COMMENT: Business & Professions Code Section 2282.5 requires the Medical Staff and Governing Body to meet and confer in good faith to resolve disputes arising under that Section. The above provision could be used to accomplish this.Alternatively, the full Governing Body and the MEC is another appropriate forum for this meet and confer. Still another alternative is to use the full Governing Body and the MEC only in the event the parties cannot reach an agreement in the Joint Conference Committee forum.Bylaws, Section 9.2-2(b), above, should further be tailored if either of these latter alternatives is chosen. If either of these alternatives is chosen, further tailoring of the MEC's duties and responsibilities is recommended.

9.2-3 Accountability

The Joint Conference Committee is directly accountable to the Medical Executive Committee and to the Governing Body.

9.3 Medical Executive Committee

9.3-1 Composition

The Medical Executive Committee shall be composed of the Medical Staff officers listed in Bylaws, Article 8, Medical Staff Officers (and Medical Director), at least one at-large representative, *[the Chief Medical Officer as an ex officio member without vote, and (insert others who will be Medical Executive Committee members)]*. The Chief Executive Officer shall serve as an ex officio member. The Chief of Staff shall chair the Medical Executive Committee. A majority of the committee shall be physicians.

COMMENT: Departmentalized hospitals may include the Department Chairs as members of the MEC; often, key Committee Chairs are also members (although both of these approaches can result in a very large committee). Often the MEC includes one or more at-large representatives as well. TJC requires that all members of the Medical Staff, including limited license practitioners, shall be eligible to be members of the MEC (an at-large position helps accommodate this), and that a majority of the members must be physicians (doctors of medicine or osteopathy) who are actively practicing at the hospital.

9.3-2 Duties

The Medical Staff delegates to the Medical Executive Committee broad authority to oversee the operations of the Medical Staff. With the assistance of the Chief of Staff, and without limiting this broad delegation of authority, the Medical Executive Committee shall perform in good faith the duties listed below.

a. Supervise the performance of all Medical Staff functions, which shall include:

1. Requiring regular reports and recommendations from the *[departments,]* committees and officers of the Medical Staff concerning discharge of assigned functions;

2. Issuing such directives as appropriate to assure effective performance of all Medical Staff functions; and

3. Following up to assure implementation of all directives.

b. Coordinate the activities of the committees *[and departments]*.

c. Assure that the Medical Staff adopts Bylaws and Rules establishing the structure of the Medical Staff, the mechanism used to review credentials and to delineate individual privileges, the organization of the quality assessment and improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities, the mechanism by which membership on the Medical Staff may be terminated, and the mechanism for hearing procedures.

d. Based on input and reports from *[the departments and the Credentials Committee]*, assure that the Medical Staff adopts Bylaws, Rules or regulations establishing criteria and standards, consistent with California law, for Medical Staff membership and privileges (including, but not limited to, any privileges that may be appropriately performed via telemedicine), and for enforcing those criteria and standards in reviewing the qualifications, credentials, performance, and professional competence and character of applicants and staff members.

e. Assure that the Medical Staff adopt Bylaws, Rules or regulations establishing clinical criteria and standards to oversee and manage quality assurance, utilization review, and other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff and its committees *[and departments]* and review and analysis of patient medical records.

f. Evaluate the performance of practitioners exercising clinical privileges whenever there is doubt about an applicant's, member's, or Allied Health Professional's ability to perform requested privileges.

g. Based upon input from *[the departments and Credentials Committee]*, make recommendations regarding all applications for Medical Staff appointment, reappointment and privileges.

h. When indicated, initiate Focused Professional Practice Evaluations and/or pursue disciplinary or corrective actions affecting Medical Staff members.

i. With the assistance of the Chief of Staff, supervise the Medical Staff's compliance with:

1. The Medical Staff Bylaws, Rules, and policies;

2. The hospital's Bylaws, Rules, and policies;

3. State and federal laws and regulations; and

4. The Joint Commission accreditation requirements.

j. Oversee the development of Medical Staff policies, approve (or disapprove) all such policies, and oversee the implementation of all such policies.

k. Implement, as it relates to the Medical Staff, the approved policies of the hospital.

l. *[With the Department Chairs,]* set *[departmental]* objectives for establishing, maintaining and enforcing professional standards within the hospital and for the continuing improvement of the quality of care rendered in the hospital; assist in developing programs to achieve these objectives including, but not limited to, Ongoing Professional Practice Evaluations, as further described at Bylaws, Article 7, Performance Evaluation and Monitoring.

m. Regularly report to the Governing Body through the Chief of Staff and the Chief Executive Officer on at least the following:

1. The outcomes of Medical Staff quality improvement programs with sufficient background and detail to assure the Governing Body that quality of care is consistent with professional standards; and

2. The general status of any Medical Staff disciplinary or corrective actions in progress.

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

o. Prioritize and assure that hospital-sponsored educational programs incorporate the recommendations and results of Medical Staff quality assessment and improvement activities.

p. Establish, as necessary, such ad hoc committees that will fulfill particular functions for a limited time and will report directly to the Medical Executive Committee.

q. Establish the date, place, time and program of the regular meetings of the Medical Staff.

r. Represent and act on behalf of the Medical Staff between meetings of the Medical Staff.

s. Take such other actions as may reasonably be deemed necessary in the best interests of the Medical Staff and the hospital.

The authority delegated pursuant to this Section 9.3-2 may be removed by amendment of these Bylaws *[, or by Resolution of the Medical Staff, approved by a 2/3 vote of the voting Medical Staff, taken at a general or special meeting noticed to include the specific purpose of removing specifically-described authority of the Medical Executive Committee].*

COMMENT: TJC Standard MS.01.01.01, EP 20 requires that the Medical Staff Bylaws describe the authority delegated to the MEC, and how that authority is delegated or removed. We recommend a broad and general grant of authority, because it is simply not possible to foresee and describe every occasion or circumstance that may necessitate MEC decision making; and because a narrow grant of authority will likely lead to constant challenges and unnecessary undermining of respect for the MEC's important role.The revised wording at Section 9.3-2(o), above, is to address TJC Standard MS.12.01.01, EP 1.

9.3-3 Meetings

The Medical Executive should be scheduled to meet on a monthly basis and shall meet at least *[10]* times during the calendar year. A permanent record of its proceedings and actions shall be maintained.

COMMENT: The frequency of meetings will depend on the size and complexity of the Medical Staff organization. However, the MEC should meet frequently enough to assure the timely performance of responsibilities, including the timely flow of information and recommendations to the Governing Body.

Article 10 Departments and Sections

COMMENT: The following provisions apply for departmentalized Medical Staffs. Some hospitals (especially larger ones) have many departments, while smaller hospitals may eliminate departments altogether. If the Medical Staff is not organized into departments, this Article 10 should be deleted and the Medical Staff should evaluate whether functions described here to be performed by the departments should be assigned to a Medical Staff Committee.

10.1 Organization of Clinical Departments

Each department shall be organized as an integral unit of the Medical Staff and shall have a Chair and a Vice Chair who are selected and shall have the authority, duties, and responsibilities specified in the Rules. Additionally, each department may appoint a Department Committee and such other standing or Ad Hoc Committees as it deems appropriate to perform its required functions. The composition and responsibilities of each standing Department Committee shall be specified in the Rules. Departments may also form sections as described below.

10.2 Designation

10.2-1 Current Designation

The current departments are:

Check all applicable departments

- ❑ Anesthesia
- ❑ Emergency
- ❑ Medicine
- ❑ Obstetrics and Gynecology
- ❑ Pathology
- ❑ Pediatrics
- ❑ Psychiatry
- ❑ Radiology
- ❑ Surgery

COMMENT: The above list is not all-inclusive; hospitals may expand or contract the number of departments, as deemed appropriate to the size and services of the hospital.

10.2-2 Future Departments

The Medical Executive Committee will periodically restudy the designation of the departments and recommend to the Governing Body what action is desirable in creating, eliminating, or combining departments for better organizational efficiency and improved patient care. Action shall be effective upon approval by the Medical Executive Committee and the Governing Body.

10.3 Assignment to Departments

Each member shall be assigned membership in at least one department, but may also be granted membership and/or clinical privileges in other departments consistent with the practice privileges granted.

10.4 Functions of Departments

The departments shall fulfill the clinical, administrative, quality improvement/risk management/utilization management, and collegial and education functions described in the Rules. When the department or any of its committees meets to carry out the duties described below, the meeting body shall constitute a peer review committee, which is subject to the standards and entitled to the protections and immunities afforded by federal and state law for peer review committees. Each department or its committees, if any, must meet regularly to carry out its duties.

10.5 Department Chair and Vice Chair

10.5-1 Qualifications

Each Department Chair and Department Vice Chair shall be active Medical Staff members, shall have demonstrated ability in at least one of the clinical areas covered by the department, shall be Board certified, and shall be willing and able to faithfully discharge the functions of his or her office. Specific qualifications shall be set forth in the Rules.

COMMENT: Recommended to help assure compliance with California hospital licensing regulations relating to the qualifications of clinical service/department chiefs.

10.5-2 Selection

Department officers shall be elected by a majority of the votes cast by the voting Medical Staff members of the department. Candidates shall be selected by the nominating and elections procedures described in the Rules.

10.5-3 Term of Office

Each Department Chair and Vice Chair shall serve a two-year term, the expiration of 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 privileges in that department. Department officers are eligible to succeed themselves.

10.5-4 Removal

A department officer may be removed for failure to cooperatively and effectively perform the responsibilities of his or her office. Removal may be initiated by the Medical Executive Committee or by written request from 20 percent of the members of the department who are eligible to vote on department matters. Such removal may be effected by a 66-2/3 percent vote of the Medical Executive Committee members or by a

66-2/3 percent vote of the department members eligible to vote on department matters. The procedures for effecting removal shall be as described in the Rules.

10.5-5 Roles and Responsibilities of Department Officers

Specific roles and responsibilities of department officers shall be as set forth in the Rules. These roles and responsibilities include at least the following:*

a. Clinically related activities of the department.

b. Administratively related activities of the department, unless otherwise provided by the hospital.

c. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.

d. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department.

e. Recommending clinical privileges for each member of the department.

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

g. Integration of the department or service into the primary functions of the organization.

h. Coordination and integration of interdepartmental and intradepartmental services.

i. Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.

j. Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.

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

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

m. Maintenance of quality control programs, as appropriate.

n. Orientation and continuing education of all persons in the department

COMMENT: *MS.01.01.01, EP 3, provides that the requirements of EP 36 must be stated in the Bylaws. The above paragraphs (a) through (n) accomplish this.

10.6 Sections

COMMENT: Bylaws, Section 10.6 is applicable only in a departmentalized Medical Staff that has further subdivided itself into sections.

Within each department, the practitioners of the various specialty groups may organize themselves as a clinical section. Each section may develop Rules specifying the purpose,

responsibilities and method of selecting officers. These Rules shall be effective when approved as required by Bylaws, Article 15, General Provisions. While sections may assist departments in performance of departmental functions, responsibility and accountability for performance of departmental functions shall remain at the departmental level.

Article 11 Meetings

11.1 Medical Staff Meetings

11.1-1 Medical Staff Meetings

There shall be at least one meeting of the Medical Staff during each Medical Staff year. The date, place and time of the meeting(s) shall be determined by the Chief of Staff. The Chief of Staff shall present a report on significant actions taken by the Medical Executive Committee during the time since the last Medical Staff meeting and on other matters believed to be of interest and value to the membership. No business shall be transacted at any Medical Staff meeting except that stated in the notice calling the meeting.

11.1-2 Special Meetings

Special meetings of the Medical Staff may be called at any time by the Chief of Staff, Medical Executive Committee, or Governing Body, or upon the written request of 10 percent of the voting members. The meeting must be called within 30 days after receipt of such request. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

11.1-3 Combined or Joint Medical Staff Meetings

The Medical Staff may participate in combined or joint Medical Staff meetings with staff members from other hospitals, health care entities, or the County Medical Society; however, precautions shall be taken to assure that confidential Medical Staff information is not inappropriately disclosed, and to assure that this Medical Staff (through its authorized representative(s)) maintains access to, and approval authority of, all minutes prepared in conjunction with any such meetings.

11.2 [Department and] Committee Meetings

11.2-1 Regular Meetings

[Departments and] committees, by resolution, may provide the time for holding regular meetings and no notice other than such resolution shall then be required. *[Each department shall meet regularly, at least quarterly, to review and discuss patient care activities and to fulfill other departmental responsibilities.]*

11.2-2 Special Meetings

A special meeting of any *[department or]* committee may be called by, or at the request of, the Chair thereof, the Medical Executive Committee, Chief of Staff, or by *[33-1/3]* percent of the group's current members, but not fewer than three members. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

11.2-3 Combined or Joint *[Department or]* Committee Meetings

The *[departments or]* committees may participate in combined or joint *[department or]* committee meetings with staff members from other hospitals, health care entities or the County Medical Society; however, precautions shall be taken to assure that confidential Medical Staff information is not inappropriately disclosed, and to assure that this Medical Staff (through its authorized representative(s)) maintains access to, and approval authority of, all minutes prepared in conjunction with any such meetings.

11.3 Notice of Meetings

Written notice stating the place, day and hour of any regular or special Medical Staff meeting or of any regular or special *[department or]* committee meeting not held pursuant to resolution shall be delivered either personally or by mail to each person entitled to be present not fewer than *[two]* working days nor more than *[45]* days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

11.4 Quorum

COMMENT: The attendance requirement for establishing a quorum should not be unrealistic.

11.4-1 Medical Staff Meetings

The presence of *[25]* percent of the voting Medical Staff members at any regular or special meeting shall constitute a quorum.

11.4-2 Committee Meetings

The presence of *[50]* percent of the voting members shall be required for Medical Executive Committee meetings. For other committees, a quorum shall consist of *[30]* percent of the voting members of a committee but in no event less than three voting committee members.

11.4-3 *[Department Meetings]*

[The presence of [25] percent of the voting Medical Staff members at any regular or special department meeting shall constitute a quorum.]

11.5 Manner of Action

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be required by these Bylaws. Committee action may be conducted by telephone or internet conference, which shall be deemed to constitute a meeting for the matters discussed in that telephone or internet conference. Valid action may be taken without a meeting if at least *[10]* days notice of the proposed action has been given to all members entitled to vote, and it is subsequently approved in writing setting forth the action so taken, which is signed by at least *[66-2/3]* percent of the members entitled to vote. The meeting chair shall refrain from voting except when necessary to break a tie, except that the Joint Conference Committee Chair may vote.

COMMENT: Amended to accommodate internet conference meetings.

11.6 Minutes

Minutes of all meetings shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer or his or her designee and forwarded to the Medical Executive Committee or other designated committee and Governing Body. Each committee shall maintain a permanent file of the minutes of each meeting. When meetings are held with outside entities, access to minutes shall be limited as necessary to preserve the protections from discovery, as provided by California law.

11.7 Attendance Requirements

COMMENT: There are no legal or accreditation standards setting specific attendance requirements for meetings. However, The Joint Commission requires that the Bylaws state the Medical Staff's requirements for frequency of meetings and for attendance. Also, reasonable attendance standards provide an excellent means for achieving broad participation of Medical Staff members in Medical Staff and department activities.

11.7-1 Regular Attendance Requirements

Each member of a Medical Staff category required to attend meetings under Rule 1.3, Prerogatives and Responsibilities, shall be required to attend *[two]* general staff meetings *[and [six] department or section meetings]* during the two-year reappointment period.

11.7-2 Failure to Meet Attendance Requirements

Medical Staff members will be notified semi-annually if they have not yet met the full attendance requirements. Practitioners who have not met meeting attendance requirements before the end of the appointment/reappointment period will be reappointed for a maximum of two years on probationary status. Practitioners who do not meet the meeting attendance requirements during the reappointment period will *[be demoted in status] [not be reappointed]*.

11.7-3 Special Appearance

A committee, at its discretion, may require the appearance of a practitioner during a review of the clinical course of treatment regarding a patient. If possible, the Chair of the meeting should give the practitioner at least 10 days advance written notice of the time and place of the meeting. In addition, whenever an appearance is requested because of an apparent or suspected deviation from standard clinical practice, special notice shall be given and shall include a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to which he or she was given special notice shall (unless excused by the Medical Executive Committee upon a showing of good cause) result in an automatic suspension of the practitioner's privileges for at least two weeks, or such longer period as the Medical Executive Committee deems appropriate. The practitioner shall be entitled to the procedural rights described in Bylaws, Article 14, Hearings and Appellate Reviews.

11.8 Conduct of Meetings

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

COMMENT: Other sources of parliamentary procedure are: Sturgis, Standard Code of Parliamentary Procedure and Parliamentary Procedure at a Glance.

Article 12 Confidentiality, Immunity, Releases and Indemnification

12.1 General

Medical Staff, *[department, section]* or committee minutes, files and records — including information regarding any member or applicant to this Medical Staff — shall, to the fullest extent permitted by law, be confidential. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the Medical Staff committee files and shall not become part of any particular patient's file or of the general hospital records. Dissemination of such information and records shall be made only where expressly required by law or as otherwise provided in these Bylaws.

12.2 Breach of Confidentiality

Inasmuch as effective credentialing, quality improvement, peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, and inasmuch as practitioners and others participate in credentialing, quality improvement, and peer review activities with the reasonable expectations that this confidentiality will be preserved and maintained, any breach of confidentiality of the discussions or deliberations of Medical Staff *[departments, sections, or]* committees, except in conjunction with another *[system member,]* health facility, professional society or licensing authority for peer review activities, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

12.3 Access to and Release of Confidential Information

12.3-1 Access for Official Purposes

Medical Staff records, including confidential committee records and credentials files, shall be accessible by:

a. Committee members, and their authorized representatives, for the purpose of conducting authorized committee functions.

b. Medical Staff *[and department]* officials, and their authorized representatives, for the purpose of fulfilling any authorized function of such official.

c. The Chief Executive Officer, the Governing Body, and their authorized representatives, for the purpose of enabling them to discharge their lawful obligations and responsibilities.

d. *[Upon approval of the Chief Executive Officer and Chief of Staff, the peer review bodies of System Affiliates, as reasonably necessary to facilitate review of an applicant or member of such Affiliate's professional staff.]*

e. Information which is disclosed to the Governing Body or its appointed representatives and to peer review bodies of System Affiliates shall be maintained as confidential.

12.3-2 Member's Access

a. A Medical Staff member shall be granted access to his or her own credentials file, subject to the following provisions:

1. Notice of a request to review the file shall be given by the member to the Chief of Staff (or his or her designee) at least three days before the requested date for review.
2. The member may review and receive a copy of only those documented, provided by or addressed personally to the member. A summary of all other information, including peer review committee findings, letter of reference, proctoring reports, complaints, etc., shall be provided to the member, in writing, by the designated officer of the Medical Staff within a reasonable period of time (not to exceed two weeks). Such summary shall disclose the substance, but not the source, of the information summarized.
3. The review by the member shall take place in the Medical Staff office, during normal work hours, with an officer or designee of the Chief of Staff present.
4. In the event a Notice of Charges is filed against a member, access to that member's credentials file shall be governed by Bylaws, Section 14.6-9.

b. A member may be permitted to request correction of information as follows:

1. After review of his or her file, a member may address to the Chief of Staff a written request for correction of information in the credentials file. Such request shall include a statement of the basis for the action requested.
2. The Chief of Staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Committee whether to make the correction as requested, and the Medical Executive Committee shall make the final determination.
3. The member shall be notified promptly, in writing, of the decision of the Medical Executive Committee.
4. In any case, a member shall have the right to add to his or her credentials file a statement responding to any information contained in the file. Any such written statement shall be addressed to the Medical Executive Committee, and shall be placed in the credentials file immediately following review by the Medical Executive Committee.

12.4 Immunity and Releases

12.4-1 Immunity from Liability for Providing Information or Taking Action

Each representative of the Medical Staff and hospital and all third parties shall be exempt from liability to an applicant, member or practitioner for damages or other relief by reason of providing information to a representative of the Medical Staff, hospital, *[system member]* or any other health-related organization concerning such person who is, or has been, an applicant to or member of the Medical Staff or who did, or does, exercise privileges or provide services at this hospital or by reason of otherwise

participating in a Medical Staff or hospital credentialing, quality improvement, or peer review activities.

12.4-2 Activities and Information Covered

a. **Activities**

The immunity provided by this Bylaws, Article 12, shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health-related institution's or organization's activities concerning, but not limited to:

1. Applications for appointment, privileges, or specified services;
2. Periodic reappraisals for reappointment, privileges, or specified services;
3. Corrective action;
4. Hearings and appellate reviews;
5. Quality improvement review, including patient care audit;
6. Peer review;
7. Utilization reviews;
8. Morbidity and mortality conferences; and
9. Other hospital, *[department, section,]* or committee activities related to monitoring and improving the quality of patient care and appropriate professional conduct.

b. **Information**

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Bylaws, Article 12, may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics or other matter that might directly or indirectly affect patient care.

12.5 Releases

Each practitioner shall, upon request of the hospital, execute general and specific releases in accordance with the tenor and import of these Bylaws, Article 12; however, execution of such releases shall not be deemed a prerequisite to the effectiveness of these Bylaws, Article 12.

12.6 Cumulative Effect

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

12.7 Indemnification

The hospital shall indemnify, defend, and hold harmless the Medical Staff and its individual members ("Indemnitee(s)") from and against losses and expenses (including reasonable attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities including, but not limited to:

a. As a member of or witness for a Medical Staff, *[department, service,]* committee, or hearing committee;

b. As a member of or witness for the hospital Governing Body or any hospital task force, group or committee; and

c. As a person providing information to any Medical Staff or hospital group, officer, Governing Body member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a Medical Staff member or applicant.

The hospital shall retain responsibility for the sole management and defense of any such claims, suits, investigations or other disputes against Indemnitees, including, but not limited to, selection of legal counsel to defend against any such actions. The indemnity set forth herein is expressly conditioned on Indemnitees' good faith belief that their actions and/or communications are reasonable and warranted and in furtherance of the Medical Staff's peer review, quality assessment or quality improvement responsibilities, in accordance with the purposes of the Medical Staff as set forth in these Bylaws. In no event will the hospital indemnify an Indemnitee for acts or omissions taken in bad faith or in pursuit of the Indemnitee's private economic interests.

COMMENT: This indemnity clause is tailored to meet the standards of California Corporations Code Section 5238. Indemnity can either be included in the Bylaws, Rules, or other hospital policies; however in light of Business & Professions Code Section 2282.5 and The Joint Commission MS.01.01.01, we suggest that such language be included in the Bylaws.

Article 13 Performance Improvement and Corrective Action

13.1 Peer Review Philosophy

13.1-1 Role of Medical Staff in Organizationwide Quality Improvement Activities

The Medical Staff is responsible to oversee the quality of medical care, treatment and services delivered in the hospital. An important component of that responsibility is the oversight of care rendered by members and Allied Health Professionals practicing in the hospital. The following provisions are designed to achieve quality improvements through collegial peer review and educative measures whenever possible, but with recognition that, when circumstances warrant, the Medical Staff is responsible to embark on informal corrective measures and/or corrective action as necessary to achieve and assure quality of care, treatment and services. Toward these ends:

a. Members of the Medical Staff are expected to actively and cooperatively participate in a variety of peer review activities to measure, assess and improve performance of their peers in the hospital.

b. The initial goals of the peer review processes are to prevent, detect and resolve problems and potential problems through routine collegial monitoring, education and counseling. However, when necessary, corrective measures, including formal investigation and discipline, must be implemented and monitored for effectiveness.

c. Peers in the *[departments and]* committees are responsible for carrying out delegated review and quality improvement functions in a manner that is consistent, timely, defensible, balanced, useful and ongoing. The term "peers" generally requires that a majority of the peer reviewers be members holding the same license as the practitioner being reviewed, including, where possible, at least one member practicing the same specialty as the member being reviewed. Notwithstanding the foregoing, DOs and MDs shall be deemed to hold the "same licensure" for purposes of participating in peer review activities.

d. *[The departments and committees may be assisted by the Medical Director.]*

13.1-2 Informal Corrective Activities

The Medical Staff officers, *[departments]* and committees may counsel, educate, issue letters of warning or censure, or focused professional practice evaluation in accordance with Bylaws, Section 7.4(a)(2) 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 respond in writing and may be given an opportunity to meet with the officer, *[department]* or committee. Any informal actions, monitoring or counseling shall be documented in the member's file. Medical Executive Committee approval is not required for such actions, although the actions shall be reported to the Medical Executive Committee. The actions

shall not constitute a restriction of privileges or grounds for any formal hearing or appeal rights under Bylaws, Article 14, Hearings and Appellate Reviews.

13.1-3 Criteria for Initiation of Formal Corrective Action

A formal corrective action investigation may be initiated whenever reliable information indicates a member may have exhibited acts, demeanor or conduct, either within or outside of the hospital, that is reasonably likely to be:

a. Detrimental to patient safety or to the delivery of quality patient care within the hospital;

b. Unethical;

c. Contrary to the Medical Staff Bylaws or Rules;

d. Below applicable professional standards;

e. Disruptive of Medical Staff or hospital operations; or

f. An improper use of hospital resources.

Generally, formal corrective action measures should not be initiated unless reasonable attempts at informal resolution have failed; however, this is not a mandatory condition, and formal corrective action may be initiated whenever circumstances reasonably appear to warrant formal action. Any recommendation of formal corrective action must be based on evaluation of applicant-specific information.

13.1-4 Initiation

a. Any person who believes that formal corrective action may be warranted may provide information to the Chief of Staff, any other Medical Staff officer, *[any Department Chair,]* any Medical Staff committee, the chair of any Medical Staff Committee, the Governing Body or the Chief Executive Officer.

b. If the Chief of Staff, any other Medical Staff officer, *[any Department Chair,]* any Medical Staff Committee, the chair of any Medical Staff committee, the Governing Body or the Chief Executive Officer determines that formal corrective action may be warranted under Bylaws, Section 13.1-3, above, that person, entity, or committee may request the initiation of a formal corrective action investigation or may recommend particular corrective action. Such requests may be conveyed to the Medical Executive Committee orally or in writing.

c. The Chief of Staff shall notify the Chief Executive Officer, or his or her designee in his or her absence, and the Medical Executive Committee and shall continue to keep them fully informed of all action taken. In addition, the Chief of Staff shall immediately forward all necessary information to the committee or person that will conduct any investigation, provided, however, that the Chief of Staff or the Medical Executive Committee may dispense with further investigation of matters deemed to have been adequately investigated by a committee pursuant to Bylaws, Section 13.1-6, below, or otherwise.

13.1-5 Expedited Initial Review

COMMENT: This Section allows an expedited initial review of problems, which is often the practice at hospitals. It is particularly helpful whenever a problem demands immediate attention.The harassment and discrimination investigations are structured so that the Medical Staff will be responsible for all initial investigations of complaints brought by patients,

and administrative staff (e.g., the Chief Medical Officer and human resources director) will be responsible for investigating all other complaints of harassment. In both cases, the Bylaws allow the investigation to be referred to an attorney. And in all cases, the Bylaws try to preserve the protections that may be available under Evidence Code Section 1157 (the law that provides an immunity from discovery for Medical Staff Committee records and proceedings) except that the records of the review by the Chief Medical Officer and human resources director of complaints not involving patients may not be immune from discovery under Evidence Code Section 1157. Also, it may be necessary to disclose information from the investigation to the victim and in defense of a harassment lawsuit, given the unique requirements of harassment cases. If the initial review process is conducted by an attorney, the attorney-client privilege will also apply, but as a practical matter, that privilege may be waived in order to disclose information for the purposes of meeting the hospital's legal obligation generally to provide information to the victim and the need to use the information to defend a harassment or discrimination lawsuit. Consideration should be given at the outset to the relative advantages and disadvantages of the different approaches.

a. Whenever information suggests that corrective action may be warranted, the Chief of Staff or his or her designee *[and/or the Medical Director]* may, on behalf of the Medical Executive Committee, immediately investigate and conduct whatever interviews may be indicated. The information developed during this initial review shall be presented to the Medical Executive Committee, which shall decide whether to initiate a formal corrective action investigation.

b. In cases of complaints of harassment or discrimination involving a patient, etc., an expedited initial review shall be conducted on behalf of the Medical Executive Committee by the Chief of Staff, the Chief of Staff's designee, *[or the Medical Director]*, together with representatives of administration, or by an attorney for the hospital. In cases of complaints of harassment or discrimination where the alleged harasser is a Medical Staff member and the complainant is not a patient, an expedited initial review shall be conducted by the *[Chief Medical Officer and the]* hospital's human resources director or their designee, or by an attorney for the hospital, who shall use best efforts to complete the expedited initial review within the time frame set out at Bylaws, Section 13.1-8, below. The Chief of Staff shall be kept apprised of the status of the initial review. The information gathered from an expedited initial review shall be referred to the Medical Executive Committee if it is determined that corrective action may be indicated against a Medical Staff member.

13.1-6 Formal Investigation

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

b. If the Medical Executive Committee concludes a further investigation is warranted, it shall direct a formal investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself or may assign the task to an appropriate officer or standing or ad hoc committee to be appointed by the Chief of Staff. The investigating body should not include partners, associates or relatives of the individual being investigated. 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). If the investigation is delegated to an officer or committee other than the Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner, using best efforts to complete the

expedited initial review within the time frame set out at Bylaws, Section 13.1-8, below, 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.

c. Prior to any adverse action being approved, the Medical Executive Committee shall assure that the member was given an opportunity to provide information in a manner and upon such terms as the Medical Executive Committee, investigating body, or reviewing committee deems appropriate. The investigating body or reviewing body may, but is not obligated to, interview persons involved; however, such an interview shall not constitute a hearing as that term is used in Bylaws, Article 14, Hearings and Appellate Reviews, nor shall the hearings or appeals Rules apply.

d. 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 action.

e. The provisions of this Bylaws Section 13.1-6 (including a determination to dispense with formal investigation and proceed immediately to further action pursuant to Section 13.1-6(a)) shall demark the point at which an "impending investigation" is deemed to have commenced within the meaning of Business & Professions Code Section 805(c).

COMMENT: The above Section is recommended to clarify the point after which a physician's voluntary resignation or acceptance of practice restrictions may require report to the Medical Board of California.

13.1-7 Medical Executive Committee Action

a. As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall take action including, without limitation:

1. Determining no corrective action should be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, clearly documenting those findings in the member's file;
2. Deferring action for a reasonable time;
3. Issuing letters of admonition, censure, reprimand or warning, although nothing herein shall be deemed to preclude *[department or]* Committee Chairs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file;
4. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of privileges including, without limitation, requirements for co-admissions, mandatory consultation or monitoring
5. Recommending reduction, modification, suspension or revocation of privileges. If suspension is recommended, the terms and duration of the suspension and the conditions that must be met before the suspension is ended shall be stated;
6. Recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;

7. Recommending suspension, revocation or probation of Medical Staff membership. If suspension or probation is recommended, the terms and duration of the suspension or probation and the conditions that must be met before the suspension or probation is ended shall be stated;
8. Referring the member to the Well-Being Committee for evaluation and follow-up as appropriate; and

COMMENT: Clarification of available options, which do include possible referral to Well-Being Committee.

9. Taking other actions deemed appropriate under the circumstances.

b. If the Medical Executive Committee takes any action that would give rise to a hearing pursuant to Bylaws, Section 14.2, it shall also make a determination whether the action is a "medical disciplinary" action or an "administrative disciplinary" action. A medical disciplinary action is one taken for cause or reason that involves that aspect of a practitioner's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care. All other actions are deemed administrative disciplinary actions. In some cases, the reason may involve both medical disciplinary and administrative disciplinary cause or reason, in which case, the matter shall be deemed medical disciplinary for Bylaws, Article 14, Hearings and Appellate Reviews, hearing purposes.

c. And, if the Medical Executive Committee makes a determination that the action is medical disciplinary, it shall also determine whether the action is taken for any of the reasons required to be reported to the Medical Board of California pursuant to California Business & Professions Code Section 805.01.

COMMENT: The addition of subparagraph (b) correlates with the new provision, at Bylaws, Section 14.8, for administrative hearings. The default to medical disciplinary classification in the event of overlap is in deference to the reporting and fair hearing requirements of California and federal law, and to help assure all available immunities remain intact.See additional comments accompanying new Section 14.8, including the important cautionary note about how these classifications may affect available protections.The addition of subparagraph (c) is to address requirements imposed by SB 700, 2010, requiring reports to the licensing board of any disciplinary action recommended or imposed because of a licentiate's:• Incompetence, or gross or repeated deviations from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public. • The use of, or prescribing for or administering to himself or herself, any controlled substance; or the use of any dangerous drug as defined in Business & Professions Code Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or the extent that such use impairs the ability of the licentiate to practice safely.• Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor. (Exception — prescribing, furnishing, or administering controlled substances for intractable pain, consistent with lawful prescribing.)• Sexual misconduct with one or more patients during a course of treatment or an examination.These actions are to be reported to the licensing board within 15 days of the MEC's action *or recommendation* — i.e., these actions must be reported whether or not a summary action has been imposed, and whether or not hearing and appeal rights have been exhausted.

13.1-8 Time Frames

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

a. Informal investigations should be completed and the results should be reported within 60 days.

b. Expedited initial reviews should be completed and the results should be reported within 30 days.

c. Other formal investigations should be completed and the results should be reported within 90 days.

13.1-9 Procedural Rights

a. If, after receipt of a request for formal corrective action pursuant to Bylaws, Section 13.1-4, above, the Medical Executive Committee determines that no corrective action is required or only a letter of warning, admonition, reprimand or censure should be issued, the decision shall be transmitted to the Governing Body. The Governing Body may affirm, reject or modify the action. The Governing Body shall give great weight to the Medical Executive Committee's decision and initiate further action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the Medical Executive Committee and the Medical Executive Committee still has not acted. The decision shall become final if the Governing Body affirms it or takes no action on it within 70 days after receiving the notice of decision.

COMMENT: The above change is to clarify that the Medical Executive Committee (MEC) need only report decisions not to initiate corrective actions in circumstances where there had been a request for corrective action.

b. If the Medical Executive Committee recommends an action that is a ground for a hearing under Bylaws, Section 14.2, 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 member has either waived his or her right to a hearing or completed the hearing.

13.1-10 Initiation by Governing Body

a. The Medical Staff acknowledges that the Governing Body must act to protect the quality of medical care provided and the competency of its Medical Staff, and to ensure the responsible governance of the hospital in the event that the Medical Staff fails in any of its substantive duties or responsibilities.

b. Accordingly, if the Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Governing Body may direct the Medical Executive Committee to initiate an investigation or disciplinary action, but only after consulting with the Medical Executive Committee. If the Medical Executive Committee fails to act in response to that Governing Body direction, the Governing Body may, in furtherance of the Governing Body's ultimate responsibilities and fiduciary duties, initiate corrective action, but must comply with applicable provisions of Bylaws, Article 13, Performance Improvement and Corrective Action, and Article 14, Hearings and Appellate Reviews. The Governing Body shall inform the Medical Executive Committee in writing of what it has done.

13.2 Summary Restriction or Suspension

COMMENT: The below revisions correlate with the new provision for a preliminary hearing to review a summary suspension. See additional Comments at new Bylaws, Section 14.5.

13.2-1 Criteria for Initiation

a. Whenever a practitioner's conduct is such that a failure to take action may result in an imminent danger to the health of any individual, the Chief of Staff, the Medical Executive Committee, *[the Department Chair in which the member holds privileges,]* or the Chief Executive Officer may summarily restrict or suspend the Medical Staff membership or privileges of such member.

b. Unless otherwise stated, such summary restriction or suspension (summary action) shall become effective immediately upon imposition, and the person or body responsible shall promptly give special notice to the member and written notice to the Governing Body, the Medical Executive Committee, and the Chief Executive Officer. The special notice shall fully comply with the requirements of Bylaws, Section 13.2-1(d), below.

c. The summary action 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 action, 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 and the affected practitioner in the choice of a substitute member.

d. Within one working day of imposition of a summary suspension, the affected Medical Staff member shall be provided with verbal notice of such suspension; followed, within three working days of imposition, by written notice of such suspension. This initial written notice shall include a statement of facts demonstrating that the suspension was reasonable and warranted because failure to suspend or restrict the member's privileges summarily could reasonably result in an imminent danger to the health of any individual. The statement of facts provided in this initial notice shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for, but is in addition to, the notice required under Bylaws, Section 14.3-1 (which applies in all cases where the Medical Executive Committee does not immediately terminate the summary suspension). The notice under Bylaws, Section 14.3-1 may supplement the initial notice provided under this Section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

e. The notice of the summary action given to the Medical Executive Committee shall constitute a request to initiate corrective action and the procedures set forth in Bylaws, Section 13.1-3, page 92, shall be followed.

13.2-2 Medical Executive Committee Action

Within one week after such summary action has been imposed, a meeting of the Medical Executive Committee *[or a subcommittee appointed by the Chief of Staff]* shall be convened to review and consider the action. 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 Bylaws, Article 14, Hearings and Appellate Reviews, nor shall any procedural Rules apply. The Medical Executive Committee may thereafter continue, modify or terminate the terms of the summary action. It shall give the practitioner special notice of its decision, within two working days of the meeting, which shall include the information specified in Bylaws, Section 14.3-1 if the action is adverse.

13.2-3 Procedural Rights

Unless the Medical Executive Committee promptly terminates the summary action, and if the summary action constitutes a suspension or restriction of clinical privileges required to be reported to the Medical Board of California pursuant to Business & Professions Code Section 805), the member shall be entitled to the procedural rights afforded by Bylaws, Article 14, Hearings and Appellate Reviews *[including, but not limited to, a right to a preliminary hearing as described at Bylaws, Section 14.5]*.

13.2-4 Initiation by Governing Body

a. If no one authorized under Bylaws, Section 13.2-1(a), above, to take a summary action is available to summarily restrict or suspend a member's membership or privileges, the Governing Body (or its designee) may immediately suspend or restrict a member's privileges if a failure to act immediately may result in imminent danger to the health of any individual, provided that the Governing Body (or its designee) made reasonable attempts to contact the Chief of Staff *[and the Chair of the department to which the member is assigned]* before acting.

b. Such summary action is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such summary action within two working days, excluding weekends and holidays, the summary action shall terminate automatically.

13.3 Automatic Suspension or Limitation

In the following instances, the member's privileges or membership may be suspended or limited as described:

13.3-1 Licensure

a. **Revocation, Suspension or Expiration.** Whenever a member's license or other legal credential authorizing practice in this state is revoked, suspended or expired without an application pending for renewal, Medical Staff membership and privileges shall be automatically revoked as of the date such action becomes effective.

b. **Restriction.** Whenever a member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any privileges which are within the scope of such limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

c. **Probation.** Whenever a member is placed on probation by the applicable licensing or certifying authority, his or her membership status and 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.

13.3-2 Drug Enforcement Administration Certificate

a. **Revocation, Suspension, and Expiration.** Whenever a member's Drug Enforcement Administration certificate is revoked, limited, suspended or expired, 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 Drug Enforcement Administration 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.

13.3-3 Failure to Satisfy Special Appearance Requirement

A member who fails without good cause to appear and satisfy the requirements of Bylaws, Section 11.7-3 shall automatically be suspended from exercising all or such portion of privileges as the Medical Executive Committee specifies.

13.3-4 Medical Records

Medical Staff members are required to complete medical records within the time prescribed by the Medical Executive Committee. Failure to timely complete medical records shall result in an automatic suspension after notice is given as provided in the Rules. Such suspension shall apply to the Medical Staff member's right to admit, treat or provide services to new patients in the hospital, but shall not affect the right to continue to care for a patient the Medical Staff member has already admitted or is treating; provided, however, members whose privileges have been suspended for delinquent records may admit and treat new patients in life-threatening situations. The suspension shall continue until the medical records are completed. If after 30 consecutive days of suspension the member remains suspended, the member shall be considered to have voluntarily resigned from the Medical Staff. Nothing in the foregoing shall preclude the implementation, by the Medical Executive Committee, of a monetary fine for delinquent medical records.

COMMENT: It is reasonable to permit members suspended for medical records delinquencies to provide services in the additional situation described above (i.e., life-threatening situations).Also some Medical Staffs find that imposition of fines, or revocations of nonclinical privileges [e.g., preferred parking spots] are more effective in dealing with medical record deficiencies. However, even if such provisions are implemented, the Bylaws should include the ultimate authority to automatically suspend and/or terminate in the event compliance cannot be achieved.

13.3-5 Cancellation of Professional Liability Insurance

Failure to maintain professional liability insurance as required by these Bylaws shall be grounds for automatic suspension of a member's privileges. Failure to maintain professional liability insurance for certain procedures shall result in the automatic suspension of privileges to perform those procedures. The suspension shall be effective until appropriate coverage is reinstated, including coverage of any acts or potential liabilities that may have occurred or arisen during the period of any lapse in coverage. A failure to provide evidence of appropriate coverage within six months after the date of automatic suspension shall be deemed a voluntary resignation of the member from the Medical Staff.

13.3-6 Failure to Pay Dues or Fines

If the member fails to pay required dues or fines within 30 days after written warning of delinquency, a practitioner's Medical Staff membership and privileges shall be automatically suspended and shall remain so suspended until the practitioner pays the delinquent dues. If after 60 consecutive days of suspension the member remains suspended, the member will be considered to have voluntarily resigned from the Medical Staff.

13.3-7 Failure to Comply with Government and Other Third Party Payor Requirements

The Medical Executive Committee shall be empowered to determine that compliance with certain specific third party payor, government agency, and professional review organization Rules or policies is essential to hospital and/or Medical Staff operations and that compliance with such requirements can be objectively determined. The Rules may authorize the automatic suspension of a practitioner who fails to comply with such requirements. The suspension shall be effective until the practitioner complies with such requirements.

13.3-8 Automatic Termination

If a practitioner is suspended for more than six months, his or her membership (or the affected privileges, if the suspension is a partial suspension) shall be automatically terminated. Thereafter, reinstatement to the Medical Staff shall require application and compliance with the appointment procedures applicable to applicants.

13.3-9 Executive Committee Deliberation and Procedural Rights

a. As soon as practicable after action is taken or warranted as described in Bylaws, Section 13.3-1, Section 13.3-2, or Section 13.3-3, page 100, 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 Bylaws, Section 13.1-6, Formal Investigation. The Medical Executive Committee review and any subsequent hearings and reviews shall not address the propriety of the licensure or Drug Enforcement Administration action, but instead shall address what, if any, additional action should be taken by the hospital. There is no need for the Medical Executive Committee to act on automatic suspensions for failures to complete medical records (Bylaws, Section 13.3-4, page 100), maintain professional liability insurance (Bylaws, Section 13.3-5, page 101), to pay dues (Bylaws, Section 13.3-6, above) or comply with government and other third party payor Rules and policies (Bylaws, Section 13.3-7, above).

b. Practitioners whose privileges are automatically suspended and/or who have been deemed to have automatically resigned their Medical Staff membership shall be entitled to a hearing only if the suspension is reportable to the Medical Board of California or the federal National Practitioner Data Bank.

13.3-10 Notice of Automatic Suspension or Action

Special notice of an automatic suspension or action shall be given to the affected individual, and regular notice of the suspension shall be given to the Medical Executive Committee, Chief Executive Officer and Governing Body, but such notice shall not be required for the suspension to become effective. Patients affected by an automatic suspension shall be assigned to another member by the *[Department Chair or]* Chief of Staff. The wishes of the patient and affected practitioner shall be considered, where feasible, in choosing a substitute member.

13.3-11 ***[Automatic Action Based upon Actions Taken by Another Peer Review Body after a Hearing]***

a. *[The Medical Executive Committee shall be empowered to automatically impose any adverse action that has been taken by another peer review body (as that term is used in the Medical Staff Hearing Law, Business & Professions Code Section 809 et seq.) after a hearing at that other peer review body that meets the requirement of the Medical Staff Hearing Law. Such an adverse action may be any action taken by the other peer review body, including, but not limited to, denying membership and/or privileges, restricting privileges or terminating membership and/or privileges. The action may be taken automatically only if the other peer review body took action based upon standards that were essentially the same as those in effect at this hospital at the time the automatic action will be taken. Also, the action that will be the basis of the automatic action must have become final within the past 36 months. The automatic action may be taken only after the practitioner has completed the hearing and any appeal at that other peer review body; however, it is not necessary to await a final disposition in any judicial proceeding that may be brought challenging that other peer review body's action.]*

b. *[The practitioner shall not be entitled to any hearing or appeal at this hospital unless the Medical Executive Committee takes an action that is more restrictive than the final action taken by the other peer review body. Any hearing and appeal that is requested by the practitioner shall not address the merits of the action taken by the original peer review body, which were already reviewed at the other peer review body's hearing, and shall be limited to only the question of whether the automatic action is more restrictive than the other peer review body's action. The practitioner shall not be entitled to challenge the automatic peer review action unless he or she successfully overturns the other peer review action in court.]*

c. *[Nothing in this Section shall preclude the Medical Staff or Governing Body from taking a more restrictive action than another peer review body based upon the same facts or circumstances.]*

COMMENT: Above noted changes are for clarification purposes only. Hospitals wishing to further streamline their hearing and appeals procedures should consider including a provision for automatic action as above. This provision allows Medical Staffs and hospitals to automatically impose any privilege restriction (including termination of privileges or denial of an application) imposed by another hospital or other "peer review body" after a hearing that complies with the requirements of the Medical Staff Hearing Law, Business & Professions Code Section 809 *et seq.* The automatic action provision has three limits: (1) The action may be automatically taken only if the original hospital took action based upon standards that were essentially the same as those that are in effect at the hospital that will be taking the automatic action; (2) the action that will be the basis of the automatic action must have become final within the past 36 months; and (3), the automatic action may not have an effect that is more restrictive than the original action's effect.The basis for this type of provision is the court's decision in *Marek v. Board of Podiatric Medicine* (1993) 16 Cal.App.4th 1089. In that case, the court upheld discipline against a podiatrist based upon discipline imposed by another state. The court rejected the argument that the podiatrist was entitled to relitigate the merits of the case since he had already "had his day in court." The automatic action feature would minimize the wasteful practice of requiring each hospital to prove the case, but it is a new provision that *has not yet been tested in court with respect to hospital Medical Staff hearings.* Accordingly, hospitals are advised to consult with counsel before imposing any automatic action pursuant to this provision.

13.4 Interview

Interviews shall neither constitute nor be deemed a hearing as described in Bylaws, Article 14, Hearings and Appellate Reviews, shall be preliminary in nature, and shall not be conducted according to the procedural Rules applicable with respect to hearings. The Medical Executive Committee shall be required, at the practitioner's request, to grant an interview only when so specified in these Bylaws, Article 13. In the event an interview is granted, the practitioner shall be informed of the general nature of the reasons for the recommendation and may present information relevant thereto. A record of the matters discussed and the findings resulting from an interview shall be made.

13.5 Confidentiality

To maintain confidentiality, participants in the corrective action process shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws for peer review and discipline.

13.6 [Systemwide Corrective Action]

13.6-1 ***[Notice of Pending Investigations/Joint Investigations]***

a. *[The Chief of Staff and the Chief Executive Officer each shall have the discretion to notify their counterpart officers or other system members whenever a request for corrective action has been received.]*

b. *[In addition, the Medical Executive Committee may authorize a coordinated investigation and may appoint other system members' Medical Staff members to assist in the coordinated investigation.]*

c. *[The Chief of Staff and the Chief Executive Officer are authorized to disclose to another system member's peer review body (or an authorized representative of that body) information from hospital and Medical Staff records to assist in the other system member's independent or joint investigation of any practitioner.]*

d. *[The results of any joint investigation shall be reported to each system member's peer review body for its independent determination of what, if any, corrective action should be taken.]*

13.6-2 ***[Notice of Actions]***

a. *[In addition to the discretionary reporting and joint investigation provisions set forth at Bylaws, Section 13.6-1, above, the Chief of Staff and/or the Chief Executive Officer are authorized to inform his or her counterpart officer at any other system member where the practitioner is known to hold privileges whenever any of the following actions has been taken:]*

1. *[Summary suspension of clinical privileges should be reported promptly upon imposition (other than automatic suspensions for failure to complete medical records or pay dues).]*

2. *[Other corrective actions may be reported at any time the Chief of Staff or Chief Executive Officer determines such a report to be appropriate, and should be reported promptly upon final action by the board.]*

b. *[The effect of such action on the involved practitioner's privileges at another system member shall be determined by the Medical Staff Bylaws or other applicable policies of that other system member; or, if there are no applicable Bylaws or policies, the information shall be deemed transmitted for the receiving system member's independent review and action.]*

c. *[The Chief of Staff and Chief Executive Officer are authorized to disclose to another system member's peer review body (or an authorized representative of that body) information from the hospital and Medical Staff records regarding such a practitioner or Allied Health Professional.]*

13.6-3 ***[Effect of Actions Taken by Other Entities]***

[Except as provided in Bylaws, Section 13.3-11, page 103, whenever the Chief of Staff or Medical Executive Committee receives information about an action taken at another system member and involving a practitioner or Allied Health Professional holding privileges at the hospital, the Chief of Staff or Medical Executive Committee shall, if time permits, independently assess the facts and circumstances to ascertain whether to take comparable action. However, when the practitioner or Allied Health Professional was summarily suspended or restricted at the other system member, any person authorized under Bylaws, Section 13.2-1, Criteria for Initiation, to impose a summary action is authorized to immediately impose a comparable suspension or restriction at this hospital, subject to review by the Medical Executive Committee in accordance with the provisions of Bylaws, Section 13.2, Summary Restriction or Suspension.]

COMMENT: Correction of cross references.Note: While this provision has some similar features as Bylaws, Section 13.3-11, the issues are somewhat different when the circumstance involves sister hospitals within a system — especially where there is a common Governing Body. Not only does the above provision include independent review by the second hospital before (or in the case of summary suspension, immediately after) imposition of the action, there is also provision for fair hearing to review the action. Hospitals that deliver telemedicine services among system hospitals should give special consideration to including provisions such as these for reporting and/or effectuating sister-hospital corrective actions.

Article 14 Hearings and Appellate Reviews

COMMENT: District hospitals also need to comply with the requirements of Health and Safety Code Section 32150 *et seq.*

14.1 General Provisions

14.1-1 Review Philosophy

The intent in adopting these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect practitioners (as defined below), and at the same time to protect the peer review participants from liability. It is further the intent to establish flexible procedures which do not create burdens that will discourage the Medical Staff and Governing Body from carrying out peer review.

Accordingly, discretion is granted to the Medical Staff and Governing Body to create a hearing process which provides for the least burdensome level of formality in the process and yet still provides a fair review and to interpret these Bylaws in that light. The Medical Staff, the Governing Body, and their officers, committees and agents hereby constitute themselves as peer review bodies under the federal Health Care Quality Improvement Act of 1986 and the California peer review hearing laws and claim all privileges and immunities afforded by the federal and state laws.

14.1-2 Exhaustion of Remedies

If an adverse action as described in Bylaws, Section 14.2 is taken or recommended, the practitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action.

14.1-3 Intra-Organizational Remedies

The hearing and appeal rights established in the Bylaws are strictly adjudicative 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 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 challenges first to the Governing Body and only thereafter may he or she seek judicial intervention.

14.1-4 *[Joint Hearings and Appeals]*

[The Medical Staff and Governing Body are authorized to participate in joint hearings and appeals in accordance with Bylaws, Section 14.12, of this Article.]

14.1-5 Definitions

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

a. Body whose decision prompted the hearing refers to the Medical Executive Committee in all cases where the Medical Executive Committee or authorized Medical Staff officers, members or committees took the action or rendered the decision which resulted in a hearing being requested. It refers to the Governing Body in all cases where the Governing Body or its authorized officers, directors or committees took the action or rendered the decision which resulted in a hearing being requested.

b. Practitioner, as used in this Article, refers to the practitioner who has requested a hearing pursuant to Bylaws, Section 14.3-2 of this Article.

14.1-6 Substantial Compliance

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

14.2 Grounds for Hearing

Except as otherwise specified in these Bylaws (including those Exceptions to Hearing Rights specified in Bylaws, Section 14.13, of this Article), any one or more of the following actions or recommended actions shall be deemed an actual or potential adverse action and constitute grounds for a hearing:

14.2-1 Denial of Medical Staff initial applications for membership and/or privileges.

14.2-2 Denial of Medical Staff reappointment and/or renewal of privileges.

14.2-3 Revocation, suspension, restriction, involuntary reduction of Medical Staff membership and/or privileges.

14.2-4 Involuntary imposition of significant consultation or Level III proctoring requirements, as described at Bylaws, Section 7.4-4(a)(3), that cannot be completed prior to the time frame required for reporting the restriction to the Medical Board of California (i.e., Level I and Level II proctoring requirements, as well as transitory restrictions that do not require reporting to the Medical Board of the Data Bank do not entitle the practitioner to a hearing).

14.2-5 Summary suspension of Medical Staff membership and/or privileges during the pendency of corrective action and hearings and appeals procedures.

14.2-6 Any other "medical disciplinary" action or recommendation that must be reported to the Medical Board of California under the provisions of California Business & Professions Code , Section 805 or to the National Practitioner Data Bank.

14.3 Requests for Hearing

14.3-1 Notice of Action or Proposed Action

a. In all cases in which action has been taken or a recommendation made as set forth in Bylaws, Section 14.2, the practitioner shall be given special notice of the recommendation or action and of the right to request a hearing pursuant to Bylaws, Section 14.3-2, below. The notice must state:

1. What action has been proposed against the practitioner;
2. Whether the action, if adopted, must be reported under Business & Professions Code Section 805;

3. A brief indication of the reasons for the action or proposed action;
4. That the practitioner may request a hearing;
5. That a hearing must be requested within 30 days; and
6. That the practitioner has the hearing rights described in the Medical Staff Bylaws, including those specified in Bylaws, Section 14.6, Hearing Procedure.

b. The notice shall also advise the practitioner that he or she may request mediation of the dispute pursuant to Bylaws, Section 14.4, page 110, of these Bylaws and that mediation must be requested, in writing, within 10 days

14.3-2 Request for Hearing

a. The practitioner shall have 30 days following receipt of special notice of such action to request a hearing (and, if applicable, a preliminary hearing, as further described in Bylaws, Section 14.5, page 111). The request shall be in writing addressed to the Chief of Staff with a copy to the Chief Executive Officer. If the practitioner does not request a hearing within the time and in the manner described, the practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. Such final recommendation shall be considered by the Governing Body within *[70]* days and shall be given great weight by the Governing Body, although it is not binding on the Governing Body.

b. 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.

c. Any time attorneys will be allowed to represent the parties at a hearing, the Hearing Officer shall have the discretion to limit the attorneys' role to advising their clients rather than presenting the case.

d. Any request for mediation must be received within 10 days of the date of receipt of the notice sent pursuant to Bylaws, Section 14.3-1(b).

COMMENT: Correction.

14.4 Mediation of Peer Review Disputes

COMMENT: This new provision is a tool that some Medical Staffs have found useful in resolving peer review disputes without necessity of a hearing. Since it is an optional provision in implementation, it is advisable to add this as an additional "tool" for addressing Medical Staff peer review disputes.

14.4-1 Mediation is a confidential process in which a neutral person facilitates communication between the Medical Executive Committee and a practitioner to assist them in reaching a mutually acceptable resolution of a peer review controversy in a manner that is consistent with the best interests of patient care.

14.4-2 The parties are encouraged to consider mediation whenever it could be productive in resolving the dispute.

14.4-3 In order to obtain consideration of mediation, the practitioner must request mediation in writing, as defined herein, within 10 days of his/her receipt of a notice of action or proposed action that would give rise to a hearing pursuant to Bylaws, Section 14.2.

14.4-4 If the practitioner and the Medical Executive Committee agree to mediation, all deadlines and time frames relating to the fair hearing process shall be tolled while the mediation is in process, and the practitioner agrees that no damages may accrue as the result of any delays attributable to the mediation.

14.4-5 Mediation cannot be used by either the Medical Staff or the practitioner as a way of unduly delaying the corrective action/fair hearing process. Accordingly, unless both the Medical Staff and the practitioner agree otherwise, mediation must commence within 30 days of the practitioner's request and must conclude within 30 days of its commencement. If the mediation does not resolve the dispute, the fair hearing process will promptly resume upon completion of the mediation.

14.4-6 The parties shall cooperate in the selection of a mediator (or mediators). Mediators should be both familiar with the mediation process and knowledgeable regarding the issues in dispute. The mediator may also serve as the Hearing Officer at any subsequent hearing, subject to the agreement of the parties which may be given prior to the mediation or after, with the parties to decide when they will agree on this issue. The costs of mediation shall be shared two-thirds by the Medical Staff and one third by the practitioner. The inability of the Medical Staff and the practitioner to agree upon a mediator within the required time limits shall result in the termination of the mediation process and the resumption of the fair hearing process.

14.4-7 Once selected, the mediator and the parties, working together, shall determine the procedures to be followed during the mediation. Either party has the right to be represented by legal counsel in the mediation process.

14.4-8 All mediation proceedings shall be confidential and the provisions of California Evidence Code Section 1119 shall apply except that communications that confirm that mediation was mutually accepted and pursued may be disclosed as proof that otherwise applicable time frames were tolled or waived. Any such disclosure shall be limited to that which is necessary to confirm mediation was pursued, and shall not include any points that are substantive in nature or address the issues presented. Except as otherwise permitted in this Section, no other evidence of anything said at, or any writing prepared for or as the result of, the mediation shall be used in any subsequent fair hearing process that takes place if the mediation is not successful.

14.5 [Preliminary Hearing]

COMMENT: Some hospitals include provisions for "bifurcated" hearings as a means to promptly address summary suspension actions — i.e., one hearing to address the need for summary action; and another hearing to address the permanent action. The below provisions for a preliminary hearing reflect a modified approach designed to achieve the benefits of an early review, without the many problems CHA has previously noted with the more traditional "bifurcated" hearing approach. This new approach provides for prompt initial review of a summary action, while minimizing the potential redundancy and added expense that the traditional bifurcated approach involved. These provisions thus provide a means for promptly assessing the need for immediate action (and thereby limiting potential damages to both the physician and the hospital in the event the summary action is determined unwarranted), while at the same time

assure that matters reviewed and determined in the preliminary hearing will, absent extenuating circumstances, be controlling in the subsequent full hearing. Finally, these provisions make it clear that both the preliminary hearing and the full hearing are conducted by the same hearing committee and same Hearing Officer, again contributing to the efficiency of these proceedings. Notwithstanding these improvements to the traditional bifurcated hearings, some attorneys believe that there remain problems in being able to effectively prepare for a preliminary hearing, given the tighter time frames involved, and/or have expressed concerns whether it is truly possible to effectively eliminate the redundancy inherent in bifurcated hearings. In summary, these optional preliminary hearing provisions remain somewhat controversial. Hospitals and Medical Staffs should consult with counsel in deciding whether to include such a provision in the Bylaws.

14.5-1 *[Any affected practitioner shall have the right to challenge imposition of a summary action, particularly on the issue of whether or not, based on the information presented to the Medical Executive Committee at the time the summary action was imposed and/or continued in effect (as described at Bylaws, Section 13.2-2), the Medical Executive Committee reasonably determined that failure to summarily restrict or suspend could reasonably result in an imminent danger to the health of an individual. Initially, the practitioner may present this challenge to the Medical Executive Committee at the meeting held within seven calendar days of imposition of the suspension action. If the Medical Executive Committee's decision is to continue the summary action, then any practitioner who has properly requested a hearing under the Medical Staff Bylaws may also request a preliminary hearing devoted exclusively to whether there is sufficient evidence based on the information presented to the Medial Executive Committee at the time the summary action was imposed and/or continued in effect, that failure to summarily restrict or suspend could reasonably result in an imminent danger to the health of an individual.]*

14.5-2 *[This preliminary hearing shall be conducted by the Hearing Officer appointed pursuant to Bylaws, Section 14.6-5, and, unless waived by the practitioner, the Hearing Committee appointed for the full hearing, comprised pursuant to Bylaws, Section 14.6-4. Except as otherwise agreed by the parties, the preliminary hearing shall be convened within 15 days of the date all members of the Hearing Committee have been appointed. The Hearing Officer and Hearing Committee members shall be subject to reasonable questions and challenges to qualifications and potential conflicts, as provided at Bylaws, Section 14.6-14, and the evidentiary portion of the preliminary hearing shall be commenced, diligently pursued, and completed as promptly as reasonably possible. Except as modified by this Bylaws, Section 14.5, the provisions of Bylaws, Section 14.6-14, shall apply; however the Hearing Officer shall be empowered to adjust time frames and modify procedures otherwise described in Bylaws, Section 14.6, as necessary to achieve a timely preliminary hearing. If the Hearing Officer determines that the member is not proceeding diligently in furtherance of a timely preliminary hearing, the Hearing Officer, in consultation with the Hearing Committee, if one has been appointed, may terminate the preliminary hearing, and order that the matter be heard as part of the full hearing, as described at Bylaws, Section 14.6.]*

14.5-3 *[At the conclusion of the preliminary hearing, the Hearing Officer, or Hearing Committee, as applicable, shall issue a written decision as to whether, based on the information presented to the Medical Executive Committee at the time the summary action was imposed and/or continued in effect (as described at Bylaws, Section 13.2-2) reasonably determined that failure to summarily restrict or suspend could reasonably result in "imminent danger" to the health of an individual. The decision may affirm or reject, but may not modify, the action imposed by the Medical Executive Committee (although it may recommend that the Medical Executive Committee consider modification). The written decision shall include documented findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached, and shall be transmitted to both the affected practitioner and the Medical Executive Committee within 15 calendar days from the conclusion of the preliminary hearing.]*

14.5-4 *[If the Hearing Officer's or Hearing Committee's (as applicable) determination is that the information presented to the Medical Executive Committee at the time the summary action was imposed and/or*

continued in effect does not reasonably support a determination that failure to summarily restrict or suspend the practitioner's privileges could reasonably result in imminent danger to the health of an individual, the determination shall be immediately transmitted to the Medical Executive Committee for reconsideration of its imposition of summary action. If the Medical Executive Committee does not rescind the summary action within 10 days of receipt of the Hearing Officer's or Hearing Committee's determination, the matter shall be immediately transmitted to the Governing Body, which shall process the matter as an appeal from a favorable hearing recommendation, as further described at Bylaws, Section 14.7; provided, however, the appeal shall be heard within 45 calendar days of the date of the Hearing Officer's or Hearing Committee's initial determination in the matter; and further provided that the full hearing on the merits is not stayed and may proceed as usual during the pendency of the appeal.]

14.5-5 *[Nothing in the foregoing precludes the Medical Executive Committee from imposing other remedial action in lieu of the initial summary action; and if such other action is itself a summarily imposed restriction of privileges that is reportable to the Medical Board of California, then the affected member shall be entitled to challenge such alternative summary actions in the same manner as described above for the initial summary action.]*

14.5-6 *[If the Hearing Officer, or Hearing Committee, determines that the information presented to the Medical Executive Committee at the time the summary action was imposed and/or continued in effect reasonably supports a determination that failure to summarily restrict or suspend could reasonably result in imminent danger to the health of an individual, the summary action shall remain in effect pending conclusion of the full hearing and any appellate review.]*

14.5-7 *[A full hearing on the merits of the summary action and any additional restrictions or discipline shall be conducted as soon as reasonably possible, in accordance with the provisions of Business & Professions Code Section 8.09* et seq. *Subject to the following limitations, the findings of fact from the preliminary hearing shall be deemed established in the full hearing; provided, however, the Hearing Committee shall be permitted to hear additional evidence and to reconsider the conclusions previously reached in light of the evidence produced at the full hearing. Notwithstanding the foregoing, a preliminary hearing determination that a summary action was not warranted shall, if upheld by the Governing Body pursuant to the appeal provisions set forth above, shall be binding on the hearing committee with respect to that particular decision.]*

14.6 Hearing Procedure

14.6-1 Hearings Prompted by Governing Body Action

If the hearing is based upon an adverse action by the Governing Body, the chair of the Governing Body shall fulfill the functions assigned in this Section to the Chief of Staff, and the Governing Body shall assume the role of the Medical Executive Committee. The Governing Body may, but need not, grant appellate review of decisions resulting from such hearings.

COMMENT: Recommended to alleviate the need for the Governing Body to conduct an appeal relating to its own decision. However, there may be circumstances where appellate review is advisable, so the provision allows the Governing Body, in its discretion, to permit an appellate review.

14.6-2 Time and Place for Hearing

Upon receipt of a request for hearing, the Chief of Staff shall schedule a hearing and, within 30 days from the date he or she received the request for a hearing, give special notice to the practitioner of the time, place and date of the hearing. The date of the commencement of the hearing shall be not less than 30 days nor more than 60 days from the date the Chief of Staff received the request for a hearing*[; provided, however, that*

when the request is received from a member who is under summary action and has timely requested a preliminary hearing as described in Bylaws, Section 14.5-1, page 112, the timely commencement of a preliminary hearing shall be deemed to satisfy the provisions of these Bylaws for timely commencement of the hearing].

14.6-3 Notice of Charges

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

14.6-4 Hearing Committee

a. When a hearing is requested, the Chief of Staff shall appoint a Hearing Committee which shall be composed of not less than three members who shall gain no direct financial benefit from the outcome and who have not acted as accuser, investigator, fact finder, initial decision maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Hearing Committee. In the event that it is not feasible to appoint a Hearing Committee from the active Medical Staff, the Chief of Staff may appoint members from other Medical Staff categories or practitioners who are not Medical Staff members. Such appointment shall include designation of the chair. When feasible, the Hearing Committee shall include at least one member who has the same healing arts licensure as the practitioner and who practices the same specialty as the practitioner. The Chief of Staff may appoint alternates who meet the standards described above and who can serve if a Hearing Committee member becomes unavailable.

b. Alternatively, an arbitrator may be used who is selected using a process mutually accepted by the body whose decision prompted the hearing and the practitioner. The arbitrator need not be either a health professional or an attorney. The arbitrator shall carry out all of the duties assigned to the Hearing Officer and to the Hearing Committee.

c. The Hearing Committee, or the arbitrator, if one is used, shall have such powers as are necessary to discharge its or his or her responsibilities.

14.6-5 The Hearing Officer

COMMENT: Recent California cases have called into question the manner in which Hearing Officers are selected. Thus, while Option 1, below, is a variation on the traditional (unilateral) method for securing a Hearing Officer and remains consistent with Business & Professions Code Section 809.2, Option 2 addresses concerns that have been raised in these recent court cases (see *Yaqub v. Salinas Valley Memorial Healthcare System*, 122 Cal.App.4th 474 (2004); *rehearing denied* October 6, 2004, *review denied* January 12, 2005) and *Haas v. County of San Bernardino*, 27 Cal.App.4th 1017 (2002). Option 2 describes a listing service that is expected to be operational by early 2011. Hospitals interested in Option 2 should check with CHA or the California Society for Healthcare Attorneys (CSHA) to see if the service is yet operational, and may wish to adopt Option 1 to be effective until Option 2 is available.

[Option 1 (to be operational until the hearing officer listing service described in Option 2 is operational)]

a. *[The use of a Hearing Officer to preside at a hearing is mandatory. The appointment of a Hearing Officer shall be by the Chief Executive Officer, as a representative of the Medical Executive Committee, as follows:]*

1. *[Together with the notice of a hearing, the practitioner shall be provided a list of at least three but no more than five potential Hearing Officers meeting the criteria set forth in Bylaws, Section 14.6-5(b), below.]*

2. *[The practitioner shall have five work days to accept any of the listed potential Hearing Officers, or to propose at least three but no more than five other names of potential Hearing Officers meeting the criteria set forth in Bylaws, Section 14.6-5(b), below.]*

3. *[If the practitioner is represented by counsel, the parties' counsel may meet and confer in an attempt to reach accord in the selection of a Hearing Officer from the two parties' lists.]*

4. *[If the parties are not able to reach agreement on the selection of a Hearing Officer within five working days of receipt of the practitioner's proposed list, the hospital's Chief Executive Officer shall select an individual from the composite list.]*

5. *[Unless a Hearing Officer is selected pursuant to stipulation of the parties, he/she shall be subject to reasonable voir dire.]*

[Option 2 to be operational once the hearing officer listing service described in Option 2 is operational]

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

1. *[As part of his/her request for a hearing pursuant to Bylaws, Section 14.3-2, the practitioner must list five attorneys who the practitioner would accept as a Hearing Officer, three of whose names must be obtained from the list maintained by the hearing officer listing service operated by the California Societ for Healthcare Attorneys, or such other hearing officer listing service as may be endorsed for that purpose by both the California Medical Association (CMA) and the California Hospital Association (CHA). The Medical Staff may then select the Hearing Officer from the practitioner's list. Failure of the practitioner to submit the requisite list shall constitute a waiver of any right to participate in the Hearing Officer selection process and the Medical Staff may then select a duly qualified Hearing Officer.]*

2. *[If the Medical Staff is not willing to accept any of the five proposed Hearing Officers identified by the practitioner, the Medical Staff, within five working days of receipt of the practitioner's list, must provide the practitioner an alternative written list of five potential Hearing Officers (three of whom must be obtained from the hearing officer listing service). Failure to provide an alternative list within the five working days shall constitute a waiver of the right to reject the practitioner's list and the Medical Staff would then be required to select one of the persons previously identified by the practitioner from the hearing officer listing service list as the Hearing Officer.]*

3. *[If the Medical Staff provides an alternative list, the practitioner has five working days to select the Hearing Officer from that list. The failure of the practitioner to respond to the proposed candidates within the five working days shall constitute a waiver of the right to reject the Medical Staff's alternative list and the Medical Staff may then select anyone from that list as the Hearing Officer.]*

4. *[If the practitioner timely rejects all of the Hearing Officer candidates from the Medical Staff's alternative list, the Medical Staff, within five working days, shall contact the hearing officer listing service for a final list of five additional Hearing Officer candidates. In submitting its request, the Medical Staff may ask the hearing officer listing service to screen potential candidates for obvious conflicts and availability. Once the list has been supplied, if the Medical Staff and the practitioner cannot agree upon a candidate, the Medical Staff and the practitioner shall, in turn, each strike two candidates and the remaining candidate shall be the Hearing Officer. The side that strikes first shall be determined by lot. Unless a Hearing Officer is selected pursuant to stipulation of the parties, as opposed to striking candidate names, he/she shall be subject to reasonable voir dire.]*

5. *[Unless waived by the parties, the Hearing Officer so selected must meet the qualifications set forth in Bylaws, Section 14.6-5(b), below.]*

COMMENT: CSHA's hearing officer listing service is expected to be operational by early 2011, and is a recommended source for procuring qualified hearing officers. In the future other organizations may develop such resources, and in such cases endorsement by CHA and CMA provides a good benchmark.

b. The Hearing Officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the hospital, the Medical Staff or the involved Medical Staff member or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as Hearing Officer. The Hearing Officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate.

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

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

e. If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as seems warranted by the circumstances, including, but not limited to, limiting the scope of examination and cross-examination and setting fair and reasonable time limits on either side's presentation of its case. *[Under extraordinary circumstances, the Hearing Officer may recommend termination of the hearing; however, the Hearing Officer may not unilaterally terminate the hearing and may only issue an order that would have the efect of terminating the hearing (a "termination order") at the direction of the Hearing Committee. The terminating order shall be in writing and shall include documentation of the reasons therefore. If a terminating order is against the Medical Executive Committee, the charges against the practitioner will be deemed to have been dropped. If, instead, the terminating order is against the practitioner, the practitioner will be deemed to have waived his/her right to a hearing. The party against whom termination sanctions have been ordered may appeal the terminating order to the hospital Governing Body. The appeal must be requested within 10 days of the terminating order, and the scope of the appeal shall be limited to reviewing the appropriateness of the terminating order. The appeal shall be conducted in general accordance with the provisions of Bylaws, Section 14.7. If the order is found to be unwarranted, the Hearing Committee shall reconvene and resume the hearing. If the Governing Body determines that the terminating order should not have been issued, the matter will be remanded to the Hearing Committee for completion of the hearing.]*

COMMENT: The California Supreme Court, in *Mileikowski v. West Hills Med. Ctr.*, (Supreme Ct. 2009) 45 Cal.4th 1259, determined that a hearing officer may not unilaterally terminate a hearing, as such a decision is tantamount to a decision on the merits, which decisions should only be made by the Hearing Committee. CHA's Interim amendments (published in August 2010) partially addressed this development. The above changes further clarify the issuance of a terminating order, and the appeal rights associated with such an order.

f. Upon adjournment of the evidentiary portion of the hearing, the Hearing Officer shall meet with the members of the hearing committee to assist them with the process for their review of the evidence and preparation of the report of their decision. Upon request from the hearing committee members, the Hearing Officer may remain during the hearing committee's full deliberations. During the deliberative process, the Hearing Officer shall act as legal advisor to the hearing committee, but shall not be entitled to vote.

g. In all matters, the Hearing Officer shall act reasonably under the circumstances and in compliance with applicable legal principles. In making rulings, the Hearing Officer shall endeavor to promote a less formal, rather than more formal, hearing process and also to promote the swiftest possible resolution of the matter, consistent with the standards of fairness set forth in these Bylaws. When no attorney is accompanying any party to the proceedings, the Hearing Officer shall have authority to interpose any objections and to initiate rulings necessary to ensure a fair and efficient process.

h. *[Further Optional Provision: To the extent that any provision in this Section of these Bylaws may conflict with any other provision of the Bylaws (e.g. granting certain duties and authority to the Chair of the Hearing Committee), this provision shall preempt and control.]*

COMMENT: Bylaws, Section 14.6-5(g), above, is a further optional provision under Option 2. If this provision is adopted, any other provisions in the Bylaws will be superseded to the degree they may conflict with provisions in this Bylaws, Section 14.6-5 relating to the powers and duties of the Hearing Officer. Thus, for example, if another provision in the Medical Staff's Bylaws grants similar powers or duties to the Chair of the hearing committee, then this optional provision would nullify those provisions and vest such powers and duties in the Hearing Officer. Each Medical Staff should consider carefully before adopting this provision to be sure it intends to supersede any such provisions that may exist.

14.6-6 Representation

COMMENT: Attorney representation at the initial hearing stage is optional under California law. However, the federal Health Care Quality Improvement Act (HCQIA) provides that one of the necessary elements for the safe harbor immunity is attorney representation at all stages of the hearing and any appeal process. While it may be possible to deny attorney representation at the initial hearing (and still gain the protection of the HCQIA by showing that the hearing was nonetheless a fair hearing), the hospital and the Medical Executive Committee would have to prove the fairness of the process (rather than being able to rely on the presumption of fairness that accompanies compliance with the safe harbor provisions). Prior editions of these Model Bylaws included two options, one providing that there would be no right to an attorney, but that the Hearing Officer had discretion to permit attorneys; the other providing a right to attorney. Peer review hearings have evolved to the point where it is no longer advisable to deny a right to an attorney; hence, the old Option 1 has been deleted. CHA now recommends that all practitioners be afforded a right to attorney representation in a hearing, subject to the conditions of Business & Professions Code Section 809.3(c), as reflected in the below provisions.

The practitioner shall have the right, at his or her expense, to attorney representation at the hearing. If the practitioner elects to have attorney representation, the body whose decision prompted the hearing may also have attorney representation. Conversely, if the practitioner elects not to be represented by an attorney in the hearing, then the body whose decision prompted the hearing shall not be represented by an attorney in the hearing. When attorneys are not allowed, the practitioner and the body whose decision prompted the hearing may be represented at the hearing only by a practitioner licensed to practice in the State of California who is not also an attorney.

14.6-7 Failure to Appear or Proceed

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

14.6-8 Postponements and Extensions

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted upon a showing of good cause, as follows:

a. Until such time as a Hearing Officer has been appointed, by the Hearing Committee or its Chair acting upon its behalf; or

b. Once appointed by the Hearing Officer.

COMMENT: Once a Hearing Officer has been appointed, it is generally more feasible to have the Hearing Officer rule on requests for postponement.

14.6-9 Discovery

a. **Rights of Inspection and Copying.** The practitioner may inspect and copy (at his or her expense) any documentary information relevant to the charges that the Medical Staff has in its possession or under its control. The body whose decision prompted the hearing may inspect and copy (at its expense) any documentary information relevant to the charges that the practitioner has in his or her possession or under his or her control. The requests for discovery shall be fulfilled as soon as practicable. Failures to comply with reasonable discovery requests at least 30 days prior to the hearing shall be good cause for a continuance of the hearing.

b. **Limits on Discovery.** The Hearing Officer shall rule on discovery disputes the parties cannot resolve. Discovery may be denied when justified to protect peer review or in the interest of fairness and equity. Further, the right to inspect and copy by either party does not extend to confidential information referring to individually identifiable practitioners other than the practitioner under review nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information.

c. **Ruling on Discovery Disputes.** In ruling on discovery disputes, the factors that may be considered include:

1. Whether the information sought may be introduced to support or defend the charges;
2. Whether the information is exculpatory in that it would dispute or cast doubt upon the charges or inculpatory in that it would prove or help support the charges and/or recommendation;
3. The burden on the party of producing the requested information; and
4. What other discovery requests the party has previously made.

d. **Objections to Introduction of Evidence Previously Not Produced for the Medical Staff.** The body whose decision prompted the hearing may object to the introduction of the evidence that was not provided during an appointment, reappointment or privilege application review or during corrective action despite the requests of the peer review

body for such information. The information will be barred from the hearing by the Hearing Officer unless the practitioner can prove he or she previously acted diligently and could not have submitted the information.

14.6-10 Pre-Hearing Document Exchange

At the request of either party, the parties must exchange all documents that will be introduced at the hearing. The documents must be exchanged at least 10 days prior to the hearing. A failure to comply with this rule is good cause for the Hearing Officer to grant a continuance. Repeated failures to comply shall be good cause for the Hearing Officer to limit the introduction of any documents not provided to the other side in a timely manner.

14.6-11 Witness Lists

Not less than 15 days prior to the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that party at the hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. The failure to have provided the name of any witness at least 10 days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

14.6-12 Procedural Disputes

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

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

14.6-13 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 practitioner is entitled to receive a copy of the transcript upon paying the reasonable cost for preparing the record. The Hearing Officer may, but shall not be required to, order that oral evidence

shall be taken only on oath administered by any person lawfully authorized to administer such oath.

14.6-14 Rights of the Parties

Within reasonable limitations, both sides at the hearing may ask the Hearing Committee members and Hearing Officer questions which are directly related to evaluating their qualifications to serve and for challenging such members or the Hearing Officer, call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, receive all information made available to the Hearing Committee, and to submit a written statement at the close of the hearing, as long as these rights are exercised in an efficient and expeditious manner. The practitioner may be called by the body whose decision prompted the hearing or the Hearing Committee and examined as if under cross-examination. The Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

14.6-15 Rules of Evidence

Judicial Rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under these Bylaws, Article 14. 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.

14.6-16 Burdens of Presenting Evidence and Proof

a. At the hearing, the body whose decision prompted the hearing shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The practitioner shall be obligated to present evidence in response.

b. An applicant for membership and/or privileges shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that he or she is qualified for membership and/or the denied privileges. The practitioner must produce information which allows for adequate evaluation and resolution of reasonable doubts concerning his or her current qualifications for membership and privileges.

c. Except as provided above for applicants for membership and/or privileges, throughout the hearing, the body whose decision prompted the hearing shall bear the burden of persuading the Hearing Committee by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.

14.6-17 Adjournment and Conclusion

The Hearing Officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted with due consideration for reaching an expeditious conclusion to the hearing.

14.6-18 Basis for Decision

The decision of the Hearing Committee shall be based on the evidence and written statements introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony.

14.6-19 Presence of Hearing Committee Members and Vote

A majority of the Hearing Committee must be present throughout the hearing and deliberations. In unusual circumstances when a Hearing Committee member must be absent from any part of the proceedings, he or she shall not be permitted to participate in the deliberations or the decision unless and until he or she has read the entire transcript of the portion of the hearing from which he or she was absent. The final decision of the Hearing Committee must be sustained by a majority vote of the number of members appointed.

14.6-20 Decision of the Hearing Committee

Within 30 days after final adjournment of the hearing, the Hearing Committee shall render a written decision. Final adjournment shall be when the Hearing Committee has concluded its deliberations. A copy of the decision shall be forwarded to the Chief Executive Officer, the Medical Executive Committee, the Governing Body, and by special notice to the practitioner. The report shall contain the Hearing Committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Both the practitioner and the body whose decision prompted the hearing shall be provided a written explanation of the procedure for appealing the decision. The decision of the Hearing Committee shall be considered final, subject only to such rights of appeal or Governing Body review as described in these Bylaws.

COMMENT: With the changes permitting appeals of preliminary hearings, the above wording regarding practitioners under summary suspension is no longer needed (as the physician will have already had an opportunity to have an expedited review (via preliminary hearing and appeal) of the summary suspension decision).

14.7 Appeal

[These procedures apply to appeals from the results of a preliminary hearing (as described at Bylaws, Section 14.5), as well as appeals from the full hearing; however, in the context of an appeal from a preliminary hearing, the appeal Hearing Officer shall be empowered to adjust time frames and modify procedures as necessary to achieve a timely appeal from a preliminary hearing.]

14.7-1 Time for Appeal

Within 40 days after receiving the decision of the Hearing Committee, either the practitioner 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 side in the hearing. If appellate review is not requested within such period, that action or recommendation shall thereupon become the final action of the Medical Staff. The Governing Body shall consider the decision within 70 days, and shall give it great weight.

14.7-2 Time, Place and Notice

If an appellate review is to be conducted, the Appeal Board shall, within 30 days after receiving a request for appeal, schedule a review date and cause each side to be given notice (with special notice to the practitioner) of the time, place, and date of the appellate review. The appellate review shall commence within 60 days from the date of such notice provided; however, when a request for appellate review concerns a member who is under suspension which is then in effect, the appellate review should commence within 45 days from the date the request for appellate review was received *[if the Appeal*

Board is conducting an appeal of the results of a preliminary hearing]. The time for appellate review may be extended by the Appeal Board for good cause.

14.7-3 Appeal Board

The Governing Body may sit as the Appeal Board, or it may appoint an Appeal Board which shall be composed of not less than three members of the Governing Body. 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. If an attorney is selected, he or she may act as an appellate Hearing Officer and shall have all of the authority of and carry out all of the duties assigned to a Hearing Officer as described in this Article 14. That attorney shall not be entitled to vote with respect to the appeal. The Appeal Board shall have such powers as are necessary to discharge its responsibilities.

14.7-4 Appeal Procedure

The proceeding by the Appeal Board shall, at the discretion of the Appeal Board, either be a de novo hearing or an appellate hearing based upon the record of the hearing before the Hearing 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 in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the hearing; or the Appeal Board may remand the matter to the Hearing Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel or any other representative designated by that party in connection with the appeal. The appealing party shall submit a written statement concisely stating the specific grounds for appeal. In addition, each party shall have the right to present a written statement in support of his, her or its position on appeal. The appellate Hearing Officer may establish reasonable time frames for the appealing party to submit a written statement and for the responding party to respond. Each party has the right to personally appear and make oral argument. The Appeal Board may then, at a time convenient to itself, deliberate outside the presence of the parties.

14.7-5 Decision

a. Within 30 days after the adjournment of the appellate review proceeding *[(10 days if the Appeal Board is conducting an appeal of the results of a preliminary hearing)]*, the Appeal Board shall render a final decision in writing. Final adjournment shall not occur until the Appeal Board has completed its deliberations.

b. The Appeal Board may affirm, modify, reverse the decision or remand the matter for further review by the Hearing Committee or any other body designated by the Appeal Board.

c. The Appeal Board shall give great weight to the Hearing Committee recommendation, and shall not act arbitrarily or capriciously. Unless the Appeal Board elects to conduct a de novo review, the Appeal Board shall sustain the factual findings of the Hearing Committee if they are supported by substantial evidence. The Appeal Board may, however, exercise its independent judgment in determining whether a practitioner was afforded a fair hearing, whether the decision is reasonable and warranted in light of the supported findings, and whether any bylaw, rule or policy relied upon by the Hearing Committee is unreasonable or unwarranted. The

decision shall specify the reasons for the action taken and provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any), and the decision reached, if such reasons, findings and conclusions differ from those of the Hearing Committee.

COMMENT: Recommended clarifications and adding deference to the factual findings of the Hearing Committee.

d. The Appeal Board shall forward copies of the decision to each side involved in the hearing.

e. The Appeal Board may remand the matter to the Hearing Committee or any other body the Appeal Board designates for reconsideration or may refer the matter to the full Governing Body for review. If the matter is remanded for further review and recommendation, the further review shall be completed within 30 days *[(15 days if the remand is in the context of an appeal from a preliminary hearing)]* unless the parties agree otherwise or for good cause as determined by the Appeal Board.

14.8 Administrative Action Hearings

The following modifications to the hearing process apply when the Medical Executive Committee (or Governing Body) has taken or recommended an action described in Bylaws, Section 14.2 for a non-medical disciplinary cause or reason. Such actions shall be deemed administrative disciplinary actions.

14.8-1 Administrative Action Hearing

The affected practitioner shall be entitled to an administrative action hearing, conducted in accordance with Bylaws, Section 14.6, except as follows:

a. At the election of the body whose decision prompted the hearing, the hearing shall be conducted by an arbitrator, meeting the qualifications of Bylaws, Section 14.6-4(b), and selected by mutual agreement of the parties, if agreement can be reached within 10 days, failing which the arbitrator shall be selected by the body whose decision prompted the hearing.

b. The arbitrator shall have all of the rights and responsibilities of a Hearing Officer and a Hearing Committee, as described in Bylaws, Section 14.6.

c. At the election of the body whose decision prompted the hearing, both parties shall have the right to be represented by an attorney, whether or not the other party elects to be represented by an attorney. The parties shall be notified of this election at the time the practitioner is notified of his/her right to a hearing. If attorney representation is permitted, the parties shall promptly notify each other of their elections regarding attorney representation, together with the name and contact information of their attorneys.

14.8-2 Nonreportability of Administrative Actions

Administrative disciplinary actions are not reportable to the Medical Board of California or the National Practitioner Data Bank.

14.8-3 Nonwaiver of Protections

Notwithstanding the foregoing, it is understood that circumstances precipitating administrative disciplinary actions may nonetheless involve or affect quality of care in the hospital (e.g., conduct that does or may impair the ability of others to render

quality care, or that affects patients' perceptions of the quality of care rendered in the hospital). Processing a matter as and administrative disciplinary action does not waive any protections that may be available under California or federal law for peer review actions taken in furtherance of quality of care or services provided in the hospital.

COMMENT: This new provision is designed to provide an opportunity for a more expeditious hearing for non-medical disciplinary actions. While in theory the administrative hearing could be structured even simpler than we have recommended here, we believe the major delay associated with hearings comes with the difficulty of scheduling a hearing committee. This provision, allowing the use of an arbitrator to conduct and decide the hearing, should significantly simplify scheduling issues. Moreover, because the arbitrator would have the authority of both the Hearing Officer and the Hearing Committee, he/she would be able to issue a terminating order in the event either party does not proceed expeditiously. Finally, since the hearing does not involve medical disciplinary actions, the Business & Professions Code Section 809.03 provision regarding attorneys does not apply. The above provision allows the peer review body to determine whether to permit attorneys, and attorney representation is not contingent upon the affected practitioner's election. As a result, the MEC will know from the outset whether it will be represented by an attorney, and if so, the attorney can prepare the case without risk that the practitioner will change his/her mind at the last minute. (This latter feature of medical disciplinary actions frequently necessitates duplicate preparation by counsel and the MEC representative and/or causes delays in proceedings.) Some caution is warranted. Whether or not all of the protections and immunities typically associated with medical staff hearings will apply to an administrative hearing will depend on the facts and circumstances of the matters at issue in any particular case. In many cases, even though a matter is not medical disciplinary per se, it may still involve evaluation and improvement of quality of care in the hospital. For example, disruptive behavior that does not directly impact any individual patient's care, may nonetheless involve conduct that could affect others' ability to provide care, or the patients' perceptions with respect to quality of care. In these types of cases, the protections would likely still be available. (The foregoing comments are not meant to suggest that only direct impact on individual patient care is a prerequisite to a medical disciplinary action. In many cases, these types of issues are and should remain handled as medical disciplinary matters.)In other cases, the relationship to quality of care may be more illusive — e.g., sexual harassment of an administrative staff member. Indeed, the more tangential the conduct is to the quality of care, the more reluctant Medical Staffs have typically been to effectively address the issues, and one of the main reasons for this recalcitrance is the reportability, to the Medical Board and the Data Bank, of medical disciplinary actions. The administrative discipline and administrative hearing provisions added to these Bylaws and Rules are new tools to help address these thorny issues. See also, related changes to the Conduct guidelines at Bylaws, Section 2.7-3, and to Rule 3, Standards of Conduct and Appendix 4K, Quality Improvement Committee — all designed to give hospitals and Medical Staffs new approaches for addressing these difficult problems.

14.9 Right to One Hearing

No practitioner 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.

COMMENT: This provision applies to both hearings and appeals, and as such should be elevated to a Section level (rather than a subsection).

14.10 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.

COMMENT: District hospitals should add the following provision.

[All proceedings conducted pursuant to these Bylaws, Article 14, shall be held in private unless otherwise ordered by the Governing Body pursuant to a request of the practitioner. The practitioner may request a public hearing. Prior to exercising its discretion on any request for a public hearing, the Governing Body shall seek and consider the comments of the Medical Executive Committee as to the implications and feasibility of conducting such a hearing in public.]

14.11 Release

By requesting a hearing or appellate review under these Bylaws, a practitioner agrees to be bound by the provisions in the Medical Staff Bylaws relating to immunity from liability for the participants in the hearing process.

14.12 Governing Body Committees

In the event the Governing Body should delegate some or all of its responsibilities described in these Bylaws, Article 14 to its committees (including a committee serving as an Appeal Board), the Governing Body shall nonetheless retain ultimate authority to accept, reject, modify or return for further action or hearing the recommendations of its committee.

14.13 Exceptions to Hearing Rights

14.13-1 Exclusive Use *[Departments] [Services]*, Hospital Contract Practitioners

a. **Exclusive Use** *[Departments] [Services]*

The procedural rights of Bylaws, Article 14 do not apply to a practitioner whose application for Medical Staff membership and privileges was denied or whose privileges were terminated on the basis that the privileges he or she seeks are granted only pursuant to an exclusive use policy. Such practitioners shall have the right, however, to request that the Governing Body review the denial, and the Governing Body shall have the discretion to determine whether to review such a request and, if it decides to review the request, to determine whether the practitioner may personally appear before and/or submit a statement in support of his or her position to the Governing Body.

b. **Hospital Contract Practitioners**

COMMENT: See the note in Bylaws, Section 2.5-2 regarding also terminating membership, as well as privileges, when an exclusive arrangement is terminated and the practitioner has no other privileges.

The hearing rights of Bylaws, Article 14 do not apply to practitioners who have contracted with the hospital to provide clinical services. Removal of these practitioners from office and of any exclusive privileges (but not their Medical Staff membership) shall instead be governed by the terms of their individual contracts and agreements with the hospital. The hearing rights of Bylaws, Article 14 shall apply if an action is taken which must be reported under Business & Professions Code Section 805 and/or the practitioner's Medical Staff membership status or privileges which are independent of the practitioner's contract are removed or suspended.

14.13-2 Allied Health Professionals

[Option 1 (corresponds to Option 2 at Bylaws, Section 6.6-1)]

[Allied Health Professional applicants (other than AHPs who are the subject of an action that must be reported under Business & Professions Code Section 805) are not entitled to the hearing

rights set forth in this Article. However, Allied Health Professionals whose already-granted privileges are subject to an action that would constitute grounds for a hearing under Bylaws, Section 14.2-2 through Section 14.2-6 shall be entitled to the procedural rights set forth in this Article 14.]

[Option 2 (corresponds to Option 3 at Bylaws, Section 6.6-1)]

[Allied Health Professionals are not entitled to the hearing rights set forth in this Article unless the action is one that must be reported under Business & Professions Code Section 805. (See Section 6.6-1 for a description of Allied Health Professional hearing rights where no 805 report is required.)]

COMMENT: California law now requires 805 reporting for marriage and family therapists and clinical social workers. If these licentiates are credentialed as AHPs, they, too, need to be afforded Article 14 hearing rights.The Medical Staff will need to tailor this Section to correspond with the option selected for Bylaws, Section 6.6-1.

14.13-3 Denial of Applications for Failure to Meet the Minimum Qualifications

Practitioners shall not be entitled to any hearing or appellate review rights if their membership, privileges, applications or requests are denied because of their failure to have a current California license to practice medicine, dentistry, *[clinical psychology]* or podiatry; to maintain an unrestricted Drug Enforcement Administration certificate (when it is required under these Bylaws or the Rules); to maintain professional liability insurance as required by the Rules; or to meet any of the other basic standards specified in Bylaws, Section 2.2-2 or to file a complete application.

14.13-4 Automatic Suspension or Limitation of 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 Bylaws, Section 13.3-1. In other cases described in Bylaws, Section 13.3-1 and Section 13.3-2, 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 or the Drug Enforcement Administration was unwarranted, but only whether the member may continue to 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 (Bylaws, Section 13.3-3), failing to complete medical records (Bylaws, Section 13.3-4), failing to maintain malpractice insurance (Bylaws, Section 13.3-5), failing to pay dues (Bylaws, Section 13.3-6), or failing to comply with particular government or other third party payor Rules or policies (Bylaws, Section 13.3-7) are not entitled under Bylaws, Section 13.3-9 to any hearing or appellate review rights except when a suspension for failure to complete medical records will exceed 30 days in any 12-month period, and it must be reported to the Medical Board of California.

14.13-5 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 the minimum activity requirements set forth in the Medical Staff Bylaws or Rules. In such cases, the only review shall be provided by the Medical Executive Committee through a subcommittee consisting of at least three 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 30 days and no more than 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 45 days after the interview. A copy of the decision shall be sent to the practitioner, Medical Executive Committee and Governing Body. The subcommittee decision shall be final unless it is reversed or modified by the Medical Executive Committee within 45 days after the decision was rendered, or the Governing Body within 90 days after the decision was rendered.

14.14 [Joint Hearings and Appeals for System Members]

14.14-1 *[Joint Hearings]*

a. *[Whenever a practitioner is entitled to a hearing because a coordinated, cooperative or joint credentialing or corrective action has been taken or recommended pursuant to Bylaws, Section 13.6, a single joint hearing may be conducted in accordance with hearing procedures that have been jointly adopted by the involved entities, provided such procedures are substantially comparable to those set forth in Bylaws, Section 14.5 and further provided at least one member of the Hearing Committee is a member of this hospital's Medical Staff.]*

b. *[In the event there is such a joint hearing, the recommendation of the Hearing Committee shall be reported to this hospital's Governing Body for final action.]*

14.14-2 *[Joint Appeals]*

[The procedures may also call for joint appeal rights, provided such procedures are substantially comparable to those set forth in Bylaws, Section 14.7 and, further, provided that at least one member of the Appeal Board is a representative of this hospital's Governing Body.]

14.14-3 *[Effect of Joint Hearings/Appeals]*

[A joint hearing and/or appeal in accordance with the foregoing shall be deemed to satisfy procedural rights afforded to the practitioner pursuant to Business & Professions Code Section 809 et seq.]

14.14-4 *[Provision for Separate Hearing]*

[Notwithstanding the foregoing, if a practitioner can demonstrate to the Medical Executive Committee (in the case of a hearing based on a recommendation of the Medical Executive Committee) or the Governing Body (in the case of a hearing based on a recommendation of the Governing Body or in the case of an appeal) prior to the initiation of a joint hearing and/or appeal that the benefits of quasi-judicial economy and efficiency are outweighed by particular burdens or unfairness unique to the individual practitioner's circumstances, the Medical Executive Committee or Governing Body may, in its sole discretion, order that a separate hearing and/or appeal be conducted solely with respect to privileges at this hospital, in accordance with this hospital's Hearing and Appellate Review Provisions. (Examples of such unique burdens or unfairness would include unavailability of witnesses or documents to the joint proceeding; but the mere fact that the outcome would affect privileges at more than one facility would not ordinarily be deemed sufficient to preclude a joint hearing.)]

Article 15 General Provisions

15.1 Rules and Policies

COMMENT: The Joint Commission's (TJC) MS.01.01.01, Elements of Performance 8, 9, 10, and 11 permit the Medical Executive Committee (MEC) to adopt Rules, subject to the following additional requirements:

• Except in circumstances where there is an urgent need to amend to comply with law or regulation, the MEC must provide prior notice to the Medical Staff of proposed changes.

• Where there has not been prior notice (due to urgent need), the MEC must provide notice of urgently-adopted provisions, an opportunity for retrospective review, and a process for conflict resolution.

• Additionally, the Medical Staff must be permitted to propose Bylaws, Rules and policies and present them directly to the Governing Body for approval (without necessity for MEC approval of the proposed provision).

• Finally, there must be a conflict resolution process for managing those situations where the Medical Staff and the MEC do not agree.

The below provisions are developed to accommodate these new TJC requirements. Of note, CHA recommends that there be a reasonable threshold for how the "Medical Staff" may directly propose a Rule to the Governing Body, and how they may invoke dispute resolution — i.e., who is entitled to act on behalf of the Medical Staff. Since only voting members of the Medical Staff are entitled to vote on any proposed Rule, the threshold should involve a stated number or percentage of the voting Medical Staff. As to where to set that threshold, the following considerations appear relevant:

• The number should be sufficiently high so that the interests of individuals or a disgruntled few are not controlling of the processes. But it also needs to be set in recognition that in small medical staffs, the interests of a few may represent the prevailing view of the Medical Staff. Finally, the number should be reasonable – i.e., not so high that the provisions can never be invoked.

• With these considerations in mind, the following numbers are suggested:
– For all Medical Staffs – at least 50% of the voting members *[this is on the theory that it would require a majority vote to pass the provision anyway, so this level of support should be demonstrated from the outset]OR [The below options reflect ranges that call for a reasonable measure of preexisting support as a prerequisite to embarking on the process, on the theory that the proponents would have the opportunity to build additional support through the process.]*
– For Medical Staffs with 1-20 voting members: 25 – 50% of the voting members
– For Medical Staffs with 21-100 voting members: 25 – 30% of the voting members

* Note changes added since publication of the Interim amendments, adding the actual vote procedures for changes proposed by petition of the Medical Staff.

15.1-1 Overview and Relation to Bylaws

These Bylaws describe the fundamental principles of Medical Staff self-governance and accountability to the Governing Body. Accordingly, the key standards for Medical Staff membership, appointment, reappointment and privileging are set out in these Bylaws. Additional provisions, including, but not limited to, procedures for implementing the Medical Staff standards may be set out in Medical Staff *[or department]* Rules, or in

policies adopted or approved as described below. Upon proper adoption, as described below, all such Rules and policies shall be deemed an integral part of the Medical Staff Bylaws.

COMMENT: TJC's new MS.01.01.01 permits much discretion regarding which provisions will appear in the Bylaws and which will appear in the Rules or policies. The only limitation is that for those Elements of Performance that require a "process" the basic steps of the process must be set out in the Bylaws. TJC does not, however, prescribe or proscribe the content of these "basic steps."

15.1-2 General Medical Staff Rules

The Medical Staff shall initiate and adopt such Rules as it may deem necessary and shall periodically review and revise its Rules to comply with current Medical Staff practice. New Rules or changes to the Rules (proposed Rules) may emanate from any responsible committee, department, medical staff officer, or by petition signed by at least *[insert minimum number or percent]* of the voting members of the Medical Staff. Additionally, hospital administration may develop and recommend proposed Rules, and in any case should be consulted as to the impact of any proposed Rules on hospital operations and feasibility. Proposed Rules shall be submitted to the Medical Executive Committee for review and action, as follows:

a. Except as provided at Section 15.1-2(d), below, with respect to circumstances requiring urgent action, the Medical Executive Committee shall not act on the proposed Rule until the Medical Staff has had a reasonable opportunity to review and comment on the proposed Rule. *[This review and comment opportunity may be accomplished by posting proposed Rules on the Medical Staff website at least [thirty] [days prior to the scheduled Medical Executive Committee meeting, together with instructions how interested members may communicate comments. A comment period of at least [15] days shall be afforded, and all comments shall be summarized and provided to the Medical Executive Committee prior to Medical Executive Committee action on the proposed Rule.]*

b. Medical Executive Committee approval is required, unless the proposed Rule is one generated by petition of at least *[insert minimum number or percent]* of the voting members of the Medical Staff. In this latter circumstance, if the Medical Executive Committee fails to approve the proposed Rule, it shall notify the Medical Staff. The Medical Executive Committee and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Section 15.1-6:

1. If conflict management is not invoked within *[30]* days it shall be deemed waived. In this circumstance, the Medical Staff's proposed Rule shall be submitted for vote, and if approved by the Medical Staff pursuant to Section 15.1-2(b)(3), the proposed Rule shall be* forwarded to the Governing Body for action. The Medical Executive Committee may forward comments to the Governing Body regarding the reasons it declined to approve the proposed Rule.

2. If conflict management is invoked, the proposed Rule shall not be voted upon or* forwarded to the Governing Body until the conflict management process has been completed, and the results of the conflict management process shall be communicated to the Governing Body.

3. With respect to proposed Rules generated by petition of the Medical Staff, approval of the Medical Staff requires the affirmative vote of a majority of the Medical Staff members voting on the matter by mailed secret ballot, provided at

least 14 days' advance written notice, accompanied by the proposed Rule, has been given, and at least *[insert minimum number or percent of return votes required]* votes have been cast.*

c. Following approval by the Medical Executive Committee or favorable vote of the Medical Staff as described above,* a proposed Rule shall be forwarded to the Governing Body for approval, which approval shall not be withheld unreasonably. The Rule shall become effective immediately following approval of the Governing Body or automatically within 60 days if no action is taken by the Governing Body.

d. Where urgent action is required to comply with law or regulation, the Medical Executive Committee is authorized to provisionally adopt a Rule and forward it to the Governing Body for approval and immediate implementation, subject to the following. If the Medical Staff did not receive prior notice of the proposed Rule (as described at Section 15.1-2(a)) the Medical Staff shall be notified of the provisionally-adopted and approved Rule, and may, by petition signed by at least *[insert number or percent]* of the voting members of the Medical Staff require the Rule to be submitted for possible recall; provided, however, the approved Rule shall remain effective until such time as a superseding Rule meeting the requirements of the law or regulation that precipitated the initial urgency has been approved pursuant to any applicable provision of this Section 15.1-2.

COMMENT: * Note changes since publication of Interim amendments, adding voting procedures.

If there is a conflict between the Bylaws and the Rules, the Bylaws shall prevail.

15.1-3 ***[Department Rules]***

[Subject to the approval of the Medical Executive Committee and Governing Body, each department shall formulate its own Rules for conducting its affairs and discharging its responsibilities. Additionally, hospital administration may develop and recommend proposed department Rules, and in any case should be consulted as to the impact of any proposed department Rules on hospital operations and feasibility. Such Rules shall not be inconsistent with the Medical Staff or hospital Bylaws, Rules or other policies.]

COMMENT: Bylaws, Section 15.1-3 should be included only if the Medical Staff departments are divided into Sections. If Section 15.1-3 is not included, 15.1-4 should be numbered 15.1-3.

15.1-4 ***[Section Rules]***

[Subject to the approval of the committee of the department that oversees the section, the Medical Executive Committee and the Governing Body, each section may formulate its own Rules for conducting its affairs and discharging its responsibilities. Additionally, hospital administration may develop and recommend proposed section Rules, and in any case should be consulted as to the impact of any proposed section Rules on hospital operations and feasibility. Such Rules shall not be inconsistent with the Medical Staff or hospital Bylaws, Rules, or policies.]

15.1-5 Medical Staff Policies

a. Policies shall be developed as necessary to implement more specifically the general principles found within these Bylaws and the Medical Staff Rules. New or revised policies (proposed policies) may emanate from any responsible committee, department, medical staff officer, or by petition signed by at least *[insert minimum number or percent]* of the voting members of the Medical Staff. Proposed policies shall

not be inconsistent with the Medical Staff or hospital Bylaws, Rules or other policies, and upon adoption shall have the force and effect of Medical Staff Bylaws.

b. Medical Executive Committee approval is required, unless the proposed policy is one generated by petition of at least *[insert minimum number or percent]* of the voting members of the Medical Staff. In this latter circumstance, if the Medical Executive Committee fails to approve the proposed policy, it shall notify the Medical Staff. The Medical Executive Committee and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Section 15.1-6.

1. If conflict management is not invoked within *[30]* days it shall be deemed waived. In this circumstance, the Medical Staff's proposed policy shall be submitted for vote, and if approved by the Medical Staff pursuant to Section 15.1-5(b)(3), the proposed Rule shall be* forwarded to the Governing Body for action. The Medical Executive Committee may forward comments to the Governing Body regarding the reasons it declined to approve the proposed policy.

2. If conflict management is invoked, the proposed policy shall not be voted upon or* forwarded to the Governing Body until the conflict management process has been completed, and the results of the conflict management process shall be communicated to the Medical Staff and the* Governing Body.

3. Approval of the Medical Staff shall require the affirmative vote of a majority of the Medical Staff members voting on the matter by mailed secret ballot, provided at least 14 days' advance written notice, accompanied by the proposed Rule, has been given and at least *[insert minimum number or percent of return votes required]* votes have been cast.*

c. Following approval by the Medical Executive Committee or the voting Medical Staff as described above*, a proposed Rule shall be forwarded to the Governing Body for approval, which approval shall not be withheld unreasonably. The policy* shall become effective immediately following approval of the Governing Body or automatically within *[60]* days if no action is taken by the Governing Body.

d. The Medical Staff shall be notified of the approved policy, and may, by petition signed by at least *[insert number or percent]* of the voting members of the Medical Staff require the policy to be submitted for possible recall; provided, however, the approved policy shall remain effective until such time as it is repealed or amended pursuant to any applicable provision of this Section 15.1-5.

15.1-6 Conflict Management

In the event of conflict between the Medical Executive Committee and the Medical Staff (as represented by written petition signed by at least *[insert number or percent]* of the voting members of the Medical Staff) regarding a proposed or adopted Rule or policy, or other issue of significance to the Medical Staff,* the President of the Medical Staff shall convene a meeting with the petitioners' representative(s). The foregoing petition shall include a designation of up to *[five]* members of the voting Medical Staff who shall serve as the petitioners' representative(s). The Medical Executive Committee shall be represented by an equal number of Medical Executive Committee members. The Medical Executive Committee's and the petitioners' representative(s) shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee, and the safety and quality of

patient care at the hospital. Resolution at this level requires a majority vote of the Medical Executive Committee's representatives at the meeting and a majority vote of the petitioner's representatives. Unresolved differences shall be submitted to the Governing Body for its consideration in making its final decision with respect to the proposed Rule, policy, or issue.*

COMMENT: See comments at Section 15.1-2.* Note changes since publication of Interim amendments. MS.01.01.01, EP 10 is not limited to conflicts relating to Rules or policies, so this revised language was added to accommodate this broader possible use of the conflict management process.

15.2 Forms

Application forms and any other prescribed forms required by these Bylaws for use in connection with Medical Staff appointments, reappointments, delineation of privileges, corrective action, notices, recommendations, reports and other matters shall be approved by the Medical Executive Committee and the Governing Body. Upon adoption, they shall be deemed part of the Medical Staff Rules. They may be amended by approval of the Medical Executive Committee and the Governing Body.

15.3 Dues

The Medical Executive Committee shall have the power to establish reasonable annual dues, if any, for each category of Medical Staff membership, and to determine the manner of expenditure of such funds received. However, such expenditures must be appropriate to the purposes of the Medical Staff *[and shall not jeopardize the nonprofit tax-exempt status of the hospital.]*

COMMENT: Business & Professions Code Section 2282.5 grants the Medical Staff the right to establish dues and to control expenditures. It is important, however, that tax-exempt hospitals' Medical Staff expenditures are compatible with the hospitals' tax exempt purposes.

15.4 Medical Screening Exams

COMMENT: Hospitals subject to the Emergency Medical Treatment and Active Labor Act (EMTALA) must comply with 42 CFR 489.24(a), and describe in Bylaws or Rules those individuals who may perform medical screening exams.

15.4-1 All patients who present to the hospital, including the Emergency Department and the Labor and Delivery Unit, and who request examination and treatment for an emergency medical condition or active labor, shall be evaluated for the existence of an emergency medical condition or, where applicable, active labor. This screening examination may be performed by the following persons:

a. **In the Emergency Department:** by a registered nurse who has been determined by the ER Nurse Manager to be qualified and experienced in emergency nursing and who is required to follow standardized procedures approved by the Medical Staff.

b. **In the Labor and Delivery Unit:** by a registered nurse who has been determined by the Labor and Delivery Nurse Manager to be qualified and experienced in obstetrical nursing and who is required to follow standardized procedures approved by the Medical Staff.

c. **In all circumstances:** in the event the registered nurse performing the screening examination is uncertain about the nature of the patient's condition or the existence of an emergency or active labor, a physician from either the Emergency Department or Labor and Delivery shall be required to examine the patient and make the determination of the existence of an emergency or active labor.

15.4-2 Medical screening examinations and emergency services shall be provided in compliance with all applicable provisions of state and federal law, and hospital policies and procedures respecting Emergency Medical Services.

15.4-3 *[Informed Consent]*

a. *[Based upon input from [the departments], [the Medical Staff shall develop a list of procedures requiring informed consent of the patients. This list may be adopted, amended or repealed by majority vote of the Medical Executive Committee and approval by the Governing Body, and upon adoption shall have the force and effect of Medical Staff Bylaws. The list shall include, but is not limited to, informed consent requirements with respect to the following procedures:]*

1. *[Surgery]*
2. *[Blood transfusions]*
3. *[Physical restraints]*
4. *[Antipsychotic medications]*
5. *[Sterilization]*
6. *[Hysterectomy]*
7. *[Abortion]*
8. *[Reuse of hemodialysis filters]*
9. *[Breast cancer treatment]*
10. *[Silicon implants and collagen injections]*
11. *[Psychosurgery]*
12. *[Convulsive therapy]*
13. *[Implantation of cells, tissue, or organs]*
14. *[Assisted reproduction procedures]*
15. *[Telemedicine]*
16. *[Such other procedures as may be identified in the informed consent policy]*

b. *[The informed consent policy shall assure that the patient [or his/her representative] [receives information necessary to make informed decisions about his/her care including, but not limited to:]*

1. *[Health status, diagnosis; and progress;]*
2. *[The nature and purpose of the proposed procedure, anesthesia to be used (if applicable), short and long-term risks and consequences, and the probability that the proposed procedures will be successful;]*
3. *[An explanation of alternative methods of treatment (if any) and their associated risks and benefits;]*
4. *[An explanation of the risks and prognosis if not treatment is rendered; and]*

5. *[An explanation of who will actually perform the procedure, who will administer the anesthesia (if applicable), and which other practitioners will perform important parts of the surgical procedures.]*

c. *[Informed consents shall be documented in the medical record.]*

COMMENT: The above Section was originally added to comply with CMS Conditions of Participation, 42 CFR 482.24(c)(2)(v), and the *Interpretative Guidelines* for this standard. The *Interpretive Guidelines* now acknowledge that procedures requiring consent may be set out in medical staff policies.The above list of procedures requiring informed consent is based upon CHA's *Consent Manual*, chapter 4, "Procedures that Require Special Consent."

15.5 Legal Counsel

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

15.6 Authority to Act

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

15.7 Disputes with the Governing Body

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

a. **Invoking the Dispute Resolution Process**

1. The Medical Executive Committee may invoke formal dispute resolution, upon its own initiative, or upon written request of 25 percent of the members of the active staff.
2. In the event the Medical Executive Committee declines to invoke formal dispute resolution, such process shall be invoked upon written petition of 50 percent of the members of the active staff.

b. **Dispute Resolution Forum**

1. Ordinarily, the initial forum for dispute resolution shall be the Joint Conference Committee, which shall meet and confer as further described in Bylaws, Section 9.2(b).
2. However, upon request of at least 2/3 of the members of the Medical Executive Committee, the meet and confer will be conducted by a meeting of the full Medical Executive Committee and the full Governing Body. A neutral mediator acceptable to both the Governing Body and the Medical Executive Committee may be engaged to further assist in dispute resolution upon request of:

   i. At least a majority of the Medical Executive Committee plus two members of the Governing Body; or
   ii. At least a majority of the Governing Body plus two members of the Medical Executive Committee.

c. The parties' representatives shall convene as early as possible, shall gather and share relevant information, and shall work in good faith to manage and, if possible, resolve the conflict. If the parties are unable to resolve the dispute the Governing Body shall

make its final determination giving great weight to the actions and recommendations of the Medical Executive Committee. Further, the Governing Body determination shall not be arbitrary or capricious, and shall be in keeping with its legal responsibilities to act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the hospital.

COMMENT: Tailored to accommodate TJC Standards LD.01.03.01, EP 7 and LD.02.04.01, EP 4.

15.8 No Retaliation

Neither the Medical Staff, its members, committees or department heads, the Governing Body, its chief administrative officer, or any other employee or agent of the hospital or Medical Staff, shall discriminate or retaliate, in any manner, against any patient, hospital employee, member of the Medical Staff, or any other health care worker of the health facility because that person has done either of the following:

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

b. Has initiated, participated, or cooperated in an investigation or administrative proceeding related to, the quality of care, services, or conditions at the facility that is carried out by an entity or agency responsible for accrediting or evaluating the facility or its Medical Staff, or governmental entity.

COMMENT: Added to help assure compliance with California law (AB 632, 2007).

Article 16 Adoption and Amendment of Bylaws

16.1 Medical Staff Responsibility and Authority

16.1-1 The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt and recommend Medical Staff Bylaws and amendments which shall be effective when approved by the Governing Body, which approval shall not be unreasonably withheld. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Governing Body. Additionally, hospital administration may develop and recommend proposed Bylaws, and in any case should be consulted as to the impact of any proposed Bylaws on hospital operations and feasibility.

16.1-2 Proposed amendments shall be submitted to the Governing Body for comments at least 30 days before they are distributed to the Medical Staff for a vote. The Governing Body has the right to have its comments regarding the proposed amendments circulated with the proposed amendments at the time they are distributed to the Medical Staff for a vote.

16.1-3 Amendments to these Bylaws shall be submitted for vote upon the request of the Medical Executive Committee or upon receipt of a petition signed by at least *[insert minimum number or percent]* of the voting Medical Staff members. Amendments submitted upon petition of the voting Medical Staff members shall be provided to the Medical Executive Committee at least 30 days before they are submitted to the Governing Body for review and comment as described in Section 16.1-3. The Medical Executive Committee has the right to have its comments regarding the proposed amendments circulated to the Governing Body when the proposed amendments are submitted to the Governing Body for comments; and to have its comments circulated to the Medical Staff with the proposed amendments at the time they are distributed to the Medical Staff for a vote.

COMMENT: Business & Professions Code Section 2282.5 establishes the Medical Staff's right to adopt Bylaws, and sets out a standard for Governing Body approval (approval shall not be unreasonably withheld), this provision affords an opportunity for the Medical Staff to have prior notice of any problematic provisions at a point where it may be possible to invoke a meet and confer session (pursuant to Bylaws, Section 9.2-2(b)) to discuss issues of disagreement. Each Medical Staff should evaluate and establish an appropriate threshold for processing amendments proposed by petition of the Medical Staff. See comments accompanying Section 15.1-2.

16.2 Methodology

16.2-1 Medical Staff Bylaws may be adopted, amended or repealed by the following combined actions:

a. The affirmative vote of a majority of the Medical Staff members voting on the matter by mailed secret ballot, provided at least 14 days advance written notice, accompanied by the proposed Bylaws and/or alterations, has been given; and

b. The approval of the Governing Body, which shall not be unreasonably withheld. If approval is withheld, the reasons for doing so shall be specified by the Governing Body in writing, and shall be forwarded to the Chief of Staff, the Medical Executive Committee and the Bylaws Committee.

16.2-2 In recognition of the ultimate legal and fiduciary responsibility of the Governing Body, the organized Medical Staff acknowledges, in the event the Medical Staff has unreasonably failed to exercise its responsibility and after notice from the Governing Body to such effect, including a reasonable period of time for response, the Governing Body may impose conditions on the Medical Staff that are required for continued state licensure, approval by accrediting bodies, or to comply with law or a court order. In such event, Medical Staff recommendations and views shall be carefully considered by the Governing Body in its actions.

COMMENT: Hospital legal counsel should be consulted before any decision to exercise the residual authority described here.The Joint Commission standards preclude unilateral amendment of the Bylaws. Nonetheless, Business & Professions Code Section 2282.5 increases the necessity for including this provision. The enacting legislation (SB 1325 [2004]) noted: "The Governing Body must act to protect the quality of medical care provided and the competency of its Medical Staff and to ensure the responsible governance of the hospital in the event that the Medical Staff fails in any of its substantive duties or responsibilities."

16.3 Technical and Editorial Corrections

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

COMMENT: As noted above, TJC does not allow the MEC to amend the Bylaws. Accordingly, the above provision has been scaled back to permit only nonsubstantive corrections. TJC MS.01.01.01 Task Force discussed at length concerns expressed by some that some hospitals might abuse such a provision by interpreting as nonsubstantive, changes that some would view as substantive. As narrowed, the above provision protects against that possibility. Nonetheless, hospitals may wish to consult with their own legal counsel and/or TJC.

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

At the time of service, I was over 18 years of age and not a party to this action. I am employed in the County of Los Angeles, State of California. My business address is 15760 Ventura Boulevard, 18th Floor, Encino, California 91436-3000.

On February 24, 2012, I served true copies of the following document(s) described as **MOTION FOR JUDICIAL NOTICE; DECLARATION OF ANNA M. SUDA; PROPOSED ORDER** on the interested parties in this action as follows:

SEE ATTACHED SERVICE LIST

BY MAIL: I enclosed the document(s) in a sealed envelope or package addressed to the persons at the addresses listed in the Service List and placed the envelope for collection and mailing, following our ordinary business practices. I am readily familiar with Horvitz & Levy LLP's practice for collecting and processing correspondence for mailing. On the same day that the correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the United States Postal Service, in a sealed envelope with postage fully prepaid.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on February 24, 2012, at Encino, California.

Robin Steiner

SERVICE LIST

El-Attar v HPMC
Case Nos. BS105623/B209056

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