WASHINGTON HEALTH

MEDICAL STAFF

BYLAWS

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Medical Staff Credentialing Policy.

1.B. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by the Chief Executive Officer, by a Medical Staff member, or by a Medical Staff committee, the individual (or the committee through its chair) may delegate performance of the function to one or more designees.

(2) When a Medical Staff member is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.C. MEDICAL STAFF DUES

(1) Annual Medical Staff dues shall be set by the Medical Executive Committee and approved by the Active Staff. They may vary by category.

(2) Dues shall be payable at the beginning of each new Medical Staff year. Failure to pay dues shall result in automatic relinquishment of Medical Staff membership and clinical privileges, as well as ineligibility to apply for Medical Staff reappointment. This automatic relinquishment will be effective immediately upon Special Notice to the individual. An individual has 14 days following the automatic relinquishment to pay his or her dues. At the end of that time period, the individual is deemed to have automatically resigned in accordance with the Credentialing Policy. (In rare circumstances, the Medical Executive Committee may excuse an individual's failure to pay dues for good cause.)

(3) Signatories to the Hospital's Medical Staff account shall be the Chief of Staff, the Chief of Credentials and Bylaws, the Chief of Professional Practice Evaluation, Chief of Quality and Utilization Management, and the Medical Staff Liaison Officer

1.D. SELF GOVERNANCE

The Medical Staff is self-governing with respect to the professional work performed at the Hospital, but is ultimately responsible to the Board for the adequacy and quality of medical care rendered to patients at the Hospital.

1.E. MEDICAL STAFF COUNSEL

Upon the authorization of the Medical Executive Committee, the Medical Staff may retain and be represented by independent legal counsel, who shall be compensated through Medical Staff funds.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Medical Staff Credentialing Policy are eligible to apply for appointment to one of the categories listed below.

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff shall consist of those members of the Medical Staff who are involved in at least 10 patient contacts at Washington Hospital or Washington Outpatient Surgery Center during the two-year appointment term.

2.A.2. Eligibility Guidelines:

Unless an Active Staff member can demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his/her practice patterns have changed and that he or she will satisfy the activity requirements of this category:

Any member who has fewer than 10 patient contacts at Washington Hospital or Washington Outpatient Surgery Center during his or her two-year appointment term will not be eligible to request Active Staff status at the time of reappointment.

The member must select and be transferred to another staff category that best reflects his or her relationship to the Medical Staff and the Hospital.

2.A.3. Prerogatives:

Active Staff members may:

(a) admit patients;

(b) Assist at Surgery

(c) vote in general and special meetings of the Medical Staff and applicable department, section, and committee meetings;

(d) hold office, serve on Medical Staff committees, and serve as department chair, section chair, and committee chair; and

(e) exercise clinical privileges granted.

2.A.4. Responsibilities:

Active Staff members must assume all the responsibilities of the Active Staff, including (but not limited to):

(a) serving on committees, as requested;

(b) participating in the professional practice evaluation and performance improvement processes (including serving as a proctor or reviewing physician, when assigned);

(c) attending at least 50% of the Medical Staff meetings, 50% of their department meetings, and 50% of their section meetings (measured annually);

(d) accepting inpatient consultations, when requested and

(e) paying application fees, dues, and assessments.

2.B. COURTESY STAFF

2.B.1. Qualifications:

The Courtesy Staff shall consist of those members of the Medical Staff who:

(a) are involved in fewer than 10 patient contacts at Washington Hospital or Washington Outpatient Surgery Center during the two-year appointment term;

(b) are members of the Active Staff or Associate Staff at another acute care hospital (unless their clinical specialty does not support an active inpatient practice and the Board makes an exception to this requirement based upon the recommendations of the Medical Staff); and

(c) agree to provide quality data and other information to assist in an appropriate assessment of current clinical competence as set forth in the Credentialing Policy.

2.B.2. Eligibility Guidelines:

Any Courtesy Staff member who has more than nine patient contacts during his or her two-year appointment term will be transferred to Active Staff status.

2.B.3. Prerogatives and Responsibilities:

Courtesy Staff members:

(a) may attend and participate in Medical Staff, department and section meetings (without vote);

(b) may not hold office or serve as department chair, section chair, or committee chair (unless waived by the Medical Executive Committee and ratified by the Board);

(c) may exercise such clinical privileges as are granted;

(d) may be invited to serve on committees (with vote);

(e) must participate in the professional practice evaluation and performance improvement processes (including serving as a proctor or reviewing physician, when assigned)

(f) must pay application fees, dues, and assessments.

(g) may Assist at Surgery

2.C. CONSULTING STAFF

2.C.1. Qualifications:

The Consulting Staff shall consist of those members of the Medical Staff who:

(a) are of demonstrated professional ability and expertise and provide a service not otherwise available on the Active Staff;

(b) provide services at the Hospital only at the request of other members of the Medical Staff;

(c) are members of the Active Staff or Associate Staff at another acute care hospital licensed in California (unless their clinical specialty does not support an active inpatient practice and the Board makes an exception to this requirement); and

(d) at each reappointment time, provide quality data and other information to assist in an appropriate assessment of current clinical competence as set forth in the Credentialing Policy.

2.C.2. Prerogatives and Responsibilities:

Consulting Staff members:

(a) may evaluate and treat (but not admit) patients in conjunction with other members of the Medical Staff, in accordance with the clinical privileges granted;

(b) may attend meetings of the Medical Staff and applicable department and section meetings (without vote) and applicable committee meetings (with vote);

(c) may not hold office or serve as department chair, section chair, or committee chair (unless waived by the Medical Executive Committee and the Board);

(d) agree that they will refrain from encouraging the transfer of this Hospital's patients to other hospital facilities (unless adequate facilities, services, and staffing are unavailable at this Hospital);

(e) must participate in the professional practice evaluation and performance improvement processes (including serving as a proctor or reviewing physician, when assigned); and

(f) must pay application fees, dues, and assessments.

2.C.3. Eligibility Guidelines:

If a member of the Consulting Staff fails to have at least two patient contacts during his or her two-year appointment term, his or her Consulting Staff status will automatically terminate. The Consulting Staff member may avoid this automatic termination by providing at least two favorable references from another acute care hospital, freestanding surgery center, or recognized medical institution.

2.D. AMBULATORY STAFF

2.D.1. Qualifications:

The Ambulatory Staff shall consist of those members of the Medical Staff who desire to be associated with the Hospital for the purpose of providing ambulatory care. Ambulatory Staff members are exempt from the threshold eligibility criterion relating to recent clinical activity in an acute care hospital (as set forth at Section 2.A of the Credentialing Policy). However, they must demonstrate recent clinical activity in an ambulatory care setting (in their primary area of practice) within the past two years.

2.D.2. Prerogatives and Responsibilities:

Ambulatory Staff members:

(a) may attend meetings of the Medical Staff and applicable department and section meetings (voting only on issues that affect members of the Ambulatory Staff, as determined by the Medical Executive Committee)

(b) may not hold office or serve as department chair or section chair (unless waived by the Medical Executive Committee and ratified by the Board);

(c) may serve on committees of the Medical Staff when appointed (with vote)

(d) may attend educational activities sponsored by the Medical Staff and the Hospital;

(e) are encouraged to communicate directly with Medical Staff members regarding the care of any patients referred, as well as to visit any such patients and record a courtesy progress note in the medical record containing relevant information from the patient's outpatient care;

(f) may review the medical records and test results (via paper or electronic access) for any patients who are referred (such review must comply with all Hospital and Medical Staff policies);

(g) are not granted clinical privileges to treat patients on an inpatient basis and may not admit or treat patients at the Hospital;

(h) may exercise any ambulatory care clinical privileges granted

(i) must participate in the professional practice evaluation and performance improvement processes (including serving as a proctor or reviewing physician, when assigned);

(j) are permitted to use the Hospital's diagnostic facilities in accordance with Hospital policy and the Medical Staff Rules and Regulations;

(k) must pay application fees, dues, and assessments.

2.E. ADMINISTRATIVE STAFF

2.E.1. Qualifications:

(a) The Administrative Staff will consist of members of the Medical Staff who are not otherwise eligible for another staff category and who are employed by or have a contract with the Hospital or Medical Staff to perform administrative activities.

(b) Administrative Staff membership will automatically terminate on the date on which the member's affiliation with the Hospital is terminated.

2.E.2. Prerogatives and Responsibilities:

Administrative Staff members:

(a) are not engaged in any clinical practice and do not have the responsibility for patient care, except as these activities may directly relate to an administrative duty;

(b) may not hold office or serve as department chair, section chair, or committee chair (unless waived by the Medical Executive Committee and ratified by the Board);

(c) may attend Medical Staff meetings; and

(d) may be invited to serve on committees (with vote).

2.F. HONORARY STAFF

2.F.1. Qualifications:

(a) The Honorary Staff shall consist of practitioners who have retired from the practice of medicine at Washington Hospital after serving for more than 10 years, who are in good standing, and who have been recommended by the Medical Executive Committee.

(b) Once an individual is appointed to the Honorary Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application/reappointment processing.

2.F.2. Prerogatives and Responsibilities:

Honorary Staff members:

(a) may not consult, admit, or attend to patients;

(b) may attend Medical Staff, department, and section meetings when invited to do so (without vote);

(c) may be appointed to committees (with vote);

(d) are entitled to attend educational programs of the Medical Staff and the Hospital;

(e) may not hold office or serve as department chairs, section chairs, or committee chairs (unless waived by the Medical Executive Committee and ratified by the Board); and

(f) are not required to pay application fees, dues, or assessments.

2.G. PROVISIONAL MEDICAL STAFF

2.G.1 QUALIFICATIONS

The Provisional Medical Staff shall consist of members who:

A. meet the general Medical Staff membership qualifications set forth in Credentialing Policy, 2.A.1,2.A.1, 2.B.1, 2.C.1, 2.G.1 Or 2.D.1

B. were not members of this Medical Staff immediately prior to their application and appointment.

2.G.2 PROVISIONAL PREROGATIVES, OBLIGATIONS, AND LIMITATIONS

A. Provisional Medical Staff members shall be designated as Provisional/Active or Provisional/Courtesy, Provisional/Consulting and Provisional/Ambulatory depending on the staff category to which the member intends to advance;

B. Must attend the next regularly scheduled Physician Orientation offering upon appointment to the Provisional staff. Upon approval of the Department Chair, with cause, may attend the next quarter offering. This bylaw does not apply to physicians offering telemedicine services only.

C. Upon written application to the MEC, a Provisional Medical Staff member may change the selected staff category. The member must meet the requirements of the requested category contained in this section.

D. All Provisional Medical Staff members shall exercise such clinical privileges as are granted pursuant to Article 8.B. Clinical Privileges;

E. Provisional/Active Medical Staff members shall attend 50% of the general meetings and 50% of the department and section meetings during the provisional term.

F. Provisional Medical Staff members shall not be eligible to hold office in the Medical Staff Organization, unless approved by the MEC. They may serve on Committees. Provisional/Active, Provisional/Consulting and Provisional/Ambulatory Medical Staff members shall have voting rights on Committees to which they are appointed. Provisional/Courtesy Medical Staff members shall have no right to vote, unless that right is specified at the time of committee appointment.

2.G.3 OBSERVATION OF PROVISIONAL MEDICAL STAFF MEMBER

Each Provisional Medical Staff member shall undergo a period of observation by designated proctors (as described in Article 8.C. Clinical Privileges).

2.G.4 TERM OF PROVISIONAL MEDICAL STAFF STATUS

Appointment to the Provisional Medical Staff may be for a period not to exceed two (2) years. At the end of one (1) year, the Provisional Medical Staff member shall be evaluated and action may be taken pursuant to Section 3.5-5.A.1-4.

2.G.5. ACTION AT CONCLUSION OF PROVISIONAL MEDICAL STAFF STATUS

A. At the end of the provisional term, not less than one (1) year, the MEC shall make one of the following recommendations

1. if the Provisional Medical Staff member has satisfactorily demonstrated his/her ability to exercise the clinical privileges initially granted by the department and is in compliance with other Medical Staff and Hospital requirements (ability to work cooperatively with other members of the Medical and Hospital Staffs, timely completion and adequacy of medical records, meeting attendance, attendance of the New Physician Orientation, etc.), advance to member of the Active, Ambulatory, Consulting or Courtesy Medical Staff;

2. to advance to Active, Ambulatory, Consulting or Courtesy or Courtesy Medical Staff with the qualification that specific privileges be denied.

3. to terminate membership and all clinical privileges;

4. to extend the provisional term for an additional one (1) year period, not to exceed a total of two (2) provisional years.

B. A recommendation made under Section 3.5-5.A.3 or Section 3.5-5.A.4 shall grant the member the right to review under Article 8.

2.H. ADVANCED PRACTICE PROVIDERS

2.H.1. Qualifications:

The Advanced Practice Provider is a collective term for the Advanced Practice Providers practicing at the Hospital. The Advanced Practice Provider is not a category of the Medical Staff, but is included in this Article for convenient reference.

2.H.2. Prerogatives and Responsibilities:

Advanced Practice Provider members:

(a) may participate in Medical Staff and department meetings (without vote);
(b) may not hold office or serve as department director or committee chair;
(c) may be invited to serve on committees (with vote);
(d) must cooperate in the professional practice evaluation and performance improvement processes;
(e) may exercise such clinical privileges as are granted (in accordance with the Credentialing Policy); and
(f) must pay any applicable application fees, dues, and assessments.

ARTICLE 3

OFFICERS

3.A. DESIGNATION

The officers of the Medical Staff shall be the Chief of Staff, Chief of Credentials and Bylaws, Chief of Professional Practice Evaluation, Chief of Quality and Utilization Management and the Medical Staff Liaison Officer. The Chief of Staff successor (the designated successor) for the subsequent two years will be designated from one of the remaining four Chiefs.

3.B. ELIGIBILITY CRITERIA

Only those members of the Active Medical Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff, unless an exception is recommended by the Medical Executive Committee and approved by the Board. They must:

(1) be appointed in good standing to the Active Staff, and have served on the Active Staff for at least three years

(2) be certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board as defined in the credentialing policy, including the grandfather clause (see, WHHS Medical Staff Credentialing Policy, 2.A.1 t.)

(3) have no pending adverse recommendations concerning Medical Staff membership or clinical privileges;

(4) not presently be serving as Medical Staff officers, Board members, department chairs, section chairs, or committee chairs at any other hospital during their term of office (if serving in other capacities at this Hospital, the officer must be attentive to both time demands and potential of conflicts of interest and accept such other positions only if those issues can be reconciled);

(5) be willing to faithfully discharge the duties and responsibilities of the position and work toward the attainment of the mission and vision of the Hospital;

(6) have an understanding of the purposes and functions of the Medical Staff organization and a demonstrated willingness to assure that patient welfare always takes precedence over other concerns;

(7) have experience in a leadership position (or other involvement in performance improvement functions);

(8) have demonstrated clinical competence in their field of practice;

(9) have demonstrated ability to work well with and motivate others;

(10) have demonstrated administrative ability as applicable to the respective office; and

(11) Must disclose any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner.

All such individuals(applicants) will need to be vetted and approved by the Leadership Development Committee and will be required to obtain education relating to Medical Staff leadership, credentialing, and/or professional practice evaluation functions prior to or during the first weeks of the term of the office and on an ongoing basis as determined by the leadership development committee.

3.C. DUTIES

3.C.1. Chief of Staff:

The Chief of Staff shall:

(a) act in coordination and cooperation with the Chief Executive Officer, Chief Medical Officer, and the Board in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies, concerns, and needs, and report on the activities, of the Medical Staff to the Chief Executive Officer and the Board;

(c) be accountable to the Board, in conjunction with the Medical Executive Committee, for the quality and efficiency of clinical services and performance within the Hospital and for the effectiveness of the performance improvement/professional practice evaluation/case management program functions delegated to the Medical Staff;

(d) call and preside at all regular and special meetings of the Medical Staff and the Medical Executive Committee, and assume responsibility for the agenda of all such meetings;

(e) appoint all committee chairs and members

(f) promote adherence to the Bylaws, policies, and Rules and Regulations of the Medical Staff and to the policies and procedures of the Hospital;

(g) serve as spokesperson for the Medical Staff in external professional and public relations;

(h) recommend Medical Staff representatives to Hospital committees; and

(i) perform all functions authorized in all applicable policies, including, when appropriate, collegial intervention in the Credentialing Policy.

(j) whoever is the designated successor to the chief of staff for the subsequent two year term will assume all duties of the Chief of Staff and act with full authority as Chief of Staff in his or her absence;

3.C.2. The Chief of Credentials and Bylaws:

The Chief of Credentials and Bylaws shall:

(a) serve as chair of the Bylaws Committee, chair of the Credentials Committee, and member of the Joint Conference Committee; and

(b) perform such additional duties as are assigned by the Chief of Staff, the Medical Executive Committee, or the Board.

3.C.3. The Chair of Professional Practice Evaluation:

The Chief of Professional Practice Evaluation shall:

(a) serve as chair of the Professional Practice Evaluation Committee; and

(b) perform such additional duties as are assigned by the Chief of Staff, the Medical Executive Committee, or the Board.

3.C.4 The Chief of Quality and Utilization Management:

The Chief of Quality and Utilization Management shall:

(a) Serve as chair of the Utilization Management Committee and

(b) perform such additional duties as are assigned by the Chief of Staff, the Medical Executive Committee, or the Board.

3.C.5. Medical Staff Liaison Officer:

The Medical Staff Liaison Officer shall:

(a) serve as an advisor and mentor to the Chief of Staff and the other officers;

(b) Will act as a liaison between the individual medical staff member and the medical staff leadership or administration.

(c) be responsible for the minutes of the Joint Conference Committee and general Medical Staff meetings;

(d) serve as a resource and subject matter expert to the Medical Executive Committee on matters pertaining to the Medical Staff Bylaws, Rules and Regulations, and other relevant policies (calling upon legal counsel as necessary);

(e) attend to correspondence and notices on behalf of the Medical Staff (as directed by the Chief of Staff);

(e) serve on select administrative committees (as chosen by the Chief of Staff and Chief Executive Officer), acting as the Medical Staff's liaison and participating in the development of hospital policies; and

(f) perform such additional duties as are assigned by the Chief of Staff, the Medical Executive Committee, or the Board.

3.D. NOMINATIONS

(1) The Leadership Development Committee shall serve as the nominating committee. It will convene at least 60 days prior to the election and will select the names of one or more qualified nominees for the relevant vacant officer positions. All nominees must meet the eligibility criteria in Section 3.B and agree to serve, if elected. Notice of the nominees shall then be provided to the Medical Staff at least 30 days prior to the election.

(2) Additional nominations may be submitted to the Nominating Committee by written petition signed by at least 16 percent of eligible voting staff members at least 15 days prior to the election. In order for a nomination to be added to the ballot, the candidate must meet the qualifications in Section 3.B, in the judgment of the Leadership Development Committee, and be willing to serve.

(3) Nominations from the floor shall not be accepted.

3.E. ELECTION

(1) Elections shall be held solely by written or electronic ballot returned to the Medical Staff Coordinator. Ballots may be returned in person, by mail, by facsimile, or by e-mail. All ballots must be received in the Medical Staff Office by the day of the election. Those who receive a majority of the votes cast shall be elected, subject to Board confirmation.

(2) In the alternative, at the discretion of the Medical Executive Committee, candidates receiving a majority of written votes cast at an official meeting shall be elected, subject to Board confirmation. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

(3) All elections for Medical Staff officers, department chairs, and assistant chairs shall be held by secret ballot.

3.F. TERM OF OFFICE

Each officer will be elected to serve a four-year term as an officer on the leadership and will require re-election for a second four-year term. The leadership slate at the time of the election will state who will be the chief of staff for the first two years and who will be chief of staff for the subsequent two years and would also state which candidate would be holding which leadership position with the understanding that the leadership positions (except for the chief of staff position) could change over the 4 year period. Any change in the leadership positions would have to approved by the MEC. All leadership positions would need to meet established metrics on an ongoing basis to be eligible to continue in their prescribed roles.

3.G. REMOVAL

(1) Removal of an elected officer or member of the Medical Executive Committee may occur on the recommendation of the leadership development committee. This may be effectuated by a two-thirds vote of the Medical Executive Committee, or by a two-thirds vote of the Active Staff, or by the Board. Grounds for removal shall be:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws;

(c) failure to perform the duties of the position held;

(d) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the Medical Executive Committee, the Active Staff, or the Board, as applicable, prior to a vote on removal. No removal shall be effective until approved by the Board.

3.H. VACANCIES

The Chief of Staff Designated Successor will automatically fill any vacancy in the office of Chief of Staff.

In the event there is a vacancy for any of the other officer positions, the Leadership Development Committee will notify all voting members of the Medical Staff that it is seeking petitions for the vacant office. (The remaining Officers will handle the duties of the vacant office until a nominee is selected.) Members have 20 days to respond to the Leadership Development Committee, which will then select a nominee from the slate of petitioners. This nominee will fill the role of the vacant officer position until an election is scheduled with MEC approval.

ARTICLE 4

CLINICAL DEPARTMENTS

4.A. ORGANIZATION

The Medical Staff may be organized into departments and sections, and/or clinical service lines, as listed in the Medical Staff Organization Manual. Subject to the approval of the Board, the Medical Executive Committee may create or eliminate such clinical units as are determined most appropriate to meet the needs of the community. References to "department" can be understood as references to "service line," as appropriate.

4.B. ASSIGNMENT TO CLINICAL DEPARTMENT

(1) Upon initial appointment to the Medical Staff, each member shall be assigned to one or more clinical departments (or service lines) and to a section, if any, within such department. Assignment to a particular clinical department and section does not preclude an individual from seeking and being granted clinical privileges typically associated with another clinical department/service line.

(2) An individual may request a change in clinical department assignment to reflect a change in the individual's clinical practice.

4.C. FUNCTIONS OF CLINICAL DEPARTMENTS

The clinical departments shall be organized for the purpose of implementing processes:

(1) to monitor and evaluate the quality and appropriateness of the care of patients served by the clinical departments; and

(2) to monitor the practice of all those with clinical privileges or a scope of practice in a given service area and recommend privileges to the credentials committee.

4.D. QUALIFICATIONS OF CLINICAL DEPARTMENT CHAIRS

Each clinical department chair and assistant chair shall satisfy all the eligibility criteria outlined in Section 3.B, unless waived by the MEC with notification to the Board

4.E. SELECTION AND REMOVAL OF CLINICAL DEPARTMENT CHAIRS

(1) Except as otherwise provided by contract, clinical department chairs and assistant chairs shall be elected by the voting members of the department, subject to approval by the Medical Executive Committee and the Board.

(2) Elections shall take place at the penultimate meeting of the department (measured across the Medical Staff year). At least 60 days prior to that meeting, the assistant chair will distribute notice of the election and a request for petitions.

(3) Petitions should be returned to the Leadership Development Committee within 20 days after the request is made. The Leadership Development Committee will then verify the qualifications of each petitioner. If the Leadership Development Committee encounters any difficulties in evaluating a petitioner's qualifications, or if the Leadership Development Committee's decision is challenged by at least 16% of eligible voting members of the department, the Medical Executive Committee will resolve the concern.

(4) The slate of candidates will be announced at the meeting preceding the election. Nominations from the floor will not be accepted after this meeting.

(5) The election will be held by secret ballot.

(6) If a vacancy should arise in the department chair position, the assistant chair will assume the role and a special election will be held to fill the role of assistant chair. The department may adopt department-specific rules on vacancies by majority vote. The assistant chair will complete the current term and his/her scheduled term

(7) Any department chair and assistant chair removal may occur on the recommendation of the leadership development committee. This is confirmed by a two-thirds vote of the clinical department members, subject to Board confirmation; or by a two-thirds vote of the Medical Executive Committee, subject to Board confirmation; or by the Board. Grounds for removal shall be:

(a) failure to comply with applicable policies and Bylaws;

(b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws;

(c) failure to perform the duties of the position held;

(d) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(8) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action is to be considered. The individual shall be afforded an opportunity to speak to the

department, the Medical Executive Committee, or the Board, as applicable, prior to a vote on removal. No removal shall be effective until approved by the Board.

(9) Clinical department chairs and assistant chairs shall serve for a term of two years and may be re-elected.

4.F. DUTIES OF CLINICAL DEPARTMENT CHAIRS

Clinical department chairs (and assistant chairs in the absence of the chair) shall work in collaboration with Medical Staff Leaders and other Hospital personnel to collectively be responsible for the following:

(1) coordinating all clinically-related activities of the department;

(2) coordinating all administratively-related activities of the department;

(3) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges, including performing ongoing and focused professional practice evaluations (OPPE and FPPE), as outlined in the professional practice evaluation and ongoing professional practice evaluation policies;

(4) recommending criteria for clinical privileges that are relevant to the care provided in the department;

(5) evaluating requests for clinical privileges for each member of the department;

(6) assessing and recommending off-site sources for needed patient care, treatment, and services not provided by the clinical department or the Hospital;

(7) integrating the department into the primary functions of the Hospital;

(8) coordinating and integrating the services provided;

(9) developing and implementing policies and procedures that guide and support the provision of care, treatment, and services in the clinical department;

(10) making recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

(11) determining the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

(12) continuously assessing and improving the quality of care, treatment, and services provided within the clinical department;

(13) maintaining quality monitoring programs, as appropriate;

(14) providing for the orientation and continuing education of all persons in the clinical department;

(15) making recommendations for space and other resources needed by the department;

(16) performing all functions authorized in the Credentialing Policy, including collegial intervention efforts;

(17) reporting to the Medical Executive Committee and to the Chief of Staff regarding all professional and administrative activities within the department; and

(18) assisting in preparation of such annual reports, including budgetary planning, pertaining to his or her department, as may be required by the Medical Executive Committee.

4.G. SECTIONS

4.G.1. Functions of Sections:

(a) Sections will perform the following activities:

(1) participation in the development of criteria for clinical privileges (when requested by the department chair);

(2) participation in professional practice evaluation and quality assurance; and

(3) discussion of a specific issue (at the special request of a department chair or the Medical Executive Committee).

(b) Sections may perform any of the following activities:

(1) continuing education;

(2) discussion of policy;

(3) discussion of equipment needs; and

(4) development of recommendations to the department chair or the Medical Executive Committee.

4.G.2. Selection and Removal of Section Chairs:

(a) Each section chair shall satisfy all the eligibility criteria outlined in Section 3.B of these Bylaws, unless waived by the Board after considering the recommendation of the Medical Executive Committee.

(b) Section chairs shall be selected and removed in the same manner outlined for department chairs in Section 4.E of these Bylaws.

4.G.3. Duties of Section Chairs:

The section chair shall carry out those functions delegated by the department chair, assistant chair, or the Medical Executive Committee, which may include the following:

(a) review and report on applications for initial appointment and clinical privileges;

(b) review and report on applications for reappointment and renewal of clinical privileges;

(c) evaluate individuals during the FPPE period in order to confirm the individual's competence;

(d) participate in the development of criteria for clinical privileges within the section;

(e) review and report regarding the professional performance of individuals practicing within the section;

(f) support the department chair in making recommendations regarding the coordination of sectional activities, as well as the Hospital resources necessary for the section to function effectively;

(g) submit reports to the department chair regarding the clinical privileges exercised within his or her section by members of (or applicants to) the Medical Staff; and

(h) perform such other duties commensurate with the office as may from time to time be requested by the department chair, assistant chair, Chief of Staff, or the Medical Executive Committee.

ARTICLE 5

MEDICAL STAFF COMMITTEES

5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

This Article and the Medical Staff Organization Manual outline the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.

5.B. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

(1) Unless otherwise indicated, all committee chairs and members shall be appointed by the Chief of Staff. Committee chairs shall be selected based on the criteria set forth in Section 3.B of these Bylaws and must signify their willingness to meet basic expectations of committee membership as set forth in Section 3.B of the Organization Manual.

(2) Unless otherwise indicated, committee chairs and members shall be appointed for initial terms of two years, but may be reappointed for additional terms. All appointed chairs and members may be removed and vacancies filled by the Chief of Staff, at his or her discretion.

(3) Unless otherwise indicated, all Hospital and administrative representatives on the committees shall be appointed by the Chief Executive Officer. All such representatives shall serve on the committees, without vote.

(4) Unless otherwise indicated, the Chief of Staff, the Chief of Medical Services, and the Chief Executive Officer (or their respective designees) shall be members, *ex officio*, without vote, on all committees.

5.C. MEETINGS, REPORTS, AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in these Bylaws or in the Medical Staff Organization Manual shall meet as necessary to accomplish its functions and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely report after each meeting to the Medical Executive Committee and to other committees and individuals as may be indicated.

5.D. MEDICAL EXECUTIVE COMMITTEE

5.D.1. Composition:

(a) The Medical Executive Committee shall consist of the officers of the Medical Staff and the department chairs.

(b) The Chief of Staff will chair the Medical Executive Committee.

(c) The Chief Executive Officer, the Chief Medical Officer, the Chief of Patient Care Services, the Chief Medical Information Officer, the Professional Practice Evaluation Officer shall be *ex officio* members of the Medical Executive Committee, without vote.

(d) The Medical Executive Committee will also include the Chair of Quality and Resource Management Committee, the Chair of the Leadership Development Committee, a representative from the Pharmacy, Nutrition, and Therapeutics committee and a representative from the Clinical Evaluation Committee, Critical Care Committee, Emergency Department, Physician Well Being, Pathology and Laboratory Services *ex officio*, without vote.

(e) Other Medical Staff members or Hospital personnel may be invited to attend a particular Medical Executive Committee meeting (as guests, without vote) in order to assist the Medical Executive Committee in its discussions and deliberations regarding an issue(s) on its agenda. These individuals shall be present only for the relevant agenda item(s) and shall be excused for all others. Such individuals are an integral part of the professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of the Medical Executive Committee.

5.D.2. Duties:

(a) The Medical Executive Committee is delegated the primary authority over activities related to the functions of the Medical Staff and for performance improvement of the professional services provided by individuals with clinical privileges. This authority may be removed by amending these Bylaws and related policies.

(b) The Medical Executive Committee is responsible for the following:

(1) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between Medical Executive Committee meetings);

(2) recommending directly to the Board on at least the following:

(i) the Medical Staff's structure;

(ii) the mechanism used to review credentials and to delineate individual clinical privileges;

(iii) applicants for Medical Staff appointment and reappointment;

(iv) delineation of clinical privileges for each eligible individual;

(v) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;

(vi) the mechanism by which Medical Staff appointment may be terminated;

(vii) hearing procedures; and

(viii) reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate;

(3) consulting with administration on quality-related aspects of contracts for patient care services;

(4) reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services;

(5) providing leadership in activities related to patient safety;

(6) providing oversight in the process of analyzing and improving patient satisfaction;

(7) ensuring that, at least every five years, the Bylaws, policies, and associated documents of the Medical Staff are reviewed and updated;

(8) providing and promoting effective liaison among the Medical Staff, Administration, and the Board; and

(9) performing such other functions as are assigned to it by these Bylaws, the Credentialing Policy, or other applicable policies.

5.D.3. Meetings:

The Medical Executive Committee shall meet at least once per month and shall maintain a permanent record of its proceedings and actions.

5.E. PERFORMANCE IMPROVEMENT FUNCTIONS

(1) The Medical Staff is actively involved in the measurement, assessment, and improvement of at least the following:

(a) patient safety, including processes to respond to patient safety alerts, meet patient safety goals, and reduce patient safety risks;

(b) the Hospital's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;

(c) medical assessment and treatment of patients;

(d) medication usage, including review of significant adverse drug reactions, medication errors, and the use of experimental drugs and procedures;

(e) the utilization of blood and blood components, including review of significant transfusion reactions;

(f) operative and other invasive procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(g) appropriateness of clinical practice patterns;

(h) significant departures from established patterns of clinical practice;

(i) use of information about adverse privileging determinations regarding any practitioner;

(j) the use of developed criteria for autopsies;

(k) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(l) nosocomial infections and the potential for infection;

(m) unnecessary procedures or treatment;

(n) appropriate resource utilization;

(o) education of patients and families;

(p) coordination of care, treatment, and services with other practitioners and Hospital personnel;

(q) accurate, timely, and legible completion of medical records;

(r) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in Appendix B of these Bylaws;

(s) review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual's performance; and

(t) communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members and the Board.

(2) A description of the committees that carry out systematic monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Medical Staff Organization Manual.

5.F. CREATION OF STANDING COMMITTEES

In accordance with the amendment provisions in the Organization Manual, the Medical Executive Committee may, by resolution and upon approval of the Board and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. In the same manner, the Medical Executive Committee may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special committee shall be performed by the Medical Executive Committee.

5.G. SPECIAL COMMITTEES

Special committees shall be created and their members and chairs shall be appointed by the Chief of Staff and/or the Medical Executive Committee. Such special committees shall confine their activities to the purpose for which they were appointed and shall report to the Medical Executive Committee.

ARTICLE 6

MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year begins on July 1 and ends on June 30.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

Regular meetings of the Medical Staff shall be held at least quarterly at a time and place designated by the Medical Executive Committee. A minimum of four meetings will be held yearly.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the Chief of Staff, the Medical Executive Committee, or by a petition signed by at least 20% of the voting staff.

6.C. DEPARTMENT, SECTION, AND COMMITTEE MEETINGS

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Organization Manual, the chairs of departments, sections and committees will establish the times for regular meetings. Departments or sections must hold regular meetings at least quarterly. The chairs shall make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

6.C.2. Special Meetings:

A special meeting of any department, section or committee may be called by the chair thereof, and must be called by the chair at the written request of the Board, the Presiding Officer, the Chief of Staff, the Medical Executive Committee, or by a petition signed by not less than 20% of the voting staff members of the department, section or committee (but in no event fewer than two members).

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

(a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of departments, sections and committees at least

14 days in advance of the meetings. The means of notification shall be at the discretion of the Medical Staff Services Department and may be accomplished through written, electronic, or telephonic means, including, but not limited to, posting and electronic scheduling. All notices shall state the date, time, and place of the meetings.

(b) When a special meeting of the Medical Staff, a department, a section, or a committee (other than the Medical Executive Committee) is called, the required notice period shall be reduced to 48 hours (i.e., must be given at least 48 hours prior to the special meeting). The required notice period for special meetings of the Medical Executive Committee shall be reduced to 24 hours. In addition, posting may not be the sole mechanism used for providing notice of any special meeting.

(c) The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

6.D.2. Quorum and Voting:

(a) For any regular or special meeting of the Medical Staff, department, section, or committee, those voting members present (but not fewer than three) shall constitute a quorum. Exceptions to this general rule exist for meetings of the Medical Executive Committee, Quality & Resource Management Committee, the Credentials Committee, and the Professional Practice Evaluation Committee; in those circumstances, the presence of at least 50% of the voting members of the committee shall constitute a quorum.

(b) Recommendations and actions of the Medical Staff, departments, sections, and committees shall be by consensus when possible. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those voting members present.

(c) In the discretion of the Presiding Officer (e.g., the Chief of Staff, the department chair, or the committee chair), as an alternative to a formal meeting, the voting members of the Medical Staff, a department, section, or a committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, telephone, or other technology approved by the Chief of Staff, and their votes returned to the Presiding Officer by the method designated in the notice. Except for amendments to these Bylaws and actions by the Medical Executive Committee, the Credentials Committee, and the Professional Practice Evaluation Committee (as noted in (a)), a quorum for purposes of these votes shall be the number of responses returned to the Presiding Officer by the date indicated (but not fewer than two). The question raised shall be determined in the affirmative and shall be binding if a majority of the responses returned has so indicated.

(d) Meetings may be conducted by e-mail, telephone conference, or videoconference.

6.D.3. Agenda:

The Presiding Officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department, or committee.

6.D.4. Rules of Order:

The Davis Rules of Order shall not be binding at meetings and elections, but will be used for reference. Rather, specific provisions of these Bylaws and Medical Staff, department, or committee custom shall prevail at all meetings. The Presiding Officer shall have the authority to rule definitively on all matters of procedure.

6.D.5. Minutes, Reports, and Recommendations:

(a) Minutes of all meetings of the Medical Staff, departments, and committees shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the Presiding Officer.

(b) A summary of all recommendations and actions of the Medical Staff, departments, and committees shall be transmitted to the Medical Executive Committee. The Board shall be kept apprised of the recommendations of the Medical Staff and its clinical departments and committees.

(c) A permanent file of the minutes of all meetings shall be maintained by the Hospital.

6.D.6. Confidentiality:

All Medical Staff business conducted by committees or departments is considered confidential and proprietary and should be treated as such. However, members of the Medical Staff who have access to, or are the subject of, credentialing and/or professional practice evaluation information understand that this information is subject to heightened sensitivity and, as such, agree to maintain the confidentiality of this information. Credentialing and professional practice evaluation documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or professional practice evaluation processes, except as authorized by the Credentialing Policy or other applicable Medical Staff or Hospital policy. A breach of confidentiality with regard to any Medical Staff information may result in the imposition of disciplinary action.

ARTICLE 7

INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, department chairs, section chairs, committee chairs, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by the District's corporate bylaws and California law.

ARTICLE 8

BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentialing Policy in a more expansive form.

8.A. QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges requested as set forth in the Credentialing Policy.

8.B. PROCESS FOR PRIVILEGING

Requests for privileges are provided to the applicable clinical department chair, who reviews the individual's education, training, and experience and prepares a report (on a form provided by the Medical Staff Office) stating whether the individual meets all qualifications. The Credentials Committee then reviews the chair's assessment, the application, and all supporting materials and makes a recommendation to the Medical Executive Committee. The Medical Executive Committee may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the Medical Executive Committee to grant privileges is favorable, it is forwarded to the Board for final action. If the recommendation of the Medical Executive Committee is unfavorable, the individual is notified by the Chief of Staff of the right to request a hearing.

8.C. PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT)

Complete applications are provided to the applicable department chair, who reviews the individual's education, training, and experience and prepares a report (on a form provided by the Medical Staff Office) stating whether the individual meets all qualifications. The Credentials Committee then reviews the chair's assessment, the application, and all supporting materials and makes a recommendation to the Medical Executive Committee. The Medical Executive Committee may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the Medical Executive Committee to grant appointment or reappointment is favorable, it is forwarded to the Board for final action. If the recommendation of the Medical Executive Committee is unfavorable, the individual is notified by the Chief of Staff of the right to request a hearing.

8.D. DISASTER PRIVILEGING

When the Emergency Operations plan has been implemented, the Chief Executive Officer or Chief of Staff may use a modified credentialing process to grant disaster privileges after verification of the volunteer's identity and licensure.

8.E. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

(1) Appointment and clinical privileges may be automatically relinquished if an individual:

(a) fails to do any of the following:

(i) timely complete medical records; ?

(ii) satisfy threshold eligibility criteria;

(iii) comply with training or educational requirements;

(iv) provide requested information; or

(v) attend a mandatory meeting to discuss issues or concerns

(b) is involved or alleged to be involved in criminal activity as defined in the Credentialing Policy;

(c) makes a deliberate misstatement or omission on an application form; or

(d) remains absent on leave for longer than one year, unless an extension is granted by the Chief of Staff and/or the Medical Executive Committee.

(2) Automatic relinquishment shall take effect immediately and shall continue until the matter is resolved, if applicable.

8.F. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the Chief Executive Officer, the Chief of Staff, the Medical Executive Committee, or a Medical Staff Officer is authorized to suspend or restrict all or any portion of an individual's clinical privileges.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the Chief of Staff or the Medical Executive Committee.

(3) The individual shall be provided a brief written description of the reason(s) for the precautionary suspension within three working days.

(4) The Medical Executive Committee will review the reasons for the suspension within a reasonable time under the circumstances, not to exceed 14 days.

(5) Prior to, or as part of, this review, the individual will be given an opportunity to meet with the Medical Executive Committee.

8.G. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES

Following an investigation or a determination that there is sufficient information upon which to base a recommendation, the Medical Executive Committee may recommend suspension or revocation of appointment or clinical privileges based on concerns about (a) clinical competence or practice; (b) safety or proper care being provided to patients; (c) violation of ethical standards or the Bylaws, policies, or Rules and Regulations of the Hospital or the Medical Staff; or (d) conduct that is inconsistent with the Medical Staff Professionalism policy.

8.H. HEARING AND APPEAL PROCESS, INCLUDING PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS AND THE COMPOSITION OF THE HEARING PANEL

(1) The hearing will begin no sooner than 30 days after the notice of the hearing, unless a date outside of this time frame is agreed upon by the parties.

(2) The Hearing Panel will consist of at least three members.

(3) The hearing process will be conducted in an informal manner consistent with California law; formal rules of evidence or procedure will not apply.

(4) A stenographic reporter will be present to make a record of the hearing.

(5) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness on any matter relevant to the issues; (d) to have representation by counsel in accordance with California law; and (e) to submit proposed findings, conclusions, and recommendations to the Hearing Panel.

(6) The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

(7) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

(8) The affected individual and the Medical Executive Committee may request an appeal of the recommendations of the Hearing Panel to the Board.

ARTICLE 9

AMENDMENTS

9.A. MEDICAL STAFF BYLAWS

(1) Neither the Medical Executive Committee, the Medical Staff, nor the Board shall unilaterally amend these Bylaws.

(2) Amendments to these Bylaws may be proposed by the Medical Executive Committee or by a petition signed by at least 33% of the voting members of the Medical Staff.

(3) All proposed amendments to these Bylaws must be reviewed by the Medical Executive Committee prior to a vote by the Medical Staff. The Medical Executive Committee shall present all proposed amendments to the voting staff by written ballot or e-mail to be returned to the Medical Staff Office by the date indicated by the Medical Executive Committee. Along with the proposed amendments, the Medical Executive Committee may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, (i) the amendment must be voted on by at least 33% of the voting staff, and (ii) the amendment must receive a majority of the votes cast.

(4) The Medical Executive Committee shall have the power to adopt technical, non-substantive amendments to these Bylaws which are needed because of reorganization, renumbering, punctuation, spelling, or other errors of grammar or expression.

(5) All amendments shall be effective only after approval by the Board, which approval shall not be unreasonably withheld.

(6) If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the Chief Executive Officer within two weeks after receipt of a request.

9.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there shall be policies, procedures, and Rules and Regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of

practice. All Medical Staff policies, procedures, and Rules and Regulations shall be considered an integral part of the Medical Staff Bylaws, but will be amended in accordance with this section. These additional documents are the Medical Staff Credentialing Policy, the Policy on Advanced Practice Professionals, the Medical Staff Organization Manual, and the Medical Staff Rules and Regulations.

(2) An amendment to the Credentialing Policy or the Policy on Advanced Practice Professionals may be made by a majority vote of the members of the Medical Executive Committee, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Medical Executive Committee. Notice of all proposed amendments to these two documents shall be provided to each voting member of the Medical Staff at least 14 days prior to the Medical Executive Committee meeting when the vote is to take place. Any voting member may submit written comments on the amendments to the Medical Executive Committee.

(3) An amendment to the Medical Staff Organization Manual or the Medical Staff Rules and Regulations may be made by a majority vote of the members of the Medical Executive Committee. Notice of all proposed amendments to these documents shall be provided to each voting member of the Medical Staff at least 14 days prior to the Medical Executive Committee meeting when the vote is to take place. Any voting member may submit written comments on the amendments to the Medical Executive Committee.

(4) All other policies of the Medical Staff may be adopted and amended by a majority vote of the Medical Executive Committee. No prior notice is required.

(5) Amendments to Medical Staff policies and Rules and Regulations may also be proposed by a petition signed by at least 25% of the voting members of the Medical Staff. Any such proposed amendments will be reviewed by the Medical Executive Committee, which may comment on the amendments before they are forwarded to the Board for its final action.

(6) Adoption of, and changes to, the Credentialing Policy, Medical Staff Organization Manual, Policy on Advanced Practice Professionals, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.

(7) The present Medical Staff Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present Rule or Regulation is inconsistent with these Bylaws, it is of no force or effect.

9.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the Medical Executive Committee with regard to:

(a) proposed amendments to the Medical Staff Rules and Regulations;

(b) a new policy proposed or adopted by the Medical Executive Committee; or

(c) proposed amendments to an existing policy that is under the authority of the Medical Executive Committee,

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by not less than 25% of the voting members of the Medical Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

(2) If the differences cannot be resolved, the matter shall be referred to the Joint Conference Committee (as described in the Organization Manual) for further review and disposition.

(3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

(4) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Rules and Regulations or other Medical Staff policies directly to the Board. Communication from Medical Staff members to the Board will be directed through the Chief Executive Officer, who will forward the request for communication to the Chair of the Board. The Chief Executive Officer will also provide notification to the Medical Executive Committee by informing the Chief of Staff of all such exchanges. The Chair of the Board will determine the manner and method of the Board's response to the Medical Staff member(s).

ARTICLE 10

ADOPTION

These Medical Staff Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, Rules, and Regulations, policies, manuals, or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: May 19, 2025

Approved by the Board: June 11, 2025

APPENDIX A

MEDICAL STAFF CATEGORIES SUMMARY

	Active	**Courtesy**	**Consulting**	**Ambulatory**	**Admin.**	**Honorary**
Number of hospital contacts/2-year	≥ 10	< 9	≥ 2	N/A	N/A	N/A
Admit	Y	Y	N	N	N	N
Exercise clinical privileges	Y	Y	Y	N	N	N
May attend meetings	Y	Y	Y	Y	Y	Y
Voting	Y	P	P	P	P	P
Hold office	Y	N, unless waiver	N, unless waiver	N, unless waiver	N, unless waiver	N, unless waiver

Y = Yes
N = No
P = Partial (with respect to voting, only when appointed to a committee)

APPENDIX B

HISTORY AND PHYSICAL EXAMINATIONS

GENERAL DOCUMENTATION REQUIREMENTS

(1) A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by an individual who has been granted privileges by the Hospital to perform histories and physicals.

(2) The scope of the medical history and physical examination is set forth in the Medical Staff Rules & Regulations, and may vary depending on the setting and the level of care, treatment, and services. At a minimum, a complete medical history and physical examination will determine whether there is anything in the patient's overall condition that would affect the planned course of the patient's treatment, addressing factors such as:

(a) patient identification;

(b) medical history, including chief complaint and details of present illness;

(c) relevant past, social, and family histories;

(d) inventory of body systems, as pertinent;

(e) summary of the patient's psychosocial needs (as appropriate to the patient's age);

(f) report of physical examination, as pertinent;

(g) information regarding allergies, immunization status (pediatrics only), and current medications;

(h) information on the conclusions or impressions drawn from the admission history and physical examination; and

(i) statement on the course of action planned for this episode of care and its periodic review, as appropriate.

H&Ps PERFORMED PRIOR TO ADMISSION

(1) Any history and physical performed more than 30 days prior to an admission or registration is invalid and may not be entered into the medical record.

(2) If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible, or electronic copy of this report may be used in the patient's medical record, provided that the patient has been reassessed within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first. The update of the history and physical examination must reflect any changes in the patient's condition since the date of the original history and physical or state that there have been no changes in the patient's condition.

SHORT STAY AND ELECTIVE PROCEDURES

(1) History and physical examinations for short stays (i.e., same day discharge) must be dictated or documented in the record by 6:00 p.m. on the day prior to surgery.

(2) History and physical examinations for all other elective surgical and invasive procedures (except PTCA) must be dictated or documented in the record on the day prior to the procedure.