

**LAKEWOOD REGIONAL MEDICAL CENTER  
MEDICAL STAFF BYLAWS**

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PREAMBLE

WHEREAS, Tenet Healthsystem Hospitals, Inc., is a subsidiary Tenet Healthcare and is doing business as LAKEWOOD REGIONAL MEDICAL CENTER organized under the laws of the State of California to serve as a general community hospital providing patient care, education and research with all of its activities subject to the ultimate authority of its Governing Board; and

WHEREAS, the laws, regulations, customs and generally recognized professional standards that govern hospitals require that all practitioners practicing at a hospital be formally organized into a collegial body of professionals, providing for its members mutual education, consultation and clinical support, constituting the hospital's medical staff; and

WHEREAS, a hospital's medical staff is the organizational component to which a hospital's board must delegate responsibilities relating to, and exact accountability for, the quality and appropriateness of professional performance; and

WHEREAS, a hospital's board and management require a source of collective advice from the professionals practicing at the hospital in aid of institutional policy formulating and enforcement, planning, coordination of services and governance; and

WHEREAS, a purpose of the hospital is to provide optimal, achievable patient care and otherwise fulfill professional and institutional obligations to patients, students and the community; and

WHEREAS, dedication to this purpose requires a cooperative effort among the professional peers practicing in the hospital and between them and the hospital board and management, with well defined lines of communication, responsibility and authority throughout the organizational structure; and

WHEREAS, these bylaws are intended to describe the internal policies and procedures of the Medical Staff and are not to be considered to create contract obligations on behalf of the Hospital or Medical staff to applicants or members.

THEREFORE, the practitioners practicing in this hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws, Rules and Regulations, and the Bylaws, Rules and Regulations of Hospital.

## DEFINITIONS

**ADMINISTRATOR or CHIEF EXECUTIVE OFFICER:** The individual appointed by the Board to act on its behalf in the overall management of the hospital.

**ALLIED HEALTH PROFESSIONAL or AHP:** An individual other than a physician, dentist, podiatrist, or psychologist who is functioning within the hospital, who exercises independent judgment within the areas of their professional competence and who is qualified to render direct or indirect patient care (which may be subject to the supervision of a practitioner) and whose patient care activities and authority are processed through the defined medical staff channels.

**CHIEF OF STAFF:** The chief officer of the medical staff elected by the members of the active medical staff.

**CLINICAL PSYCHOLOGIST or PSYCHOLOGIST:** A professional who possesses a Ph.D. in clinical psychology from an accredited university and possesses a current license issued by the California Medical Board with specialization in clinical psychology.

**DEPARTMENT CHAIR:** A member of the active medical staff who is duly appointed or elected to serve as the head or director of a clinical department.

**EX OFFICIO:** A member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

**GOVERNING BODY or BOARD:** The local governing board of the hospital.

**HOSPITAL:** Lakewood Regional Medical Center

**Investigation:** A process specifically instigated by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a member of the medical staff, and does not include activity of the medical staff aid committee.

**LOCUM TENENS:** A LIP temporarily taking the place of another.

**MAIL:** Except for communications that the Bylaws specify must be sent by certified mail, all notices and references to "mail" in these bylaws shall be deemed to include U.S. Mail, e-mail, private courier, hand delivery and/or facsimile. All members are required to provide the Medical Staff Office an e-mail address where they may receive notices, including but not limited to notices of proposed revisions or approved revisions to Medical Staff bylaws, rules or policies, which members then may either review online or obtain from the Medical Staff Services Office.

**MEDICAL DISCIPLINARY CAUSE/MEDICAL DISCIPLINARY CAUSE OR REASON (MDCR):** A basis for disciplinary action involving aspects of a LIP's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

**MEDICAL STAFF:** Those physicians, dentists, podiatrists, and psychologists who have been granted recognition as members of the medical staff pursuant to the terms of these Bylaws.

**MEDICAL STAFF EXECUTIVE COMMITTEE or EXECUTIVE COMMITTEE:** The executive committee of the medical staff which shall constitute the governing body of the medical staff as described in these Bylaws.

**MEDICAL STAFF MEMBER or MEMBER:** Unless otherwise expressly limited, any physician (M.D. or D.O.), dentist, podiatrist, or psychologist holding a current

license to practice within the scope of their license who has been granted membership on the medical staff.

**MEDICAL STAFF YEAR:** From January 1 to December 31 each calendar year.

**LICENSED INDEPENDENT PRACTITIONER:** Any physician (M.D. or D.O.), dentist, podiatrist, or psychologist holding a current license to practice within the scope of his or her license.

**PREPONDERANCE OF CARE:** (As relates to patient care activity requirements to retain staff status) more of a LIPs patients are admitted or cared for at this hospital than at any other hospital where the physician has privileges.

**PREROGATIVE:** A participatory right granted by virtue of staff category or otherwise, to a staff member or non-hospital employed allied health professional, and exercisable subject to the conditions and limitations imposed by these Bylaws and in other hospital and medical staff policies.

**PRIVILEGES or CLINICAL PRIVILEGES:** The permission granted to a medical staff member to render specific patient services.

**Telemedicine:** The use of electronic communication or other communication technologies to provide or support clinical care at a distance. Diagnosis and treatment of a patient may be performed via telemedicine link in those clinical services as recommended by the medical staff.

**Telemedicine Practitioner:** any licensed and appropriately credentialed practitioner who prescribes, renders a diagnosis or otherwise provides clinical treatment to a patient who has expressly applied for and been granted telemedicine privileges.

ARTICLE 1 NAME

The name of this organization shall be the Medical Staff of Lakewood Regional Medical Center.

ARTICLE 2 PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

2.1 PURPOSES

The purposes of the medical staff are:

1. To constitute a professional collegial body, providing for its members mutual education, consultation and professional support, to the end that patient care provided at the hospital is consistently maintained at that level of quality which is optimally achievable given the state of the healing arts and the available resources.
2. To serve as the collegial body through which individual LIP's may obtain membership prerogatives and clinical privileges at the hospital to provide clinical services to patients and to engage in teaching and research.
3. To develop an organizational structure, reflected in medical staff bylaws, rules and regulations and other related protocols and manuals, which adequately defines responsibility and accompanying authority and accountability of every organizational component and is designed to assure that each member exercises responsibility and authority commensurate with their contributions to patient care and to the teaching and research needs at the hospital, and fulfills like accountability obligations and to create a framework within which medical staff members can act with a reasonable degree of freedom and confidence.
4. To provide a mechanism for accountability to the Board, through defined medical staff components, for the appropriateness of the patient care services, professional and ethical conduct, and teaching and research activities of each individual LIP holding membership in the medical staff.
5. To provide a means or method by which members of the medical staff can formulate recommendations for the hospital's policy-making and planning processes, and through which such policies and plans are communicated to and observed by each member of the staff.
6. To provide a mechanism by which one level of care will be provided to patients throughout the facility.
7. To acknowledge and adhere to the Patients Rights in accordance with California Title 22, Section 70707 and Joint Commission on Accreditation of Healthcare Organizations Rights and Responsibilities of Patients.

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2.2 RESPONSIBILITIES

To effectuate the purposes enumerated above, it is the obligation and responsibility of the medical staff:

1. To participate in quality improvement processes as required by applicable laws, regulations and accreditations standards in accordance with the Medical Staff Bylaws, Rules and policies and those Hospital policies that have been approved by the Medical Executive Committee. The foregoing shall include without limitation:
  - a) Evaluating LIP and institutional performance through valid and reliable measurement systems based at least in part on objective, clinically valid criteria.
  - b) Engaging in the ongoing monitoring of critical aspects of care and enforcement of medical staff and hospital policies.
  - c) Evaluating LIP credentials for initial and continued membership in the medical staff organization and for the delineation of clinical privileges for each individual LIP in the hospital.
  - d) Arranging for staff participation in programs designed to meet the educational needs of its members.
  - e) Assuring that medical and health care services at the hospital are appropriately employed for meeting patients' medical, social and emotional needs, consistent with sound health care resource utilization practices.
2. To make recommendations to the board concerning appointments and reappointments to the staff, including membership category and department assignment, clinical privileges, specified services for allied health professionals, and corrective action.
3. To maintain sound professional practice and an atmosphere conducive to the diagnosis and treatment of illness, to teaching and to research.
4. To develop or participate in and to monitor the staff's education and training programs.
5. To develop, administer, and recommend amendments to these bylaws, its supporting manuals and plans and the rules and regulations of the staff and its various components to reflect the hospital's current practices with respect to medical staff organization and functions.
6. To enforce compliance with the bylaws and rules and regulations of the staff and of its administrative and clinical components, and with hospital bylaws and policies.
7. To participate in the Board's short and long range planning activities, to assist in identifying community health needs and to suggest to the Board appropriate institutional policies and programs to meet those needs.
8. To exercise the authority by these bylaws as necessary to fulfill the foregoing responsibilities in a proper and timely manner.

ARTICLE 3 MEMBERSHIP

3.1 GENERAL QUALIFICATIONS

Every LIP who seeks or enjoys staff membership must, at the time of appointment and continuously thereafter, demonstrate to the satisfaction of the medical staff and of the Board the following qualifications. Failure to do so shall be cause for expulsion or exclusion from the medical staff.

1. Licensure: A currently valid license issued by the State of California to practice medicine, dentistry, podiatry, or clinical psychology.
2. Liability Insurance: Current valid malpractice insurance coverage with minimum amount of \$1,000,000 per incident; \$3,000,000 aggregate.
3. DEA Certificate: With the exception of Pathologists, a current valid Controlled Substances Registration Certificate from the Drug Enforcement Administration is required. Any restrictions imposed on a member's DEA certificate will be automatically imposed on the member's prescribing privileges.
4. Performance: Professional education, training, experience and clinical results, documenting a continuing ability to provide optimally achievable patient care services.
5. Attitude: A willingness and capability, based on current attitude and evidence of performance.
  - a) To demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of healthcare teams and to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession and society.
  - b) To participate equitably in the discharge of staff obligations appropriate to staff membership category; and
  - c) To adhere to generally recognized standards of professional ethics, including, without limitation, prohibitions against fee splitting, "ghost" surgery, delegating the responsibility for diagnosis or care of patients to a LIP not qualified to undertake that responsibility and failing to obtain informed patient consent to treatments.
6. Disability: To be free of or have under adequate control any significant physical or behavioral impairment that interferes with, or presents a substantial probability of interfering with, qualifications required by Section 1, Items 4 and 5 of this Article, such that patient care is or is likely to be adversely affected.
7. Hospital and Community Need and Ability to Accommodate: In acting on new applications for staff membership and clinical privileges, in staff membership status, or in clinical unit affiliation,

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consideration must be given to and an explicit finding made concerning the hospital's current and projected patient care, teaching and research needs and the hospital's ability to provide the facilities, beds and support services that will be required if the application is acted upon favorably. In making these required need/ability determinations, consideration will be given to utilization patterns, present and projected patient mix, actual and planned allocations of physical, financial and human resources to general and specialized clinical and support services, and the hospital's and medical staff's general and specific goals and objectives as reflected in the hospital's short and long range plans. The hospital shall include medical staff members and MEC input in the process whereby the Hospital's short and long range plans that affect or determine the resources necessary to support present privileges or planned additional privileges are developed.

8. Effects of Other Affiliations: No person shall be entitled to membership in the medical staff merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at another health care facility. Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this hospital.
9. Non-discrimination: No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of age, sex, race, creed, color, handicap or national origin or on the basis of any other criterion unrelated to the delivery of quality patient care in the hospital, to professional qualifications, to the MEC approved hospital policies, purposes, needs and capabilities, or to community need.

### 3.2 BASIC OBLIGATIONS OF INDIVIDUAL STAFF MEMBERSHIP

Each member of the medical staff, regardless of their assigned staff category, and each LIP exercising privileges under these bylaws, shall fulfill each of the following obligations. Failure to do so may result in disciplinary action and/or termination of membership and privileges:

1. Provide their patients with care at the generally recognized professional level of quality and efficiency.

When a physician accepts the responsibility for a patient who is admitted to his/her service, he/she becomes immediately responsible for the patient. This specifically includes those patients admitted through the E.R. without a regular physician.

2. Abide by the medical staff Bylaws, Rules and Regulations, and by all other lawful standards, policies (procedures) of the medical staff and such hospital policies and procedures as have been approved by the MEC.
3. Discharge such staff, committee, department and hospital functions for

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which they are responsible by staff category assignment, appointment, election or otherwise.

4. Prepare and complete in timely fashion the medical and other required records for all patients they admit or in any way provide care to in the hospital.
5. Abide by generally recognized standards of professional ethics.
6. Satisfy the continuing education requirements established by the medical staff.
7. Make appropriate arrangements for coverage of the member's patients as determined by the medical staff.
8. Promptly notify the Medical Staff if, at any time during his/her appointment to the Medical staff a member is subject to a pending accusation or decision against his/her professional license.
9. Promptly notify the medical staff of any home or office address or telephone changes. Unsuccessful documented attempts to contact the member via telephone to his/her office and home will be placed in the member's credential file. If no response is received within thirty (30) days after one written attempt to contact the physician by certified mail at the home address which is on record with the Medical Staff Office and one written attempt to contact the physician by certified mail at the office address which is on record with the Medical Staff Office, the member will be deemed to have resigned from the Medical Staff and will not be entitled to the hearing or appellate review procedures described in Articles 8 and 9 of these Bylaws.

### 3.3 HARASSMENT AND DISCRIMINATION PROHIBITED

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

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

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

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

All allegations if proven false, will result in appropriate corrective action, against the accuser, from reprimands up to and including termination of medical staff privileges or membership, if warranted by the facts.

ARTICLE 4 CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The staff shall be divided into the following categories: active, courtesy, provisional and honorary.

Each medical staff member shall be assigned to a Medical Staff Category based upon the qualifications defined in the Rules. 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 Rules. Changes in Medical Staff Category shall not be grounds for a hearing unless they affect the Member's privileges.

4.2 LIMITATION OF PREROGATIVE

The prerogatives set forth under each staff category are general in nature and may be subject to limitation by special conditions attached to a LIP's staff membership, by other sections of these Bylaws, the Medical Staff rules or policies, or by policies of the Hospital that have been approved by the MEC. The prerogatives of dentist, podiatrist, and clinical psychologist members of the staff shall be limited to those for which they are qualified by medical education, training or experience.

4.3 QUALIFICATIONS GENERALLY

Every LIP who seeks or enjoys membership, except those physicians granted honorary staff status, must satisfy, at the time of appointment and continuously thereafter, the basic qualifications set forth in Article 3, as well as any additional qualification(s) that are attached to the staff category to which they seek appointment or of which they are a member.

4.4 RESIDENTS

4.4-1 RESIDENTS UNDER THE AUSPICES OF RESIDENCY PROGRAM.

- a. The terms "residents" and "interns" (hereinafter referred to collectively as "residents") as used in these bylaws, refer to practitioners who are currently enrolled in a graduate medical education program approved by the MEC and the Governing Board, and who as part of their educational program, will provide health care services at the hospital. Residents shall not be considered independent practitioners, shall not be eligible for clinical privileges or medical staff membership, and shall not be entitled to any of the rights, privileges, or to the hearing or appeal rights under these bylaws. In compliance with federal laws, it shall not be necessary to submit a query to the National Practitioner Data Bank prior to permitting a resident to provide services at this hospital. Residents may render patient care services at the hospital only pursuant to and limited by the following:

- (1) The Medical Staff Rules and Regulations, policies

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and protocols, which include roles and responsibilities and patient care activities of each participant in the professional educational program.

- (2) The written affiliation agreement between the hospital and the sponsoring medical school or training program; such agreement shall identify the individual or entity responsible for providing professional liability insurance coverage for residents in the amount of \$1 million/#3 million, and with a carrier approved by the Governing Board of this hospital, and
- (3) The protocols established by the MEC, in conjunction with the sponsoring school or training program, regarding the scope of the resident's authority, direction and supervision of the resident, and other conditions imposed upon the resident by this hospital or its medical staff.

- b. While functioning at this hospital, residents shall abide by all provisions of the medical staff bylaws, rules and regulations, and hospital and medical staff policies, and shall be subject to limitation or termination of their ability to function at the hospital at any time in the discretion of the administrator or Chief of Staff. Residents may perform only those services set forth in the training protocols developed by the applicable training program to the extent that such services do not exceed or conflict with the rules and regulations of the medical staff or hospital policies and to the extent approved by the Governing Board. Residents shall be responsible and accountable at all times to a member of the medical staff and shall be under the supervision and direction of a member of the medical staff of this hospital. Residents shall be required to attend medical staff meetings when invited or as required and may be appointed to medical staff committees but shall have no voting rights.

4.4-2 RESIDENTS PROVIDING PATIENT CARE SERVICES NOT UNDER THE  
AUSPICES OF RESIDENCY PROGRAM.

As defined in Section 4.4-1, above, residents are distinguished from practitioners who, though currently enrolled in a graduate medical education program, provide patient care services independently at the hospital (e.g., moonlighting, or locum tenens coverage) and not as part of their educational program, such practitioners who provide independent services must meet the qualifications for medical staff membership and privileges as provided in these bylaws and shall be credentialed in accordance with Article 6 and 7 of these bylaws in the same manner as a practitioner seeking initial appointment to the medical staff.

ARTICLE 5 ALLIED HEALTH PROFESSIONALS

5.1. QUALIFICATIONS

Only Allied Health Professionals (sometimes referred to hereinafter as AHPs and to be interpreted as including persons who are functioning within the hospital under independent contract) holding a license, certificate or such other credential as may be required by applicable state law and who satisfy the basic qualifications required for medical staff membership (including an office located close enough and a residence located close enough to the hospital, or otherwise arrange to provide continuous care to his/her patients) are eligible to provide specified services in the hospital. The Medical Executive Committee, with the approval of the Board, may establish additional qualifications required of members of any particular category of AHPs. Examples: medical social workers, psychologists, speech pathologists, audiologists, physician's assistants, nurses, midwives, nurse LIPs, etc.

5.2 PROCEDURE FOR SPECIFICATION AND TERMINATION OF SERVICES

- 1) An application for specific services for an AHP shall be submitted and processed in the same manner as provided in Article 7 for clinical privileges. An AHP shall be individually assigned to the clinical department appropriate to his/her professional training and shall be subject to formal review every two years.
- 2) Except as required by law, nothing contained in these Bylaws shall be interpreted to entitle an AHP to the hearing and appeal rights described in Article 9. Although AHP's are not entitled to the procedural rights set forth in Article 9, an AHP shall have the right to a review of any actions that would constitute grounds for a hearing or fair review under Article 9 if such action were to be taken against a member of the Medical Staff. The AHP shall be notified of the adverse action and the reasons for the action. The AHP shall have fifteen days following receipt of the notification to file a written request with the Chief of Staff for review of the action. Upon receipt of the written request, the Medical Executive Committee or a committee duly appointed by either the Medical Executive Committee or Chief of Staff on behalf of the Medical Executive Committee shall review the basis for the adverse action. As part of the review, the AHP shall be invited to attend a meeting with the committee which will review the adverse action and to present information, documents and respond to questions. The interview shall be informal, shall not constitute a hearing or fair review as defined in Article 9 of the Bylaws, and shall follow such procedures as the committee deems appropriate. Following the review, the Medical Executive Committee shall determine whether the adverse action should be upheld, terminated or modified. The AHP shall be notified in writing of the outcome and the basis for the decision by the Chief of Staff or designee. If the AHP is dissatisfied with the outcome of the review, the AHP then may request that the Governing Board review the MEC's decision by submitting a written request for further review to the Hospital's Chief Executive Officer within fifteen days of receipt of notice of the outcome. The written request must state the reasons why the MEC's decision should not be upheld and provide specific supporting information and/or documentation. The Governing Board will review the

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AHP's written request and have discretion either to decline the AHP's request for further review or to grant an appeal to review the request in accordance with such procedures as the Governing Board deems appropriate.

5.3 PREROGATIVES

The prerogatives of an AHP shall be to:

1. Provide specified patient care services under the supervision or direction of a member of the physician medical staff (except as otherwise expressly provided by resolution of the MEC approved by the Board) and consistent with the limitations stated in Article 7, Section 4.
2. Write orders only to the extent established by rules of the medical staff and the departments to which the AHP is assigned, but not beyond the scope of the AHP licensure, certificate or other legal credential.
3. Attend hospital education programs and meetings of the staff, departments and committee(s) where their special training and knowledge are desirable.
4. Exercise such other prerogatives as approved by the MEC and the Board. These prerogatives may not exceed the AHPs medical education, training and experience.

5.4 RESPONSIBILITIES AND OBLIGATIONS

Each AHP shall:

1. Meet the same basic obligations as required by Article 3 for Medical Staff members.
2. Retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the hospital for whom they are providing services, or arrange (or alert the attending LIP of the need to arrange) a suitable alternative for such care and supervision.
3. Participate as appropriate in the Quality Improvement Program activities commensurate with their education, training and demonstrated ability, and discharge such other functions as may be required from time-to-time by rule or resolution of the staff or any of its departments or committees which is approved by the MEC and the Board.

ARTICLE 6 APPOINTMENT AND REAPPOINTMENT

6.1 GENERAL

Except as otherwise specified herein, no person (including persons engaged by the Hospital in administratively responsible positions) shall exercise clinical privileges in the Hospital unless and until that person applies for and receives appointment to the Medical Staff or is granted temporary privileges as set forth in these Bylaws. By applying to the Medical Staff for appointment or reappointment (or, in the case of members of the honorary staff, by accepting an appointment to that category), the applicant acknowledges responsibility to first review these Bylaws and agrees that throughout any period of Membership that person will comply with the responsibilities of Medical Staff Membership and with the Bylaws and Rules and Regulations of the Medical Staff as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws.

6.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. This burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the Credentials Committee or Executive Committee which may select the examining physician. The applicant hereby authorizes the examining physician to release all relevant medical information to authorized representatives of the Medical Staff. If there is a reasonable question regarding the applicant's quality of patient care, the applicant may be required to pay the expenses of having an independent expert review medical records of patients treated by the applicant and make a report to the Department and medical Executive Committee.

6.3 APPOINTMENT AUTHORITY

Appointments, denials and revocations of appointment to the Medical Staff shall be made as set forth in these Bylaws, but only after there has been a recommendation from the Executive Committee, or as set forth in Section 8.2-8. The Executive Committee will review each LIP applying for Medical Staff membership and make a recommendation concerning his/her appointment based on criteria relating to the applicant's quality of medical care and other criteria, which shall be consistently and uniformly applied to all LIPs applying for Medical Staff membership. The Governing Board of the Hospital will not act on the appointment of any LIP to the Medical Staff unless the LIP has been reviewed by the Executive Committee pursuant to the appointment process set forth in these Bylaws and the Executive Committee has made a recommendation concerning the appointment of the LIP. In the event the Executive Committee fails, without good cause, to make a recommendation within six (6) months from receipt of a completed application, the Governing Board may take such action as allowed under Section 8.2-8.

#### 6.4 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these Bylaws, initial appointments to the medical Staff shall be for a period of six (6) months, which may be extended up to twelve (12) months before being considered for advancement to a regular staff category. Reappointment to the medical staff and granting, renewal or revision of clinical privileges are made for a period of no more than two years.

#### 6.5 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

##### 6.5-1 PRE-APPLICATION PROCESS

a) The Executive Committee shall implement a pre-application process that requires individuals who wish to be initial applicants to complete a pre-application form that is developed by the Executive Committee. The pre-application form shall require that potential initial applicants provide information and documents that demonstrate the individual meets (i) criteria specified in the Medical Staff's bylaws, rules or policies to be eligible to be considered for medical staff or allied health professional staff membership, and (ii) the applicable criteria established by the medical staff in its bylaws, rules or policies to be eligible to apply for clinical privileges in the individual's proposed area of practice.

b) An individual must submit the following in order to meet the criteria to receive an application for appointment:

(1) A current, unrestricted license to practice in California and no record of revocation, suspension or probation (of licensure in any state) which became final within past ten years except for administrative reasons not related to crimes or professional competence or conduct.\*

(2) With the exception of pathologists, current, unrestricted federal DEA registration.

(3) Satisfactory completion of, or current enrollment in, an accredited postgraduate residency training program in the specialty in which the pre-applicant will seek clinical privileges.

(4) Board certification by the appropriate specialty Board (ABMS and/or AOA) or proof that the pre-applicant have met/will meet the requirements for examination for certification by the appropriate specialty Board, if required by the Medical Staff Bylaws, Rules or policy.

(5) Proof of Pre-Applicant's current professional medical liability coverage by an insurance carrier licensed to do insurance business in the State of California or an organization qualified pursuant to Section 1280.7 of the California Insurance Code, such coverage to be in the minimum amount of \$1,000,000 per incident and \$3,000,000 per aggregate. If Pre-Applicant is practicing in a state other than the State as of the date of the Request for Application, Pre-Applicant may instead provide proof of current professional liability insurance coverage by a carrier approved to provide coverage in the state of practice.

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(6)No record of conviction of Medicare, Medicaid, or insurance fraud and abuse, payment of civil money penalties for same, or exclusion or other adverse actions taken from such programs (i.e., OIG, GSA). [No time limit]

(7)No felony conviction for or withhold of felony adjudication for a crime against a person (includes a no contest plea). [No time limit]

(8)Any felony conviction within the past ten years.\*

(9)No record of conviction of, withhold of adjudication for, or plea of guilty or no contest to, any other felony, or any misdemeanor related to (a) the practice of your profession; (b) other health care matters; (c) third-party reimbursement; (d) violence; or (e) the use, prescription distribution, or furnishing of DEA scheduled drugs (Schedules I through V) within the past ten years\*.

(10)No record of denial, revocation, termination, or involuntary relinquishment of appointment or clinical privileges in same or similar specialty at this or any other hospital or healthcare facility within the past ten years.\*

\*Occurrences greater than 10 years past require practitioner to submit written explanatory summary and authorization for the medical staff to obtain further information from involved entities in addition to a completed application for appointment.

c)No application for appointment will be provided to a potential applicant, nor will an application be accepted from a potential applicant, until the pre-application process confirms the individual is eligible to apply for membership and eligible to apply for the applicable clinical privileges in the individual's proposed area of practice.

d)If review of the pre-application demonstrates the individual meets the criteria to receive an application, the medical staff shall provide the individual an application for appointment.

e)If an individual does not meet both the criteria to be eligible to (i) be considered for membership, and (ii) apply for clinical privileges in the individual's proposed area of practice, the individual is not entitled to an application for appointment and is not entitled to a medical staff hearing. The individual will be notified of the criteria not satisfied. The individual shall be deemed to have accepted such determination, unless the individual, within thirty (30) days of the date of the notification, submits to the Medical Executive Committee documentation that demonstrates the information and documentation the individual provided during the pre-application process demonstrated the individual met the criteria to receive an application.

f)The Medical Executive Committee may establish administrative procedures to implement the pre-appointment process, such as pre-application fees, requirements for timely completing the pre-application process, and requirements for timely submitting an

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application for appointment after the medical staff provides the application for appointment.

g) The completed pre-application form and the information and documents collected as part of the pre-application process are the medical staff's confidential peer review materials, not to be retained in any administrative files nor used for any administrative purposes.

#### 6.5-2 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

An application form shall be developed by the Executive Committee.

The form shall require detailed information which shall include, but not be limited to, information concerning:

- a) the applicant's qualifications, including, but not limited to professional training and experience, hospital affiliations, current licensure, current DEA registration, and continuing medical education information related to the clinical privileges to be exercised by the applicant;
- b) peer references familiar with the applicant's professional competence and ethical character;
- c) requests for membership categories, departments, and clinical privileges;
- d) past or pending professional disciplinary action, licensure limitations, or related matters;
- e) physical and mental health status;
- f) professional liability insurance;
- g) All voluntary or involuntary and all past or pending termination of medical staff membership or limitation, reduction or loss of clinical privileges at any other hospital.
- h) All voluntary or involuntary relinquishment, and all past or pending termination of licensure including DEA certification.

Each application for initial appointment to the Medical Staff shall be in writing, submitted to the Medical Staff Office on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), along with the prescribed processing fee, if any, and signed by the applicant. When an applicant requests an application form, that person shall be given a copy of these Bylaws, Rules and regulations.

#### 6.5-3 EFFECT OF APPLICATION

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

- a) signifies willingness to appear for interviews in regard to the

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application;

- b) authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorized such individuals and organizations to candidly provide all such information;
- c) consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and document to permit such inspection and copying;
- d) releases from any liability to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant;
- e) releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant;
- f) consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the Hospitals or Medical Staff may have, and releases the Medical Staff and Hospital from liability for so doing to the fullest extent permitted by law;
- g) if a requirement then exists for Medical Staff dues, acknowledges responsibility for timely payment;
- h) pledges to provide for continuous quality care for patients;
- i) pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing continuous care of his or her patients, seeking consultation whenever necessary, refraining from providing "ghost" surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised LIPs.

#### 6.5-4 VERIFICATION OF INFORMATION

The applicant shall deliver an application to the Medical Staff Office along with the application fee. The application and all supporting materials then available shall be transmitted to the Credentials Committee.

The Credentials Committee and the administrator shall seek to collect or verify from primary sources the references, licensure status, and other evidence submitted in support of the application. The applicant shall be notified of any problems in obtaining the information. It shall be the applicant's obligation to obtain the required information. If all supporting documents have not been supplied by the applicant, the application is not otherwise complete, or additional information or documents are required by the Medical Staff in order to review the applicant's qualifications, the applicant will be notified and given 60 days to provide the required information or documents. Action on an

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individual's application for appointment or initial clinical privileges is withheld until the information is available and verified. If the applicant fails to provide the required information or documents within sixty (60) days, the applicant's application will be deemed voluntarily withdrawn and the applicant will be so notified. Notwithstanding any other provision of these Bylaws, anyone whose application has been discontinued for failure to supply the required documentation shall not be entitled to procedural rights provided in Article IX of these Bylaws. If collection and verification is accomplished, all such information shall be transmitted to the Credentials Committee and appropriate department(s).

6.5-5 CREDENTIALS COMMITTEE ACTION

The Credentials Committee shall review the application, evaluate and verify the supporting documentation and other relevant information. The Credentials Committee may elect to interview the applicant and seek additional information. As soon as practicable, the Credentials Committee shall transmit to the Chairman of the appropriate department a written report and its recommendations as to appointment, and if appointment is recommended, as to membership category, department affiliation to be granted, and any special conditions to be attached to the appointment. The Credentials Committee may also recommend that the department defer action on the application for a stated reason.

6.5-6 DEPARTMENT ACTION

After receipt of the application from the Credentials Committee, the department to which the application is submitted shall review the application and supporting documentation, and may conduct a personal interview with the applicant at the chairman's or committee's discretion. The department shall evaluate all matters deemed relevant to a recommendation, including information relative to clinical privileges requested by the applicant, and shall transmit to the Executive Committee a written report and recommendation as to appointment and, if appointment is recommended, as to department affiliation, clinical privileges to be granted, and any special conditions to be attached. The chairman may also request that the Executive Committee defer action on the application for a stated reason.

6.5-7 EXECUTIVE COMMITTEE ACTION

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

6.5-8 EFFECT OF EXECUTIVE COMMITTEE ACTION

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- a) Favorable Recommendation: When the recommendation of the Executive Committee is favorable to the applicant, it shall be promptly forwarded, together with supporting documentation, to the Governing Board.
- b) Adverse Recommendation: When a final recommendation of the Executive Committee is adverse to the applicant, the Governing Board and the applicant shall be promptly informed by written notice. The applicant shall then be entitled to the procedural rights as provided in Article 9.

6.5-9 ACTION ON THE APPLICATION

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

- a) If the Executive Committee issues a favorable recommendation, and:
  - 1) the Governing Board concurs in that recommendation, the decision of the Board shall be deemed final action.
  - 2) the tentative final action of the Governing Board is unfavorable, the Administrator shall give the applicant written notice of the tentative adverse recommendation and the applicant shall be entitled to the procedural rights as set forth in Article 9. If the applicant waves his or her procedural rights, the decision of the Governing Board shall be deemed final action.
- b) In the event the recommendation of the Executive Committee, or any significant part of it, is unfavorable to the applicant, the procedural rights set forth in Article 9 shall apply.
  - 1) If the applicant waves his or her procedural rights, the recommendations of the Executive Committee shall be forwarded to the Governing Board for final action, which shall affirm the recommendation of the Executive Committee if the Executive Committee's decision is supported by substantial evidence.
  - 2) If the applicant requests a hearing following the adverse Executive Committee recommendation pursuant to Section 6.5-9(b) or an adverse Governing Board tentative final action pursuant to Article 6.5-9(a)(2), the Governing Board shall take final action only after the applicant has exhausted his or her procedural rights as established by Article 9. After exhaustion of the procedures set forth in Article 9, the Governing Board shall make a final decision and shall affirm the decision of the Medical Review Committee if the Medical Review Committee's decision is supported by substantial evidence, following a fair procedure. The Governing Board's decision shall be in writing and shall specify the reasons for the action taken.

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6.5-10 EXPEDITED ACTION

If the Medical Staff Office determines an application meets the Fast Track Credentialing Policy criteria, the file may be referred for expedited action. The file is then forwarded to the Credentials Committee Chair or his/her designee, and the Chair of each Department in which the applicants seeks membership or privileges. If the Credentials Committee or designee and each Department Chair or designee who is responsible for reviewing the application agree that the applicant qualifies for expedited action and for the requested privileges, the file shall be referred to the Chief of Staff, who will then decide whether to recommend to the Governing Board that the requested membership and privileges be granted on an expedited basis. The expedited action processing will be terminated and routine processing resumed if anyone responsible for reviewing the application questions processing the application on an expedited basis or granting the requested appointment or privileges. There is no right to expedited action and no right to a hearing and appeal if either expedited action is not taken on an application or if expedited action is discontinued and the routine processing resumed.

6.5-11 NOTICE OF FINAL DECISION

- a) Notice of the final decision shall be given to the Chief of Staff, the Executive and the Credentials Committee, the Chairman of each department concerned, the applicant and the Administrator.
- b) A decision and notice to appoint or reappoint shall include, if applicable: (1) the staff category to which the applicant is appointed; (2) the department to which that person is assigned; (3) the clinical privileges granted; and (4) any special conditions attached to the appointment.

6.5-12 TIMELY PROCESSING OF APPLICATIONS

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

- a) evaluation, review, and verification of application and all supporting documents: 30 days from receipt of all necessary documentation;
- b) review and recommendation by Credentials Committee: 30 days after receipt of all documentation from the Medical Staff Office;
- c) review and recommendation by department(s): 60 days after receipt of all necessary documentation from the Credentials Committee;
- d) review and recommendation by Executive Committee: 30 days after receipt of all necessary documentation from the department(s); and

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- e) final action: 180 days after receipt of all necessary documentation by the Medical Staff Office or seven (7) days after conclusion of hearings.

6.6 REAPPOINTMENTS AND REQUESTS FOR MODIFICATION OF STAFF STATUS OR PRIVILEGES

6.6-1 APPLICATION

- a) At least one hundred and eighty days (180) days prior to the expiration date of the current staff appointment (except for temporary appointments), a reapplication form developed by the Executive Committee shall be mailed or delivered to the member. A second request via certified mail will be sent to the member after 30 days. If an application for reappointment is not received at least one hundred and twenty days (120) days prior to the expiration date, written notice shall be promptly sent to the applicant advising that the application has not been received and the member's clinical privileges will be suspended (except with respect to his/her patients already in the hospital) and his/her rights to admit and/or attend patients until the completed application and or information requested to complete an application previously submitted is received in the Medical Staff Office. If the application is not returned or completed by the applicant at prior to 90 days of the expiration of the member's appointment, it is considered a voluntary resignation. The member must reapply as a new applicant.

At least sixty (60) days prior to the expiration date, each Medical Staff member shall submit to the Credentials Committee the completed application form for renewal of appointment to the Medical Staff for the coming year, and for renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 6.5-2, as well as other relevant matters. Upon receipt of the application, the information shall be processed as set forth commencing at Section 6.5-4.

- b) A Medical Staff member who seeks a change in Medical Staff status or modification of clinical privileges may submit such request at any time except that such application may not be filed within twelve (12) months of the time a similar request has been denied.

6.6-2 EFFECT OF APPLICATION

The effect of an application for reappointment or modification of staff status or privileges is the same as that set forth in Article 6.5-3.

6.6-3 STANDARDS AND PROCEDURES FOR REVIEW

When a Staff Member submits the first application for appointment, and every two years thereafter, or when the member submits a written request for modification of staff status or clinical privileges, the member shall be subject to an in-depth review generally following the procedures set forth in Article 6.5-4 through 6.5-12.

6.7 LIPS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

6.7-1 EXCLUSIVE SERVICES

The Hospital may determine as a matter of policy that certain Hospital clinical facilities may be used only on an exclusive basis in accordance with written agreements between the Hospital and qualified professionals. Such agreements may cause staff members, except in emergency or life-threatening circumstances, to observe this exclusivity policy in arranging for the care of their patients. Applications for initial appointment or for clinical privileges related to those Hospital facilities and services specified in said agreement(s) will not be accepted for processing unless submitted with confirmation from the Administrator of an existing or proposed agreement with the Hospital.

6.7-2 MEMBERSHIP QUALIFICATIONS

A LIP who is providing such contract services to the Hospital must meet the same membership qualifications; must be processed for appointment, reappointment, and clinical privilege delineation in the same manner; and must, fulfill all of the obligations for his/her membership category as any other applicant or staff member.

6.7-3 QUALITY CONTROL

In approving any such LIP(s) for Medical Staff membership, the Medical Staff must require that the services provided meet JCAHO requirements, are subject to the appropriate quality controls, and are evaluated as part of the overall Hospital quality improvement program.

6.7-4 RIGHT TO USE FACILITIES

Because practice at the Hospital is always contingent upon continued staff membership and is also constrained by the extent of clinical privileges enjoyed, a LIP's right to use the Hospital's facilities is automatically terminated when staff membership expires or is terminated. Similarly, the extent of his clinical privileges is automatically limited to the extent that pertinent clinical privileges are reduced or eliminated. In such instances, the LIP shall be afforded a formal hearing or fair review under those circumstances described in Article 9.

6.8 LEAVE STATUS

6.8-1 REQUEST

A member may request a voluntary leave of absence from the Medical Staff by submitting a written request to the Administrator who will transmit this notice to the Credentials Committee and the Executive Committee. The written notice shall state the specific period of time, which may not exceed the practitioner's next reappointment or 1 year, whichever comes first. During the period of leave, the staff member shall not exercise any privileges.

#### 6.8-2 MEDICAL LEAVE OF ABSENCE

The Medical Executive Committee shall determine the circumstances under which a particular medical staff member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. At the discretion of the medical executive committee, unless accompanied by a reportable restriction of privileges, the leave shall be deemed a "medical leave" which is not granted for a medical disciplinary cause or reason.

#### 6.8-3 TERMINATION OF LEAVE

At least 30 days prior to termination of the leave, or at any earlier time, the member may request reinstatement of his privileges and prerogatives by submitting a written notice to that effect to the Administrator, who will transmit this notice to the Credentials and Executive Committees. The member shall submit a written summary, detailing his professional and patient care activities during the leave. The Executive Committee, on receipt of the recommendation of the Credentials Committee, shall make its recommendation to the Governing Body concerning the reinstatement of the member's privileges and prerogatives. Thereafter, the procedure provided in Section 2.10 above shall apply.

#### 6.8-4 FAILURE TO REQUEST REINSTATEMENT

Failure without good cause to request reinstatement or to provide a summary of professional and other activities as above required shall constitute a voluntary resignation from the staff and shall result in termination of staff membership, privileges, and prerogatives. The Executive Committee shall in its sole discretion, and after giving such LIP the opportunity to address the committee, determine whether or not a good cause existed. A LIP whose membership is so terminated shall not be entitled to the procedural rights provided in Article 9. A request for staff membership subsequently received from a staff member so terminated shall be treated and processed as an application for initial appointment.

#### 6.8-5 OBSERVATION REQUIREMENT

At the discretion of the Governing Board, reinstatement may be made subject to an observation requirement for a period of time during which the LIP's clinical performance is observed by one or more designated Medical Staff (or Clinical Department) members to determine the LIP's continued satisfaction of qualifications.

### 6.9 RESIGNATION FROM MEDICAL STAFF

#### 6.9-1 WRITTEN REQUEST

Any LIP who desires to resign from the Medical Staff may submit his letter of resignation, through his assigned Department Chair, to the Executive Committee of the Medical Staff, stating such request, or verbally to the Medical Staff Office, who will forward the request through the proper

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channels. The Executive Committee shall forward its recommendation to the Governing Body.

6.9-2 OBLIGATIONS

No application for resignation shall be considered until obligations to the Hospital have been satisfactorily completed by the applicant, including completion of all medical records and their arrangements, satisfactory to the Hospital for such conclusion.

6.9-3 NON-COMPLIANCE

Any LIP not complying with the previous paragraph shall be considered as having resigned from the staff with prejudice and this shall be appropriately recorded. Subsequent application for Medical Staff membership or clinical privileges will not be processed insofar as outstanding obligations remain or are no longer able to be completed. This status will be reported to any requests for references.

6.10 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION, ADVERSE CORRECTIVE ACTION DECISION, OR RESIGNATION IN LIEU OF MEDICAL DISCIPLINARY ACTION

6.10-1 LIPS AFFECTED

A waiting period of twenty-four (24) months shall apply to the following LIPs:

- 1) an applicant who has received a final adverse decision regarding appointment or privileges;
- 2) an applicant who withdrew his application for membership or privileges following an adverse recommendation by the Executive Committee or Governing Body;
- 3) a former Medical Staff member whose Medical Staff membership and clinical privileges were terminated or restricted;
- 4) a former Medical Staff member who resigned from the Medical Staff following the issuance of a Medical Staff or Governing Body recommendation adverse to the member's Medical Staff membership or clinical privileges; or
- 5) a Medical Staff member who has received a final adverse decision resulting in (1) termination or restriction of his clinical privileges or (2) denial of his request for additional clinical privileges, the foregoing to apply for those clinical privileges that were terminated, restricted or denied.

6.10-2 WAITING PERIOD

The waiting period will begin when the decision became final, the date the application or request was withdrawn, or the date the former Medical Staff member's resignation became effective, whichever is applicable. For the purposes of this section, an adverse decision shall be considered final at the time of completion of (1) all hearing, appellate review, and other

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quasi-judicial proceedings conducted by the Hospital bearing on the decision and (2) all judicial proceedings bearing upon the decision which are filed and served within twenty-four (24) months after the completion of the Hospital proceedings described above.

6.10-3 ADVERSE DECISION

For the purpose of this Section, a decision is considered to be adverse only if it is based on medical disciplinary cause, unethical conduct, conduct disruptive to the Hospital operation, or a failure to meet minimum professional standards and not if it is based upon reasons that are not medical, ethical or professional in nature. Actions which are not considered adverse for the purpose of this Section include actions based on a failure to maintain malpractice insurance which can be cured by securing such insurance.

6.10-4 REAPPLICATION AFTER WAITING PERIOD

After the waiting period, the LIP may reapply for Medical Staff membership and/or clinical privileges. The request shall be processed as an initial application. The LIP shall furnish evidence that the basis for the earlier adverse action no longer exists and/or of reasonable rehabilitation correcting any problems which prompted the previous adverse action. The application shall not be processed unless the LIP submits satisfactory evidence to the Executive Committee that he has complied with all of the specific requirements any such adverse decision may have included, such as completion of training or proctoring conditions. The Executive Committee's decision as to whether satisfactory evidence has been submitted shall be final, subject only to further review by the Governing Body within 45 days after the Executive Committee decision was rendered.

6.11 REINSTATEMENT OF MEDICAL STAFF MEMBERSHIP AND PRIVILEGES

Former members who have resigned from the Medical Staff may request reinstatement of original staff privileges and membership, if they have voluntarily resigned or were deemed to have resigned for 60 days of suspension for delinquent medical records within the past 30 days.

However, to be reinstated, former members are required to update their credential file, which may include but not be limited to: license, insurance, office information, practice information including updates to hospital affiliations. The applicant may have the burden of producing information for an adequate evaluation of his/her qualifications and suitability for the privileges and staff category requested and of resolving any reasonable doubts about these matters and of satisfying requests for information.

Former members who wish to be reinstated to the medical staff, must submit their request in writing to the Medical Executive Committee. If they are requesting reinstatement after resignation for medical records, they must first complete the delinquent records in question, and pay the application fee established by the medical staff. They are not required to complete an application and if approved, will be reinstated to their original staff category and privileges. However, to be reinstated, former members are required to update their credential file, which may include but not be limited to: license, insurance, office information, practice information

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including updates to hospital affiliations.

Former members who are reinstated shall have the same reappointment cycle as they had prior to the resignation.

Former members who have requested reinstatement after 30 days of their resignation must complete a new application and submit the application fee as required by the medical staff. Such application is processed in the same manner as any new applicant to the Medical Staff. The applicant for reinstatement has the burden of producing information for an adequate evaluation of his/her qualifications and suitability for the privileges and staff category requested and of resolving any reasonable doubts about these matters and of satisfying requests for information. If appointed to the Medical Staff, they will be appointed to the Provisional Staff with observation and proctoring per their department's rules and regulations.

ARTICLE 7            CLINICAL PRIVILEGES

7.1    EXERCISE OF PRIVILEGES

Every LIP providing direct clinical services at this Hospital, by virtue of Medical Staff membership or otherwise, shall in connection with such practice and except as provided in Section 3 and 4 below, be entitled to exercise only those privileges specifically granted to him/her by the Governing Board. Said privileges must be within the scope of the license authorizing the LIP to practice in this state and consistent with any restriction thereon. Regardless of the privileges granted, each LIP must obtain consultation when necessary for the safety of his/her patients or when required by these bylaws, the rules and regulations and other policies of the Medical Staff, any of its clinical units, or the Hospital.

7.2    DELINEATION OF CLINICAL PRIVILEGES

7.2-1 APPLICATION

Privilege forms will be recommended by the Medical Staff and approved by the board. Clinical privileges may be granted only upon formal request on forms provided by the Medical Staff Office with subsequent processing and approval. Every application for staff appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. A request by a member for a modification of privileges must be supported by documentation of additional training and/or experience supportive of the request. 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 procedure-specific telemedicine privileges.

7.2-2 BASIS FOR PRIVILEGE DETERMINATION

Requests for clinical privileges shall be evaluated on the basis of the LIP's training, experience and education; his/her demonstrated current competence; evidence of current licensure; any required references; and other relevant information, including an appraisal by the Chair of the Department in which such privileges are sought, and health status as it may affect the LIP's ability to exercise the privileges if granted. In granting privileges, consideration must be given to objective information received from sources outside the Hospital, to the need for an adequate ongoing experience (volume) to maintain proficiency, to the Hospital's ability to support such patient care services, and to the objective findings of patient care evaluation and peer review activities. Peer input shall be obtained and considered in the determination of clinical privileges.

7.2-3 PROCEDURE

All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article 6 for Medical Staff membership. Requests for clinical privileges for dentists, oral surgeons and podiatrists, shall be processed in the same manner specified in this Article for other LIPs, and shall be based on their training, experience, education, and demonstrated competence, and the need for their services in the Hospital.

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Surgical procedures that each dentist and/or podiatrist may perform shall be under the overall supervision of the Chair of Surgery. Except for those situations set forth in the following paragraph for which the oral and maxillofacial surgeon and podiatrist may perform the history and physical, an adequate history and physical examination on all dental, podiatric, oral and maxillofacial surgical and psychiatric patient admissions shall be performed and recorded in the medical record by a physician member of the Medical Staff, or, in some cases, by a physician approved by the Medical Staff. The dentist or podiatrist shall be responsible for completing the part of the history and physical examination related to the dental or podiatric problems. A physician member of the Medical Staff shall be responsible for the care of any medical problem present at the time of admission or that arises during hospitalization.

Histories and physicals only may be performed by those granted the privilege to perform histories and physicals. Every patient must receive a history and physical within twenty-four hours of admission, unless a previous history and physical performed within thirty (30) days of admission (or registration if any outpatient procedure) is on record, in which case that history and physical will be updated within twenty-four (24) hours of admission. Each patient must have a history and physical within twenty-four (24) hours prior to surgery or a procedure requiring anesthesia services, unless a previous history and physical performed within thirty (30) days prior to the surgery or procedure requiring anesthesia is on record, in which case that history and physical will be updated within twenty-four (24) hours prior to surgery.

Oral and maxillofacial surgeons who have successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the US Office of Education and have been determined by the medical staff to be competent to do so, may perform a history and physical examination and determine the ability of their patient to undergo surgical procedures the oral and maxillofacial surgeon proposed to perform on ASA 1 classified patients only. Completion of a history and physical by a qualified oral and maxillofacial surgeon under this subsection shall satisfy the appraisal portion of the requirements of Section 7.2-4 below. For patients with existing medical conditions or abnormal findings beyond the surgical indications, a physician member of the medical staff or physician approved by the medical staff must conduct or directly supervise the admitting history and physical examination, except the portion related to oral and maxillofacial surgery, and assume the responsibility for the area of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside the scope of the oral and maxillofacial surgeon's lawful scope of practice.

Podiatric surgeons who have successfully completed a postgraduate program in podiatric surgery accredited by a nationally recognized accrediting body approved by the US Office of Education and have been determined by the medical staff to be competent to do so, may perform a history and physical examination and determine the ability of their patient to undergo surgical procedures the podiatrist proposed to perform on ASA 1 and ASA 2 classified patients only. Completion of a history and physical by a qualified podiatrist under this subsection shall satisfy the appraisal portion of the requirements of Section 7.2-4 below. For patients with existing medical conditions or abnormal findings beyond the surgical indications, a physician member of the medical staff or physician approved by the medical

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staff must conduct or directly supervise the admitting history and physical examination, except the portion related to podiatric surgery, and assume the responsibility for the area of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside the scope of the podiatrist's lawful scope of practice.

#### 7.2-4 MEDICAL APPRAISAL

All patients admitted for care in the hospital by a dentist, podiatrist, clinical psychologists, or oral and maxillofacial surgeon shall receive the same basic medical appraisal as patients admitted to other services, and the dentist, podiatrist, clinical psychologists and oral and maxillofacial surgeon shall seek consultation with a physician member to determine the patient's medical status and need for medical evaluation whenever the patient's clinical status indicates the presence of a medical problem. Where a dispute exists regarding proposed treatment between a physician member or a physician approved by the medical staff and all limited license LIPs based upon medical or surgical factors outside the scope of licensure of the limited license LIP, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate department(s).

#### 7.2-5 UNAVAILABLE CLINICAL PRIVILEGES

Notwithstanding any other provisions of these bylaws, to the extent that any requested clinical privileges are not available at the Hospital (whether because of exclusive contract, lack of facilities, policy decision of the Governing Board, or otherwise), the request therefor shall be rejected without the necessity of processing pursuant to Article 6 above. Because such a rejection is unrelated to the applicant's qualifications, an applicant whose request is so rejected shall not be entitled to the procedural rights provided in Article 9. Before the board adopts a policy to eliminate or restrict the services or privileges that are available at the hospital, the Board shall solicit input from the MEC.

### 7.3 PROCTORING/OBSERVATION

#### 7.3-1 General Proctoring Requirements

- (a) Except as otherwise determined by the Medical Executive Committee and Governing Body, all initial appointees to the Medical Staff and all Members granted new Privileges shall be subject to a period of proctoring in accordance with standards and procedures set forth in the Rules and at a minimum, 4 cases of retrospective review. In addition, Members may be required to be proctored as a condition of renewal of Privileges (for example, when a Member requests renewal of a Privilege that has been performed so infrequently that it is difficult to assess the Member's current competence in that area). Proctoring which is imposed for non-disciplinary reasons, such as insufficient volume to demonstrate current competence, does not result in the procedural rights described in Article 9.
- (b) Monitoring may be implemented whenever the Medical

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Executive Committee, a department or department chair determines that additional information is needed to assess a LIP's performance. Monitoring is not a disciplinary measure, but rather is an information gathering measure. Monitoring does not give rise to the procedural rights described in Article 9 unless the monitoring becomes a restriction of privileges because procedures cannot be done unless a proctor is present.

- (c) During the proctoring, the LIPs must demonstrate they are qualified to exercise the Privileges that were granted and are carrying out the duties of their Medical Staff category.

7.3-2 Completion of Proctoring

Proctoring shall be deemed successfully completed when the LIP completes the required number of proctored cases within the time frame established in the Bylaws and the Rules, and the Medical Executive Committee has determined the LIP's professional performance in the cases met the standard of care of the Hospital.

7.3-3 Effect of Failure to Complete Proctoring

- (a) Failure to Complete Necessary Volume: Any Member who fails to complete the required number of proctored cases within the time frame established in the Bylaws and Rules shall be deemed to have voluntarily withdrawn his or her request for membership (or the relevant Privileges), and he or she shall not be afforded the procedural rights provided in Article 9. However, the department has the discretion to extend the time for completion of proctoring in appropriate cases subject to ratification by the Medical Executive Committee. The inability to obtain such an extension shall not give rise to procedural rights described in Article 9.
- (b) Failure to Satisfactorily Complete Proctoring: If a LIP completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring, he or she may be terminated (or the relevant Privileges may be revoked), and he or she shall be afforded the procedural rights as provided in Article 9.
- (c) The failure to complete observation for any specific Privilege shall not, by itself, preclude advancement from provisional staff. If advancement is approved prior to completion of observation, the observation will continue for the specified Privileges. The specific Privileges may be voluntarily relinquished or terminated if observation is not completed thereafter within a reasonable time.

7.4 TEMPORARY PRIVILEGES

7.4-1 CONDITIONS/CIRCUMSTANCES

Upon written concurrence of the respective Chair of the Department, the Chief of Staff and Hospital Administrator (or in either of their absence, the Vice Chair of the Department, the Vice Chief of Staff or the administrative designee) temporary privileges may be granted to a physician, dentist, podiatrist or allied health professional licensed to practice in this State, under the following conditions/circumstances, only, with consideration on a case by case basis:

Temporary Privileges shall be granted based upon an important patient care, treatment or service need (i.e. urgent needs of the department, consultations, locum tenens) or pendency of an application for up to but not to exceed 120 days. Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting LIP's qualifications, ability and judgment to exercise the privileges requested. This shall include but not be limited to evidence of current licensure, DEA registration and proof of adequate professional liability protection, and training/experience.

Unless otherwise specified in the following paragraphs, all requests for temporary privileges must be received in the Medical Staff Office at least forty-eight (48) hours prior to the perceived need.

a) Urgent Needs of Department

Upon written concurrence, as noted in Subsection 2, temporary privileges may be granted to meet the urgent needs of a department where a shortage of appointed medical staff members exists and where such a shortage might inhibit provision of the full scope of services usually available to patients or where such shortage might affect the customary high quality of care, and only upon presentation of a completed application (as defined by these Bylaws) and request for delineated privileges, awaiting recommendations for appointment, and which has been reviewed by the Chair of the Credentials Committee.

Requests for temporary privileges for major invasive procedures may be considered under the circumstances stated above.

b) Consultation

Upon written concurrence, as noted in Subsection 2, temporary privileges may be granted for consultation to a LIP with knowledge and/or expertise that is not available among members of the Medical Staff.

The requesting physician must be a member of the medical staff, in good standing.

Requests for temporary privileges to perform major invasive procedures may be considered under these circumstances.

Ordinarily, temporary privileges may not be granted for more than one (1) patient per calendar year, after which the LIP shall be

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required to apply for medical staff membership before attending additional patients.

c) Locum Tenens

Following a written request, no less than sixty (60) days in advance, by a member in good standing of the medical staff, and upon written concurrence of the Chair of the respective Department, and the Chief of Staff and the Hospital Administrator, temporary privileges may be granted to a LIP requested to serve locum tenens for the Medical Staff member for an initial period of thirty (30) days. Such privileges may be renewed for two (2) successive periods of thirty (30) days in a calendar year but not to exceed his services as locum tenens, and shall be limited to treatment of the patients of the LIP for whom she/he is serving as locum tenens.

In exercising such privileges, the applicant shall act under the supervision of the Chair of the Department to which he/she is assigned, or the Chair's designee, and in accordance with proctoring, and any or all other provisions which may be implied or otherwise specified in these Bylaws or Rules and Regulations.

d) Pendency of Application

Temporary Privileges may be granted for a period of up to 120 days when the new applicant for medical staff membership or privileges is waiting for a review and recommendation by the medical staff executive committee and approval by the governing board. Specific criteria to allow for the granting of temporary privileges is specified in the medical staff policy. The CEO may grant temporary privileges upon recommendation of either the applicable clinical department chair or the Chief of Staff.

In exercising such privileges, the applicant shall act under the supervision of the Chair of the department to which he/she is assigned, or the Chair's designee and in accordance with proctoring or other provisions which may be implied or otherwise specified in these Bylaws or Rules and Regulations.

e. Temporary Staff

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

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

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the medical executive committee. Finally, they may attend medical staff meetings outside of their committees, upon invitation.

f. Emergency and Disaster Privileges

1. In the case of an emergency, any member of the medical staff, to the degree permitted by the scope of the applicant's license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm provided that the care provided is within the scope of the individual's license. The member shall make every reasonable effort to communicate promptly with the department chair concerning the need for emergency care and clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the department chair with respect to further care of the patient at the hospital.
2. In the event of an emergency, any person shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to qualified members of the medical staff when it becomes reasonably available.
3. Disaster privileges may be granted when the emergency management plan has been activated and the organization is unable to handle the immediate patient needs. During disaster(s) in which the emergency management plan has been activated, the Chief Executive Officer or Chief of Staff or his or her designee(s) has the option to grant disaster privileges. The person responsible is not required to grant privileges to any individual and is expected to make such decisions on a case-by-case basis at his or her discretion. The chief Executive Officer or Chief of Staff or his or her designee(s) may grant disaster privileges upon presentation of any of the following:
  - i. A current license to practice and a valid picture ID issued by a state, federal or regulatory agency.
  - ii. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).
  - iii. Presentation by a current hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity.

After the disaster situation is under control, and as soon as possible, the verification process of the credentials and privileges of individuals who have received disaster privileges will occur. The privileging process and primary source verification as specified in these Bylaws under Article 6 will be followed.

7.4-2 APPROVAL

Temporary privileges granted for any of the aforementioned circumstances shall require the written approval of the Chair of the respective Department (acting as designee of the Chief of Staff, or the Chief of Staff and the Hospital Administrator. The Vice Chair of the respective

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Department may act in the absence of the Chair of the Department; the Vice Chief of Staff may act in absence of the Chief of Staff; an administrative designee may act in the absence of the Hospital Administrator.

7.4-3 TERMINATION

Upon recommendation of the Hospital Administrator or the Chair of the Department, the Chief of Staff may, at any time, terminate a LIP's temporary privileges effective as of the discharge from the hospital of the LIP's patients then under the LIP's care.

Where it is determined that the life or health of such patient(s) would be endangered or threatened by continued treatment by the LIP, the termination may be imposed by any person entitled to impose a summary suspension and the same shall be immediately effective.

The Chief of Staff shall assign a member of the Medical Staff to assume responsibility for the care of such terminated LIP's patient(s) until they are discharged from the hospital. The wishes of the patient(s) shall be considered where feasible in selection of such substitute LIP.

7.4-4 RIGHTS OF THE LIP

A LIP granted temporary privileges for any of the circumstances aforementioned shall be entitled to the procedural rights afforded by these Bylaws if the temporary privileges are terminated or suspended for disciplinary reasons.

ARTICLE 8 CORRECTIVE ACTIONS

8.1 ROUTINE MONITORING AND EDUCATION

The clinical departments and committees are responsible for carrying out delegated review and quality improvement review functions. They may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the LIP is only required to provide reasonable notice of admissions and procedures) in the course of carrying out their duties without initiating formal corrective action proceedings. Comments, suggestions and warnings may be issued orally or in writing. The LIP shall be given an opportunity to respond in writing and may be given an opportunity to meet with the department or committee. Any informal actions, monitoring or counseling shall be documented in the member's file. Executive Committee approval is not required for such action, although the actions shall be reported to the Executive Committee. This shall not be construed to confer any rights upon a LIP to any routine monitoring and education prior to corrective action. These actions shall not constitute a restriction of privileges or grounds for any formal hearing, fair review or appeal rights under Article 9.

8.2 FORMAL REQUEST FOR CORRECTIVE ACTION

8.2-1 GROUND, INITIATION

Whenever the conduct of any Medical Staff member (affected LIP) is considered to be lower than the standard of the Medical Staff, or to be disruptive to the operations of the hospital, or to constitute fraud or abuse, or to constitute a felonious act in this State; or to be detrimental to the quality of patient care at the hospital, or to be detrimental to the hospital's licensure or accreditation; or to be detrimental to hospital or Medical Staff efforts to comply with any professional review organization, third-party payor (private or governmental), these bylaws, or in violation of the rules, regulations, or policies of the hospital, Medical Staff or any department or committee thereof, corrective action against the affected LIP may be requested by any member ("requesting party") of the Medical Staff or Governing Body or by the Administrator. All requests for corrective action shall be in writing, shall be submitted to the Executive Committee, and shall set forth the specific conduct constituting the basis for the request.

8.2-2 INVESTIGATION

The Executive Committee, before taking action on the request, shall conduct such investigation as it deems necessary, which may include informal interviews with the requesting party and the affected LIP (each out of the presence of the other), informal interviews with or reports from other persons, any required or requested departmental review, and chart reviews if applicable. Neither the investigation nor any other activities of the Executive Committee in acting upon a request for corrective action shall constitute a hearing, they shall be informal, and none of the procedural rules provided in Article 9 with respect to hearings and appeals shall apply.

8.2-3 TIME FOR TAKING ACTION; NOTICE, RIGHT TO HEARING

Within 60 days after receipt by the Executive Committee of a request for corrective action, or within such reasonable additional time as the Executive

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Committee deems necessary, the Executive Committee shall take action upon the request. If that action is adverse to the LIP, the Executive Committee shall also determine if it is based on a medical disciplinary cause or reason. Within five days after taking action, the Executive Committee shall give written notice to the affected LIP and the Governing Body. Such notice shall state which of the actions set forth in this Section the Executive Committee has taken. If the action is of a type requiring special notice as described in Article 9 Section 4, the content shall be as described in Section 3.2 of Article 9. In no event shall the LIP be entitled to the rights under Article 9 when the only action of the Executive Committee was to issue a letter of admonition or reprimand. In the case of a letter of admonition or reprimand, the affected LIP shall have the right to appear before his department on the matter and the department may consider additional information received from the LIP.

8.2-4 POSSIBLE ACTIONS

The action of the Executive Committee on a request for corrective action may be to reject the request; to issue a letter of admonition or reprimand, to impose terms of probation or a requirement for proctoring, co-admitting, or consultation, to recommend reduction, suspension, or revocation of clinical privileges, to recommend that an already imposed summary suspension of staff membership or clinical privileges be terminated, modified, or sustained; to recommend that the LIPs staff membership be suspended or revoked, or to take or recommend other actions deemed appropriate by the Executive Committee.

8.2-5 REQUESTING PARTY LIMITATIONS

The requesting party shall not participate as a member in any meetings, deliberations, or decisions of the Executive Committee, any Medical Review Committee, or the Governing Body, relative to the matters raised by or as a result of his request for corrective action, until after the final decision of the Governing Body has been rendered regarding said matters. The requesting party may, however, contribute to any investigation and be a witness consultant, or representative at any hearing or appeal held under Article 9 of these bylaws regarding such matters.

8.2-6 NOTICE TO ADMINISTRATOR

The Chair of the Executive Committee shall promptly notify the Administrator in writing of each request for corrective action received by the Executive Committee and the date of its receipt, and shall keep the Administrator fully informed of all communications, meetings, and other actions taken in connection with each request.

8.2-7 EXECUTIVE COMMITTEE RECONSIDERATION

If any member of the Executive Committee is dissatisfied with the action or lack of action by the Executive Committee on a request for corrective action, any of such individuals may request reconsideration by the Executive Committee. The Executive Committee shall have the absolute discretion to grant or deny such request, without prejudice to the affected LIP's rights described under Article 9 of these bylaws.

8.2-8 GOVERNING BODY ACTION

If after receiving either written notice of alleged conduct constituting grounds for corrective action, or a written request for corrective action, the Executive

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Committee fails or declines to investigate, or initiate corrective action, the matter shall be forwarded to the Governing Body. If the Governing Body reasonably determines that the Executive Committee's action or inaction is contrary to the weight of the evidence presented, the Governing Body or its designee shall consult with the Chief of Staff, thereafter the Governing Body may direct the Executive Committee to conduct an investigation or otherwise initiate corrective action. In the event the Executive Committee fails to take action in response to a direction from the Governing Body, the Governing Body, after written notification to the Executive Committee, may conduct an investigation or otherwise initiate corrective action proceedings. Such proceedings shall afford the affected LIP the procedural rights described in Article 9 of these bylaws.

8.2-9 RETENTION/LOSS OF PRIVILEGES

The affected LIP shall retain his membership and privileges and the use thereof pending final action by the Governing Body unless such membership and privileges are otherwise suspended as provided in this Article.

8.3 SUMMARY SUSPENSION

8.3-1 GROUNDS; AUTHORITY

A LIP's clinical privileges may be summarily suspended or restricted where the failure to take such action may result in an imminent danger to the health of any individual. The following persons are authorized by the Medical Staff to take such action: the Chief of Staff, the chairman of a clinical department, the Executive Committee, or the Administrator.

Suspension pursuant to this subsection shall be temporary and shall be effective only until further action by the Executive Committee pursuant to Section 4.4 herein below.

For the purposes of this Section, the term "suspending party" shall mean the individual, committee, or body who imposes a summary suspension, the terms "restriction" or "restrictions" shall refer individually or collectively to the imposed consultation, co-admitting, proctoring, and/or similar conditions or restrictions, and the terms "suspension," "suspended LIP," and the like, shall include the summary imposition of restrictions, as the case may be.

When no such person or committee is available to impose a summary suspension or restrict clinical privileges, the Governing Body or its designee, may take such action if a failure to do so may result in imminent danger to the health of any individual. Prior to exercising this authority, the Governing Body or its designee must make reasonable attempts to contact the Chief of Staff, as the representative of the Executive Committee. Summary action by the Governing Body which has not been ratified by any person or body authorized by the Medical Staff to summarily suspend within two (2) working days, excluding weekends and holidays, shall terminate automatically without prejudice to further summary action as warranted by the circumstances.

8.3-2 EFFECTIVE DATE; NOTICE

A summary suspension shall become effective immediately upon imposition and the person or body imposing same shall promptly give written or oral notice of the suspension, stating by whom it was imposed, and the specific reasons for same, to

the suspended LIP.

Said notice shall be deemed to have been given on the date on which it is either personally delivered or mailed to the suspended LIP, whichever occurs first. Said notice or any subsequent communication shall inform the suspended LIP of the mandatory informal interview under Section C.3 below, and of his rights under Articles 8 and 9. A copy of said notice shall forthwith be delivered to the Administrator, the Executive Committee, and the Governing Body.

#### 8.3-3 INVESTIGATION

The Executive Committee, before taking further action, shall conduct such investigation as it deems necessary, which shall include at least one meeting of the Executive Committee, an informal interview with the suspending party (if other than the Executive Committee), and an informal interview with the affected LIP within seven (7) days after notice of the suspension unless the LIP and Executive Committee agree to an extension. Such investigation may include chart reviews, if applicable, and informal interviews with or reports from other persons or relevant departments or committees. Neither the investigation nor any other activities of the Executive Committee in taking its further action shall constitute a hearing, they shall be informal, and none of the procedural rules provided in Article 9 of these bylaws with respect to hearings and appeals shall apply. If the LIP declines to meet with the Executive Committee, he will be deemed to have waived any subsequent right to challenge the summary action under Article 9.

#### 8.3-4 FURTHER ACTION, TIME

Within seven (7) days after the date of the LIP's interview, the Executive Committee shall take further action with respect to the suspension. Such further action may consist of the one of the following alternatives:

- a) To terminate the suspension.
- b) To sustain the suspension, by one or more of the following methods as deemed appropriate by the Executive Committee.
  - (1) By making any imposed consultation, monitoring, or similar restrictions effective until altered or terminated pursuant to other provisions of these bylaws. In so sustaining, the Executive Committee may add further restrictions or substitute other restrictions, which shall also become similarly effective.
  - (2) By converting a suspension of privileges to a revocation of the same, other, more, or all privileges.
  - (3) By sustaining the suspension during a period of further investigation deemed necessary.
- (c) To modify the suspension, by sustaining a portion thereof and terminating the remainder thereof.

Such further action shall remain in effect unless and until altered or terminated pursuant to other provisions of these bylaws. Failure to take further action within the time period set forth above shall be deemed a decision by the Executive Committee to sustain the suspension, as of the last date of said time

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period, as follows: by making effective any restrictions that had been imposed and by revoking any privileges that had been suspended.

8.3-5 NOTICE OF FURTHER ACTION

Within five days after taking its further action, the Executive Committee shall promptly give written notice of its action to the suspended LIP, the Administrator, and the person or body who imposed the suspension (if other than the Executive Committee).

8.3-6 EXECUTIVE COMMITTEE RECONSIDERATION

Following the decision of the Executive Committee regarding further action, the provisions of Article 9 shall govern the rights to hearing and appellate review. The suspended LIP shall have no rights to hearing, or appellate review if the suspension is terminated, but any member of the Executive Committee or Governing Body who is dissatisfied with a decision of the Executive Committee that modifies or terminated a suspension may request reconsideration by the Executive Committee.

8.3-7 ALTERNATE PATIENT COVERAGE

Immediately upon the imposition of a summary suspension, the Chief of Staff or responsible departmental chair shall provide for alternate medical coverage for the patients of the suspended LIP remaining in the hospital at the time of such suspension, if the appropriate privileges to provide such coverage were suspended. The wishes of the patients shall be considered in the selection of such alternative coverage.

8.3-8 TERMINATION OF STAFF MEMBERSHIP; READMISSION

When all of a LIP's privileges are revoked pursuant to Section 2.4 above, his staff membership and all attendant rights and prerogatives, except those available rights to hearing and appeal, shall also terminate as of the date of such total revocation, unless and until the Executive Committee, at any time prior to final decision of the Governing Body, or the Governing Body in its final decision, reinstates one or more of such privileges or prerogatives. In the absence of such reinstatement, any such LIP whose staff membership has terminated and who desires to reacquire staff membership and privileges shall make proper and formal application therefor provided that no such application shall be made or processed within 24 months after the effective date of such termination. Such LIP, his application, and the processing thereof shall comply with the provisions of these bylaws applicable to first-applicants.

8.3-9 PRIVILEGE RESTORATION AND RESTRICTION REMOVAL

Any particular privilege revoked under Section 2.4 above may be restored, and any restriction made permanent pursuant to said Section 2.4 above may be removed, only upon formal application by the LIP, unless the privilege is restored or restriction is removed by the Executive Committee prior to final decision by the Governing Body or by the Governing Body in its final decision. However, no such application shall be made or processed within 12 months after the date such privilege was revoked or such restriction was made permanent, as the case may be. Such LIP, his application, and the processing thereof shall comply with the provisions of these bylaws applicable to first-time applicants for the revoked privilege or for those privileges most directly related to the restriction in question, as the case may be.

#### 8.4 AUTOMATIC SUSPENSION OR EXPULSION

##### 8.4-1 MEDICAL RECORDS: SUSPENSION

For failure to complete medical records within fourteen (14) days after the patient is discharged, a LIP's clinical privileges (except with respect to his patients already in the Hospital) and his rights to admit patients and to provide any other professional services shall be administratively suspended if he has failed to complete the records within ten (10) days after he is given a final written notice and shall remain so suspended until all delinquent medical records are completed. With the exception of emergency care, those cases already booked for surgeries or outpatient procedures, and the care of patients already hospitalized at the time of suspension, such temporary suspension shall include all admitting and clinical privileges, and assisting at elective operations and any new scheduled cases for surgery and outpatient services. Unverified emergency admissions shall not be used to bypass such restriction. Failure to complete the medical records within three months after the date a suspension became effective or 90 cumulative days in a calendar year shall be deemed to be a voluntary resignation of the LIP's Medical Staff membership and privileges. The LIP will be required to reapply for Medical Staff privileges and subject to the application fees as set forth in Section 6.5. Upon reapplication to the medical staff after voluntary resignation for delinquent medical records, the required application fee will be two (2) times the Medical Executive approved application fee, due and payable upon submission of the completed application to the Medical Staff Office.

For purposes of this section, records assigned for peer review and/or provisional proctoring not completed in the above time frame shall be considered as delinquent records.

If a provisional member is placed on suspension for incomplete records on more than 3 occasions, or more than a cumulative total of 30 days, the member shall be removed from staff.

For the purposes of this section, a failure to complete records will not be cause of administrative suspension if:

- a) The member is ill, on vacation, or out of town for an extended period of time.
- b) The LIP has dictated the reports and is waiting for Hospital personnel to transcribe them.

##### 8.4-2 MEDICAL RECORDS: REPORT

If required by Business and Professions Code Section 805, an administrative suspension for failure to complete medical records will be reported under that section if the suspension is for more than a cumulative total of thirty (30) days in any twelve (12) month period and the Chief of Staff has determined that the failure to complete the records constitutes conduct reasonably likely to be detrimental to patient safety or to the delivery of patient care.

8.4-3 LICENSE: EXPULSION

Any staff member whose license to practice is revoked, not renewed, or totally suspended by the applicable state agency shall automatically be expelled from the Medical Staff, effective upon receipt by the hospital of notice of such official action. The member will not have the right of hearing or appeal as provided under Article 9 of these bylaws.

If a member's license to practice is made subject to probationary conditions by the licensing agency, the member's privileges and membership shall automatically become subject to the terms of the probation, effective upon and for at least the term of the probation.

8.4-4 DRUGS AND MEDICINE: SUSPENSION, ORDER OF PROBATION

All of a practitioner's clinical privileges (other than psychologists) shall be immediately automatically suspended if a practitioner (other than a psychologist) fails to maintain a valid DEA certificate with all scheduled substances. Such automatic suspension shall be effective until the governmental agency reinstates the practitioner's right or license, including all scheduled substances, and the practitioner provides a copy of the necessary license, certification or permit to Medical Staff Services Office. A practitioner (other than a psychologist) who is without a DEA certificate for 30 days shall be deemed to have voluntarily resigned from the Medical Staff. Notwithstanding the foregoing, from time to time, if the applicable governmental agency is not timely providing certificates, which confirm renewal, the MEC may implement measures to verify the practitioner's continuing right to prescribe controlled substances pending receipt of the certificate. If a practitioner's right or license to prescribe controlled substances or medications is restricted or subject to an order of probation, the practitioner's privileges to prescribe controlled substances or medications at or through the Hospital or any of its facilities shall automatically become subject to such restrictions or terms of the probation effective upon and for at least the term of the restriction or probation, unless the MEC determines otherwise and so notifies the affected practitioner.

8.4-5 LOSS OF MALPRACTICE INSURANCE

An automatic suspension shall occur whenever a LIP does not meet the malpractice insurance requirement under Article 3, Section 1 of these bylaws. The suspension shall remain in place until the LIP provides evidence to the Executive Committee that he has secured professional liability coverage in the amount required. A failure to provide such evidence within six months after the date the automatic suspension became effective shall be deemed to be a voluntary resignation of the LIP's Medical Staff membership.

8-4.6 FAILURE TO SUBMIT A COMPLETE APPLICATION TIMELY

An automatic suspension shall occur whenever a LIP (other than a temporary appointment) fails to submit a completed application at least one hundred twenty (120) days prior to the expiration of the member's current appointment. Such automatic suspension shall suspend the member's rights to admit and/or attend patients (except with respect to the member's patients already in the Hospital) until the member either notifies the Medical Staff in writing that the member will not be requesting reappointment or submits to the Medical

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Staff Office a complete application. A member who is suspended pursuant to this Section 8.4-6 will not have the right to a hearing or appeal as provided under Article 9 of these Bylaws.

8-4.7 CHIEF OF STAFF

It shall be the duty of the Chief of Staff to cooperate with the Administrator in enforcing all automatic suspensions and expulsions and in making necessary reports of same. The Administrator shall inform the Chief of Staff of the names of staff members who have been suspended or expelled under this Section.

8-4.8 NOTICES

The Administrator shall immediately notify the affected staff member and the Chief of Staff in writing, either by personal delivery or mail, of any suspension or expulsion under this Section. Such notice shall set forth the effective date of and the reason for the suspension or expulsion.

8.4-9 PROCEDURAL RIGHTS - MEDICAL RECORDS AND MALPRACTICE INSURANCE

LIPs whose clinical privileges are automatically suspended and/or who have resigned their Medical Staff membership pursuant to the provisions of Section 8.4 shall not be entitled to the procedural rights set forth in Article 9, unless suspension is reportable under Business and Professional Code Section 805. LIPs whose clinical privileges are automatically suspended and/or who have resigned their Medical Staff membership pursuant to the provisions of Section 4.5 above (failure to maintain malpractice insurance) shall not be entitled to the procedural rights set forth in Article 9.

8.4-10 OTHER INVESTIGATION AND DISCIPLINARY ACTIONS

Notwithstanding anything in these bylaws to the contrary, if the Executive Committee in its sole discretion deems it desirable, it may investigate any matter or any Medical Staff member brought to its attention by any source and may take any action it deems appropriate with respect thereto, including but not limited to the possible actions set forth in Section 8.2-4 above. Such investigation shall not be deemed a hearing and may be substantially as described in Section 8.2-4 above. The Executive Committee shall act with reasonable promptness and shall give notice within five days there from to any affected LIP and the Administrator. Only such LIP shall have a right to request a hearing under Article 9 and only if the action thus taken or recommended falls into one or more of the categories specifically set forth in Article 9, Section 4.

ARTICLE 9 HEARING AND APPELLATE REVIEW PROCEDURES

9.1 DEFINITIONS AND GENERAL PROVISIONS

9.1-1 DEFINITIONS

For the purposes of this Article 9, the following definitions shall apply:

- a) "Affected LIP" shall mean the Medical Staff member or applicant for Medical Staff membership with respect to whom any of the actions specified in Section 4 below has been taken or recommended, and whose staff membership or privileges may be affected thereby.
- b) "Body whose decision prompted the hearing" shall mean the person, committee, or body (which will generally be the Executive Committee) that, pursuant to these bylaws, took the action or made recommendation that resulted in hearing being requested.
- c) "Practitioner who requested the hearing" shall mean the Executive Committee or Governing Board member, other than the affected LIP, who, pursuant to these bylaws, was entitled to and has requested a hearing.
- d) "Parties" or "party," unless clearly indicated otherwise by particular context, shall mean, collectively or individually as the case may be, the affected LIP, the Executive Committee, the body whose decision prompted the hearing (if other than the Executive Committee), and, if applicable, the member who requested the hearing.
- e) "Recommended" or "recommending," with respect to any of the actions set forth in Section 4 below, shall mean the recommendation made to the Governing Body by the last committee or body to consider the matter prior to its being referred to the Governing Body, regardless of whether such recommendation to the Governing Body was based on any recommendation of another committee or person or otherwise.
- f) "Fair Review" shall mean the process offered to an Affected LIP in situations described in Section 9.4-2 when actions or recommendations are imposed or recommended that are not grounds for a formal hearing.

9.1-2 REVIEW PHILOSOPHY

The intent in adopting these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect LIPs (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. 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 State Peer Review Act and Claim all privileges and immunities afforded by the Federal State laws.

#### 9.1-3 INTRA-ORGANIZATIONAL REMEDIES

The hearing and appeal rights established in the bylaws are strictly "judicial" rather than "legislative" in structure and function. The hearing committees have no authority to adopt or modify rules and standards, or to decide questions about the merits or substantive validity of bylaws, rules, regulations or policies. The Governing Board may, however, entertain challenges to the merits or substantive validity of bylaws, rules, regulations 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 LIP may appeal directly to the Board or its designee. The LIP must submit his challenges first to the Hospital Governing Board and only thereafter may he seek judicial intervention.

#### 9.1-4 EXHAUSTION OF REMEDIES

If an adverse ruling is made with respect to a LIP's Staff membership, Staff status, or clinical privileges at any time, regardless of whether he is an applicant or a Medical Staff member, the LIP must exhaust the intra-organizational remedies afforded by these Bylaws before resorting to formal legal action challenging the decision, the procedures used to arrive at it, or asserting any claim against the Hospital or any participants in the decision process.

#### 9.2 SUBSTANTIAL COMPLIANCE

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

#### 9.3 NOTICES AND REQUEST FOR FORMAL HEARING OR FAIR REVIEW

##### 9.3-1 IN GENERAL

Each notice given in connection with the provisions of this Article 9 shall be in writing and shall be deemed to have been given on the date on which it is either delivered personally or if mailed postage prepaid, five (5) working days after it is deposited in the United States mail if by regular mail or the date shown on the receipt if by certified mail, whichever occurs first. The Administrator shall cooperate and assist in the giving of all notices on behalf of the Governing Body, the Medical Review Committee (MRC), the fair review panel, the Executive Committee, and the body whose decisions prompted the hearing, if other than the Executive Committee.

##### 9.3-2 NOTICE OF ACTION

Whenever any of the actions constituting grounds for formal hearing or fair review set forth in Section 4.1 or 4.2 below has been taken or recommended, the person, committee, or body causing same to occur shall give written notice thereof to the affected LIP. The notice shall state what action has been taken or recommended, whether the action, if adopted, must be reported under Business and Professions Code Section 805; a brief statement of the reasons for the action; that the LIP has the right to request a formal hearing or fair review; the time limit of 30 days within which to request a formal hearing or fair review; and that the LIP has the hearing rights described in these Bylaws.

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9.3-3 REQUEST FOR FORMAL HEARING OR FAIR REVIEW

The affected LIP shall have 30 days following the date of a notice of adverse action to request a formal hearing or a fair review. A letter requesting a hearing or fair review shall be in writing and delivered to the Chief of Staff, with a copy to the Administrator, and be received by the Chief of Staff within thirty days. Failure of the affected LIP to request a formal hearing or fair review within the time and in the manner set forth in this subsection shall be deemed an acceptance of the recommendation or action and a waiver by such party of all rights to formal hearing, fair review, and appellate review. The matter shall thereupon be forwarded to the Governing Body for its final decision in accordance with Article 9, Section 11.

9.4 GROUND S FOR FORMAL HEARING OR FAIR REVIEW

9.4-1 GROUND S FOR FORMAL HEARING

Except as otherwise provided in these bylaws, the taking or recommending of any one or more of the following actions shall constitute grounds for a formal hearing pursuant to the procedure set forth in Section 5, 6, 7 and 8.

- a) Denial of initial appointment to staff for medical disciplinary cause,
- b) Denial of staff reappointment for medical disciplinary cause,
- c) Suspension of staff membership for more than thirty (30) days in any twelve (12) month period for medical disciplinary cause,
- d) Summary suspension of staff membership for more than fourteen (14) consecutive days for medical disciplinary cause,
- e) Expulsion or termination from staff for medical disciplinary cause,
- f) Denial of requested clinical privileges for medical disciplinary cause,
- g) Reduction or termination of clinical privileges for medical disciplinary cause,
- h) Suspension of clinical privileges for more than thirty (30) days in any twelve (12) month period for medical disciplinary cause;
- i) Summary suspension of clinical privileges for more than fourteen (14) consecutive days for medical disciplinary cause;
- j) Revocation of clinical privileges for medical disciplinary cause; or
- k) Requirement of consultation or co-admitting, for medical disciplinary cause.

9.4-2 GROUND S FOR FAIR REVIEW

Except as otherwise provided in these bylaws, the taking or recommending of any one or more of the following actions in accordance with these bylaws shall constitute grounds for a fair review pursuant to the procedures set forth in Sections 9 and 10 below:

- a) Denial of initial appointment to staff for reasons other than medical disciplinary cause;

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- b) Denial of staff reappointment for reasons other than medical disciplinary cause;
- c) Suspension of staff membership for less than thirty (30) calendar days in any twelve (12) month period for any reason or for more than 30 calendar days for reasons other than medical disciplinary cause;
- d) Summary suspension of membership for less than fourteen (14) consecutive calendar days for any reason or for more than 14 consecutive calendar days for reasons other than medical disciplinary cause;
- e) Expulsion or termination from staff for reasons other than medical disciplinary cause;
- f) Denial of requested clinical privileges for reasons other than medical disciplinary cause;
- g) Reduction or termination of clinical privileges, other than in compliance with a generally acceptable procedure included in these Bylaws, the Rules or a policy adopted by the Medical Executive Committee or a generally policy decision of the hospital that has been approved by the Medical Executive Committee for reasons other than medical disciplinary cause;
- h) Suspension of clinical privileges for less than thirty (30) calendar days for any reason or for more than 30 calendar days for reasons other than medical disciplinary cause;
- i) Summary suspension of clinical privileges for less than fourteen (14) consecutive calendar days for any reason or for more than 14 consecutive calendar days for reasons other than medical disciplinary cause;
- j) Revocation or privileges other than in compliance with a generally applicable policy decision of the hospital for reasons other than medical disciplinary cause;
- k) Requirement of consultation or co-admitting other than noncompliance with generally applicable Medical Staff bylaws, rules and regulations or departmental rules and regulations for reasons other than medical disciplinary cause; or
- l) Demotion or denial of requested advancement in staff category for reasons other than medical disciplinary cause.

9.5 CONDUCT OF FORMAL HEARING

9.5-1 TIME AND PLACE FOR HEARING

Within 30 days after the Chief of Staff received a request for a hearing and, not less than thirty (30) days prior to the date of the hearing, the Chief of Staff shall give notice to the parties of the time, place, and date of the formal hearing, and shall deliver a copy of these bylaws to the affected LIP. The date of commencement of the formal hearing shall not be less than thirty (30) days nor more than sixty (60) days from the date the Chief of Staff received the request for a formal hearing, except that when the request is received from a member who has been summarily suspended, the formal hearing shall commence as soon as the arrangements may reasonably be made consistent with the goal of also completing

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any corrective action proceeding and holding a single hearing. The notice shall contain the names of the witnesses who are then expected to testify on behalf of the Medical Staff.

9.5-2 NOTICE OF CHARGES AND WITNESSES

As a part of, or together with, the notice of hearing required by Section 5.1 above, the Chief of Staff shall give written notice of the reasons for the action or recommendation, including the acts or omissions with which the LIP is charged and a list of any chart numbers under question or the grounds upon which the application was denied, if applicable. Amendments to the foregoing notice may be made from time to time prior to or during the formal hearing by the medical Staff representative, prior to the close of the case by the Medical Staff, to reflect the results of any further investigation regarding the affected LIP. Such amendments may delete, modify, or add to the acts, omissions, charts, grounds or reasons specified in the original notice. Notice of each amendment shall be given forthwith to the affected LIP, the hearing officer, and each party.

If the affected LIP promptly gives a written request to the MRC, he shall be entitled to a reasonable postponement of the formal hearing to prepare a response or defense to any amendment that adds acts, omissions, charts, or reasons to the original notice.

Upon the request of either party, each party at least ten (10) working days prior to the hearing, shall furnish to the other an updated list of the names and addresses of the individuals, so far as is then actually anticipated, who will give testimony or evidence in support of that party at the hearing. The witness list shall be amended if any additional witnesses are identified. A failure to comply with this requirement is good cause to postpone the hearing.

9.5-3 MEDICAL REVIEW COMMITTEE: APPOINTMENT, REMOVAL, AND QUALIFICATIONS

Promptly after a hearing has been properly requested, the Chief of Staff [or alternatively the Executive Committee] shall appoint a Medical Review Committee ("MRC") consisting of not less than three nor more than seven members who have the requisite expertise to ensure an efficacious and fair hearing. At any hearing session or time of formal action, a majority of the MRC shall be present. The number of members in the MRC may be decreased at any time during the formal hearing process without the necessity of starting the hearing anew, provided the Presiding Officer, appointed pursuant to subsection 5.5 below, finds that there is a reasonable basis for the reduction, such as the unwillingness of one or more members to continue, and provided further that the resulting number shall not be less than three. The individuals appointed to the MRC shall be licensed to practice medicine, but need not be members of the Medical Staff. They may have knowledge of the matters to be heard, but each shall be unbiased and shall not have actively participated in the formal consideration of the matter at any previous level (i.e., shall not have acted as an accuser, investigator, fact finder or initial decision-maker in the same matter). No person who is in direct economic competition with the affected LIP or who stands to gain direct financial benefit from the outcome shall be appointed to the MRC. Whenever possible, at least one member of the MRC should practice the same specialty as the affected LIP.

At the election of the Executive Committee, as an alternative to an MRC, an arbitrator may be used who is selected using a process mutually accepted by the body whose decision prompted the hearing and the affected LIP. The arbitrator

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need not be a health professional. The arbitrator shall carry out all the duties assigned to the Presiding Officer and MRC.

9.5-4 HEARING OFFICER

Upon the request of the affected LIP, the Executive Committee, the MRC, the Chief of Staff, or the Governing Body, the Administrator or his designee may appoint a hearing officer to conduct the hearing and rule on procedural matters. The hearing officer shall be an attorney at law qualified to preside over a formal hearing and preferably have experience in Medical Staff matters. He shall not be biased for or against the LIP, will gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate for any party. The hearing officer shall act as advisor to the MRC as to procedural matters, including the drafting of its decision and report, and may participate in its deliberations, but shall not be entitled to vote.

9.5-5 PRESIDING OFFICER

The Presiding Officer at the hearing shall be the hearing officer, as described in subsection 5.4, above, or if no hearing officer has been appointed, the Chairman of the MRC as designated by the Chief of Staff. The Presiding Officer should be familiar with Medical Staff administrative proceedings. He shall conduct the hearing impartially such that the proceeding will be, to the extent reasonably possible, fair, efficient, and protective of the rights of all parties and witnesses. He shall decide all procedural matters and shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing. He shall have the authority and discretion, in accordance with these Bylaws, to grant continuances, to rule on disputed discovery requests, to decide what evidence may not be introduced, to rule on challenges to hearing committee members, to rule on challenges to himself serving as a hearing officer, and to rule on questions which are raised prior to or during the hearing pertaining to matters of law, procedure, or the admissibility of evidence.

9.6 FORMAL HEARING PROCEDURE

9.6-1 FAILURE TO APPEAR

Failure of the affected LIP to appear and proceed at the formal hearing shall be deemed to constitute the affected LIP's voluntary acceptance of the recommendation or action involved and it shall thereupon become the final recommendation of the Medical Staff unless the MRC finds good cause for such failure, based upon written request by the affected LIP or his representative. Such final recommendation shall be considered by the Governing Body within seventy (70) days. The recommendation shall be given great weight but shall not be binding on the Governing Body.

9.6-2 PRE-HEARING PROCEDURE

It shall be the duty of LIP and the body whose decision prompted the hearing to exercise reasonable diligence in notifying the Presiding Officer of any pending or anticipated procedural irregularity, as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may expeditiously be made. Objection to any such pre-hearing decisions shall be raised at the formal hearing and when so raised shall be preserved for consideration at any appellate review hearing which thereafter might be requested.

#### 9.6-3 DISCOVERY

##### a) Rights of Inspection and Copying

The affected LIP may inspect and copy (at his 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 affected LIP has in his possession or under his control.

The requests for discovery must be fulfilled as soon as practicable. Failures to comply with reasonable discovery requests at least thirty days prior to the hearing shall be good cause for a continuance of the hearing.

##### b) Limits of Discovery

The Presiding Officer, upon the request of either side may deny a discovery request on any of these grounds:

- (1) The information refers solely to individually identifiable LIPs other than the affected LIP.
- (2) Denials justified to protect peer review or justice.

In ruling on discovery disputes, the factors that may be considered include:

- (3) Whether the information sought may be introduced to support or defend the charges.
- (4) Whether the information is "exculpatory" or "inculpatory" i.e., whether there is a reasonable probability that the result of the hearing would be influenced significantly by the information if received into evidence.
- (5) The burden on the party of producing the requested information.
- (6) What other discovery requests the party has previously made.

##### c) 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 Presiding Officer unless the LIP can prove he previously acted diligently and could not have submitted the information.

#### 9.6-4 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 ten days prior to the hearing. A failure to comply with this rule is good cause for the Presiding Officer to grant a continuance. Repeated failures to comply shall be good cause for

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the Presiding Officer to limit introduction of any documents not provided to the other side in a timely manner.

9.6-5 REPRESENTATION

As limited by this Section 6.5, each of the parties shall have the right to representation at the hearing. Such representation may consist of one licensed LIP for each side who preferably is a Medical Staff member and who is not an attorney. A representative may also be a witness.

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on conduct or professional competency. Accordingly, neither the LIP, the Executive Committee, nor the Governing Body shall be represented at the formal hearing unless the MRC in its discretion, permits both sides to be represented by legal counsel. Neither the Executive Committee nor Governing Body shall be represented by an attorney if the affected LIP is not so represented. The foregoing shall not be deemed to deprive any party of its right to the assistance of legal counsel for the purpose of preparing for the hearing.

9.6-6 RECORD OF THE HEARING

The MRC shall maintain a record of the hearing by using a certified shorthand reporter to record the hearing. The LIP shall be entitled to receive a copy of the transcript upon paying the reasonable cost for preparing the record.

9.6-7 OATH OF WITNESSES

The Presiding Officer may, but is not required to, order that oral evidence shall be taken only on oath administered by any person designated by such body and entitled to notarize documents in this State or by affirmation under penalty of perjury to the Presiding Officer.

9.6-8 ORGANIZATION AND CONDUCT OF HEARING PROCESS

- a) The Medical Staff representative shall present an opening statement summarizing the background of the matter, the notices given, any administrative decisions rendered to date, and, if he chooses, the salient general conclusions the representative expects to prove.
- b) The Medical Staff representative shall then present the facts upon which he is relying, by calling the witnesses and presenting the written evidence to support the case. He may call any person or opposing party, who is present, in support of the case.
- c) At the close of the Medical Staff representative's case, unless the MRC believes that the action or recommendation being reviewed was clearly not supported by the Medical Staff representative's presentation (in which case the hearing may terminate by such a ruling at this point), the affected LIP or his representative shall make an opening statement and shall make a case presentation of evidence and testimony. He may call any person or opposing party, who is present, in support of the case.
- d) Upon the close of the initial presentations of the opposing parties, each party shall be entitled to present evidence to rebut the presentation of the other, subject to reasonable limitations by the hearing officer as to order, time, relevance, and repetition.

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- e) Upon the close of all presentations and evidentiary rebuttals, the parties shall be entitled, subject to reasonable limitations by the hearing officer, to give closing statements and arguments.
- f) Upon the close of all presentations, rebuttals, statements, and argument, all persons other than the MRC and hearing officer shall thereupon leave the hearing. The MRC shall thereafter, at the convenience of its members, deliberate in order to reach its decision. The hearing shall be adjourned when the deliberations are completed.
- g) Liberality may be exercised in accommodating the schedules of witnesses, MRC members, parties, and representatives, in allowing modification of required notices, in allowing recesses or extensions of time upon a reasonable showing of need, and in allowing changes in the order of the proceedings or the presentation of evidence. The decision of the hearing officer after consultation with the MRC regarding such matters shall be final, subject to later reconsideration for good cause only.
- h) No person shall disrupt any hearing. Any person in attendance (whether a party or any other person) who disrupts a hearing after being warned by the Presiding Officer to cease such disruption on penalty of indefinite exclusion, shall, at the direction of the Presiding Officer, leave the hearing. Unless directed otherwise for good cause by the Presiding Officer, the hearing shall proceed in the absence of such excluded person. If such excluded person is the affected LIP or a witness, he shall have the right to submit to the MRC, not later than ten days after such exclusion (unless extended by the Presiding Officer for good cause), a written affidavit of his testimony or other evidence, with copies thereof to the other parties.
- i) Except as otherwise provided in these bylaws and subject to reasonable restriction by the Presiding Officer, the following shall be permitted to attend the entire hearing in addition to the MRC, Presiding Officer, court reporter, and parties, the Administrator, one or more persons designated by the Administrator, the Medical Staff coordinator or assistant, one or more key consultants for each party, one or more key witnesses for each party, and one or more representatives of the entity that owns the hospital.

9.6-9 BURDEN OF GOING FORWARD AND BURDEN OF PROOF

In all cases, the body whose decision prompted the hearing shall have the burden of initially presenting evidence to support the charges and its recommendation. Thereafter the burden differs, depending upon whether the LIP is applying for membership or privileges or is a member who already has the membership or privileges. At any hearing involving denial of Medical Staff membership or denial of privileges (i.e., the grounds for hearing specified in Subsections a or f of Section 4.1) the LIP has the burden of proving by a preponderance of the evidence that he is qualified for membership and/or the denied privileges. The LIP must produce information which allows for an adequate evaluation and resolution of qualifications.

In all other cases involving members who already have been granted membership and the privileges, the body whose decision prompted the hearing shall have the burden of proving by a preponderance of the evidence that the action or recommendation is reasonable and warranted.

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9.6-10 POSTPONEMENT AND EXTENSIONS

Postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by any affected person and shall be permitted by the Presiding Officer on a showing of good cause.

9.6-11 ADMISSIBLE EVIDENCE AND GENERAL PROCEDURES

Except as otherwise provided in these bylaws, the following rules apply in the hearing with respect to evidence and briefs:

- a) The general rule of evidence shall be that any relevant matter, whether written or oral, upon which responsible individuals would be expected to rely in the conduct of serious affairs, shall be admitted, regardless of its admissibility in a court of law.
- b) Parties, representatives, and any member of the MRC shall have the right to:
  - (1) As MRC members and the hearing officer questions directly related to whether any of them are impermissibly biased, subject to reasonable restriction by the Presiding Officer to prevent abuse of the right, and to challenge such members or the hearing officer,
  - (2) Call and examine witnesses on relevant matters,
  - (3) Introduce relevant exhibits,
  - (4) Cross-examine each witness on relevant matters, after such witness testifies on direct examination,
  - (5) Present evidence that tends to impeach any witness on relevant matters, provided that, to prevent abuse of this right, the Presiding Officer may, in his discretion, require a prior offer of proof summarizing such evidence and may in his discretion reject such evidence if the party fails to submit such offer of proof or if the offer of proof reasonably justified such rejection.
  - (6) Receive all information made available to the MRC.
- c) Evidence of relevant activities or practices at any location or facility shall be admissible unless limitations are imposed by the Presiding Officer upon a showing of good cause.
- d) No legal doctrine shall prevent the introduction of any evidence or the reassertion of any charge, but this entire Section shall not be used to avoid the prohibition of Section 12 below against more than one hearing on any issue, unless substantial evidence is offered that was not available at the time of the prior hearing.
- e) Each party has a right to submit a written statement in support of his position at the close of the hearing.
- f) Any relevant material contained in Medical Staff files regarding the affected LIP is admissible, including but not limited to applications, references, and accompanying documents, so long as it is provided to all parties.

9.7 DECISION AND REPORT OF MRC: NOTICE

Within 30 days after final adjournment of the hearing, the MRC shall render and deliver to the Administrator a written decision that shall be in the form of a recommendation to affirm, terminate, or modify the action or recommendation that prompted the hearing, and if to modify, the recommended modifications shall be set forth. The decision shall be based on any written statements and all evidence produced at the hearing, including any recognized matters, and reasonable inferences that may be drawn therefrom. The decision shall include a concise statement of the MRC's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Within five (5) days after receiving the report, the Administrator shall give a copy of the decision to the Governing Body, the affected LIP, the Executive Committee, and each other party (if any). A copy of the Medical Staff bylaws including a written explanation of the appellate procedure shall accompany the copy of the decision.

9.8 GOVERNING BODY ACTION AFTER MRC DECISION

The Governing Body shall take no action regarding the underlying matter or the decision and report of the MRC, until after the expiration of the time for requesting appellate review under Section 11.1 below, provided that if any appellate review is properly requested under Section 11.1, the Governing Body shall take no action except in compliance with the procedures and provisions of this Article 9. If any appellate review is not properly requested and the time therefor has expired, the Governing Body shall make its final decision in accordance with Section 11.5.

9.9 NOTICE OF RIGHT TO FAIR REVIEW

Whenever any actions constituting grounds for a Fair Review under Section 9.4-2 above, has been taken or recommended, the Medical Executive Committee shall give written notice to the Affected LIP. The notice shall:

- a) describe what action has been taken or recommended.
- b) state the reasons for the action or recommendation.
- c) state that the Affected LIP is entitled to a Fair Review, which must be requested in writing and the request received by the CEO within thirty (30) days after the Affected LIP's receipt of the notice adverse action or recommended action.

9.10 FAIR REVIEW PROCEDURE

The procedure for requesting , arranging for and conducting a fair review and governing board appeal from a fair review shall be the same as for hearings except that, (1) there is no right to discovery, (2) the hearing shall be before an arbitrator to be designated by the CEO with pre-procedural rights for voir dire to confirm the proposed arbitrator is qualified and not biased, (3) the parties must exchange documents and witness lists at least five (5) working days prior to the hearing, and testimony of witnesses and copies of evidence not timely exchanged may be barred, (4) the body whose decision prompted the hearing has the initial burden of producing evidence to support its action or recommendation, with the burden shifting to the affected LIP to produce evidence and demonstrate that the decision was unreasonable, (5) neither party has the right to personal attendance, oral argument or representation by an attorney at

the Governing Board appeal.

#### 9.11 APPEALS TO THE GOVERNING BODY

##### 9.11-1 TIME FOR APPEAL

Within forty days after the date of receipt of the MRC or Fair Review panel decision, either the LIP, the body whose decision prompted the hearing or review, or the Governing Body (on its own motion) may request an appellate review by the Governing Body. Said request shall be delivered to the Administrator in writing either in person, or by certified or registered mail, return receipt requested, and it shall briefly state the reasons for the appeal.

If appellate review is not requested within this period, both sides shall be deemed to have accepted the action involved and its decision shall thereupon become the final action of the Medical Staff. Such final recommendation shall be considered by the Governing Body within seventy (70) days. The recommendation shall be given great weight, but shall not be binding on the Governing Body.

##### 9.11-2 TIME, PLACE AND NOTICE

When appellate review is requested, the Governing Body shall, within forty-five (45) days after the date of receipt of such an appeal notice, schedule and arrange for an appellate review. The Governing Body shall give the LIP notice of the time, place, and date of the appellate review. The date of appellate review shall be not less than fifteen nor more than ninety (90) days from the date of receipt of the request for appellate review. If, however, a LIP is under suspension, the appellate review shall be held as soon as the arrangements may reasonably be made, but not more than forty-five (45) days from the date of receipt of the request for appellate review. The time for appellate review may be extended for good cause by the Governing Body, or appeal board (if any).

##### 9.11-3 APPEAL BOARD

The Governing Body may sit as the appeal board or it may appoint an appeal board which shall be composed of Governing Body members and shall have at least three (3) members. 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 participate in the matter at any previous level, (ie, as an accuser, investigator, fact finder, or initial decision-maker in the same matter). For the purposes of this Section, participating in an initial decision to recommend an investigation shall not be deemed to constitute participation in a prior hearing or appeal on the same matter.

##### 9-11.4 APPEAL PROCEDURE

At the election of the Governing Body, the proceedings by the appeal board shall either be a de novo hearing or an appellate review based upon the record of the hearing before the MRC or Fair Review Panel. When an appellate review is elected, the following procedures shall apply: The appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the MRC or Fair Review Panel in the exercise of reasonable diligence and subject to the same rights of cross examination or confrontation provided at the hearing or fair review; or the appeal board may remand this matter to the MRC or Fair Review Panel for the taking of further evidence and for decision. Each party has the right to be represented by an attorney (if the action must be reported under Business and Professions Code Section 805) or any other representative the party chooses.

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The Appeal Board has the discretion to determine when to allow attorney representation when the decision resulted from fair review. The appeal board may select an unbiased attorney to assist it by fulfilling the duties of presiding and hearing officer, as described in Section 5.4 and 5.5. Each party has the right to present a written statement in support of his position on appeal. In an appeal from a formal hearing, the appeal board shall allow each party or representative to personally appear and present oral arguments. If oral argument is not allowed for a formal hearing decision, the party when requesting appellate review must be given a chance to respond to the other party's written statement. This "reply" is not required if oral argument is allowed. At the conclusion of oral argument, if allowed, the appeal board may thereupon conduct, at a convenient time, deliberations outside the presence of the parties and their representatives.

If an appeal board is appointed, the appeal board shall present to the Governing Body its written recommendations as to whether the Governing Body should affirm, modify, or reverse the MRC or Fair Review Panel decision, or remand the matter to the MRC or Fair Review Panel for further review and decision. If no appeal board is appointed, the procedures outlined in this subsection shall apply to an appeal before the Governing Body.

9.11-5 DECISION

Within fifteen days after adjournment of the appellate review proceedings, the Governing Body shall render a final decision in writing. Final adjournment shall not occur until the Governing Body has completed its deliberations. The Governing Body may affirm, modify, or reverse the MRC or Fair Review Panel decision, or, in its discretion, remand the matter for further review and recommendation by the MRC or Fair Review Panel or any other body or person. The Governing Body shall give great weight to the recommendation of the Medical Staff and shall not act arbitrarily or capriciously. The Governing Body is allowed, however, to exercise its independent judgment in determining whether a LIP was afforded a fair hearing or review, whether the decision is reasonable and warranted, and whether any bylaws provision, rule or regulation relied upon by the hearing committee in reaching its decision is reasonable and warranted. Copies of the decision shall be delivered to the LIP and to the Executive Committee, by personal delivery or by mail.

9.11-6 FURTHER REVIEW

Except when the matter is remanded for further review and recommendation, the final decision of the Governing Body following the appeal procedures set forth in this Article shall be effective immediately and shall not be subject to further review. If the matter is remanded to the MRC or Fair Review Panel or any other body or person, said committee, body, or person shall promptly conduct its review and make its recommendations to the Governing Body in accordance with the instructions given by the Governing Body. The time for a further review and report shall not exceed ninety (90) days except as the parties may otherwise stipulate.

9.12 RIGHT TO ONLY ONE MRC HEARING AND APPELLATE REVIEW

Notwithstanding any other provision of these Bylaws, no party shall be entitled to more than one MRC or other evidentiary hearing or more than one appellate review on any matter that has been the subject of action by either the Executive Committee or the Governing Body or both.

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9.13 INFORMAL INTERVIEWS

Nothing in these bylaws shall be deemed to prevent any committee or person contemplating any action or recommendation set forth in Section 4 above from inviting the affected LIP to participate in an informal discussion of the contemplated action or recommendation. Such discussion shall not be deemed to constitute a hearing under this Article 9.

9.14 EXCEPTIONS TO HEARING AND REVIEW RIGHTS

9.14-1 CLOSED STAFF OR EXCLUSIVE USE DEPARTMENTS, HOSPITAL CONTRACT PHYSICIANS AND MEDICO-ADMINISTRATIVE OFFICERS

a) Closed Staff or Exclusive Use Departments

The Governing Board may determine with consent of the Medical Executive Committee as a matter of policy and in accordance with state and federal law, that certain hospital clinical facilities may be used only on an exclusive basis in accordance with written contracts between the hospital and qualified professionals, or in a limited fashion pursuant to a closed/limited staff policy. The formal hearing and fair review rights of Articles 8 and 9 do not apply to a LIP whose application for Medical Staff membership and privileges was denied or whose privileges were terminated on the basis the privileges he seeks are granted only pursuant to a closed staff or exclusive use policy. Such LIPs 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 LIP may personally appear before and/or submit a statement in support of his position to the Governing Body.

b) Hospital Contract Physicians and Medico-Administrative Officers

The fair hearing rights of Articles 8 and 9 do not apply to LIPs serving the Hospital as hospital contract physicians or in medico-administrative capacities. Removal of these LIPs from office shall instead be governed by the terms of their individual contracts and agreements with the Hospital. The hearing rights of this Article 8 and of Article 8 shall apply if an action is taken which must be reported under Business and Professional Code Section 805 and/or the LIP's Medical Staff membership status or clinical privileges which are independent of the LIP's contract are also removed or suspended.

9.14-2 Allied Health Professionals

Allied Health Professionals are not entitled to the fair review rights set forth in this Article unless the action involves a clinical psychologist and must be reported under Business and Professions Code Section 805.

9.14-3 DENIAL OF APPLICATIONS FOR FAILURE TO MEET THE MINIMUM QUALIFICATIONS

LIPs shall not be entitled to any formal hearing, fair review, or appellate review rights if their membership or privileges, applications or requests are denied because of their failure to have a current and unrestricted California license to practice medicine, dentistry, podiatry or clinical psychology; to maintain an unrestricted Drug Enforcement Administrative certificate (for physicians); to maintain professional liability insurance as required by the rules, and/or to file a complete application.

9.14-4 AUTOMATIC SUSPENSIONS AND RESIGNATIONS

LIPs whose clinical privileges are automatically suspended and/or who have resigned their Medical Staff membership for failing to complete medical records and failing to maintain malpractice insurance under Article 8, Section 4, are not entitled to any formal hearing, fair review, or appellate rights under Article 9 except when a suspension for failure to complete medical records is reported pursuant to Article 8, Section 4.3.

9.14-5 FAILURE TO MEET MINIMUM ACTIVITY REQUIREMENTS

LIPs shall not be entitled to the hearing and appellate review rights if their membership or privileges are denied, restricted or terminated or their 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. Notwithstanding the foregoing, if the LIP believes the activity count is erroneous and that s/he has met the minimum activity requirements, within thirty days of notification of actions taken based upon the failure to meet minimum activity requirements, the LIP can submit to the Medical Staff Office a list of his or her activity to demonstrate satisfaction of such requirements. The Medical Staff then will review the list submitted by the LIP to ascertain if there was an error in the Medical Staff's calculations.

9.15 SETTLEMENTS

If a proposed settlement of the subject matter is agreed upon between the affected LIP and the Executive Committee, such proposed settlement may be submitted in writing directly to the Governing Body for its rejection or approval. If the Governing Body rejects such submitted settlement, the settlement shall terminate as if it has never been agreed upon. If the Governing Body approves such a submitted settlement, it shall render its final decision in the matter in accordance with the settlement and the decision shall be effective immediately and shall not be subject to further hearing or review. Failure of the Governing Body to reject or approve such a settlement within 30 days after its submission to the Governing Body shall be deemed a final decision by the Governing Body to approve it.

9.16 CONFIDENTIALITY OF PROCEEDINGS

Except as otherwise authorized in these bylaws or by law, all parties, participants, and attendees shall keep the hearing and appellate review proceedings and the contents thereof confidential, and no one shall disclose or release any information from or about the proceedings to any person or the public. Any party or participant who is damaged by a violation of this Section may enforce this Section by court order upon request for injunctive or other appropriate relief.

ARTICLE 10 CLINICAL DEPARTMENTS

10.1 ORGANIZATION OF CLINICAL DEPARTMENTS

Each clinical department shall be organized as a separate part of the medical staff and shall have a chairman who is selected and has the authority, duties, and responsibilities as specified in these Bylaws and in the staff Rules and Regulations.

10.2 DESIGNATION

10.2-1 CURRENT CLINICAL DEPARTMENTS

The current clinical departments are:  
Obstetrics/Gynecology/Pediatrics, Cardiology, General/Family Practice, Emergency Medicine, Anesthesiology, Surgery, Medicine, Radiology, and Anesthesiology.

10.2-2 FUTURE CLINICAL DEPARTMENTS

When deemed appropriate for better organizational efficiency and improved patient care, the MEC with the approval of the Board may create anew, eliminate, subdivide or combine clinical departments.

10.3 ASSIGNMENT TO CLINICAL DEPARTMENTS

Each member of the staff and each Allied Health Professional shall be assigned membership in one clinical department by the Medical Executive Committee but may be granted clinical privileges or specified services in one or more of the other departments. The exercise of clinical privileges or the performance of specified services within any department shall be subject to the rules and regulations of that department and the authority of the department chief. If an individual has clinical privileges in a particular department but is not a member of that department the individual is not entitled to attend that department's meetings, however, (a) the individual may request that department chair's permission to attend those portions of the meeting, if any, in which cases will be reviewed or education will be provided that is pertinent to the privileges the individual holds in that department, and (b) the chair or department may request or require the individual attend portions of a department meeting when the department is reviewing the individual's care or conduct.

10.4 FUNCTIONS OF CLINICAL DEPARTMENTS

It is the responsibility of each department to fulfill administrative and quality of care maintenance and improvement functions.

10.4-1 GENERAL FUNCTIONS

Each department will discharge the following quality improvement and accountability functions, either alone or in concert with other organizational components of the medical staff and of the hospital:

- a) Fulfill the responsibilities designated to the department as set forth in the Bylaws, Rules & Regulations conducting specified monitoring activities, for the purpose of evaluating the clinical work performed under its jurisdiction, including mortality case review, drug reaction case review, transfusion reaction case review and surgical case review.
- b) Establish minimum requirements for the clinical privileges that may be

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exercised by its members and others exercising clinical privileges within its jurisdiction, review the demonstrated results of privileges so exercised, and frame recommendations for future privileges.

- c) Monitor its members' performance, on a continuing and concurrent basis, for adherence to staff, hospital, and department policies and procedures, including requirements for alternate coverage and for obtaining consultation, for adherence to sound principles of clinical practice generally, for appropriate surgical and other procedures, for unexpected clinical occurrences, and for patient safety.
- d) Establish such committees or other mechanisms as are necessary and desirable to properly perform quality improvement functions.
- e) Conduct or participate in, and make recommendations to the Medical Education/Library Chairman regarding the need for continuing education programs pertinent to changes in the state-of-the-art practice of medicine and to findings of the quality improvement program.
- f) Review and evaluate medical records to determine that they: (1) properly describe the condition and progress of the patient, the therapy and tests provided, the results thereof, and the identification of responsibility for all actions taken, and (2) are sufficiently complete at all times so as to facilitate continuity of care and communications between all those providing patient care services in the hospital.
- g) Submit written department/committee minutes and reports to the MEC on a regularly scheduled basis concerning: (1) findings of the department's quality improvement activities, including assessment and analysis of findings, problems identified, action and priority recommended; (2) administrative activities; and (3) such other matters as may be assigned to the department by the MEC or Board.
- h) Meet periodically (at least twice in each year) for the purpose of fulfilling the administrative and quality of care functions assigned to the department. At the discretion of the department chairman, additional meetings may be called throughout the year as needed.

10.5 DEPARTMENTS AS COMMITTEES OF THE MEDICAL STAFF

Notwithstanding anything in these Bylaws which may be to the contrary each department/committee shall carry out its primary responsibility of evaluating and improving the quality of care rendered in the hospital as an organized departmental committee of the medical staff, consisting of those members who have been assigned to such department or committee pursuant to these bylaws and who continue to be members thereof in good standing.

ARTICLE 11 MEDICAL STAFF OFFICERS AND DEPARTMENT OFFICIALS

11.1 OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be:

- a) Chief of Staff
- b) Vice Chief of Staff
- c) Immediate Past Chief of Staff
- d) Secretary-Treasurer

11.2 QUALIFICATION OF OFFICERS

Officers of the Medical Staff must be members of the active staff at the time of nomination and election and must remain members in good standing during their term of office and must be willing and able to faithfully discharge the duties of the office held. Failure to maintain such status shall immediately create a vacancy in the office involved. The Chief of Staff and Vice Chief of Staff must have demonstrated executive abilities and be recognized for the high level of clinical competence. No individual may hold two offices concurrently.

11.3 NOMINATING COMMITTEE/NOMINATING

- a) The Nominating Committee shall convene no later than two (2) months prior to the annual meeting of the Medical Staff and shall submit to the Active Medical Staff one or more qualified nominees for each of the following offices: Chief of Staff, Vice Chief of Staff, and Secretary-Treasurer.
- b) The Nominating Committee membership shall consist of the three (3) immediate past chiefs of staff and the immediate past chairmen of all the clinical departments. In the event one or more of those nominating committee members are serving as an officer during the current year they will be excluded and a substitute member of the Committee shall be appointed by the Chief of Staff. The most immediate past chief of staff in attendance at the meeting shall act as chairman. A current staff officer cannot be a member or attend the nominating committee meeting.

Nominations of candidates for office, in addition to those selected by the Nominating Committee, may be made by members of the Active Medical Staff in writing, addressed to the Medical Staff Office. Such nominations must be signed by at least ten (10%) of the members of the active staff and must be received within ten (10) days of the mailing date of the Nominating Committee's notification of selections. Additional nominations received will be included on the ballot mailed and indicated as nominations from the floor.

Active Staff members shall receive ballots at least one (1) month prior to the annual meeting and ballots should be marked and returned no later than one month from the date they were mailed from the Medical Staff Office, so that they may be counted and results announced.

11.4 ELECTION OF OFFICERS

Officers shall be elected by mail ballot. Only staff members accorded the prerogative to vote for staff officers shall be eligible to vote. A nominee shall be elected upon receiving a majority of valid votes cast. If no nominee for the office receives a

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majority vote on the first ballot, a runoff election shall be held promptly between the two (2) candidates receiving the highest number of votes.

Ballots shall be mailed to the Active Staff via certified mail, return receipt, with a double return envelope system enclosed. Physicians' ballots may be hand-delivered with a signed receipt. Ballots will be considered invalid if returned in an unsigned "return envelope".

When counting ballots, each candidate shall be entitled to be present or have a representative of his/her choice present during the process.

Ballots shall not be destroyed until after the next MEC meeting convenes and approves the results, including any ballots deemed invalid.

If nominees for all offices are running uncontested, after the slate of nominations is sent to the Active Staff, a unanimous decision is assumed and no ballots will be required to be sent out.

In the case of a tie, the majority vote of the medical executive committee shall decide the election by secret written ballot at its next meeting or a special meeting called for that purpose.

Upon approval by the MEC of election results, appointees will be announced at the annual meeting of the Medical Staff. All procedural action consistent with Bylaws, Article 5, Section 4, Subsection 7 and Article 7, Section 2, Subsection C and as elsewhere specified in the Bylaws, shall apply.

11.5 TERM OF OFFICE

Each officer shall serve a two-year term, commencing on the first day of the Medical Staff year following the officer's election. Each officer shall serve until the end of their term and until a successor is elected, unless they shall sooner resign or be removed from office. The officers of the Medical Staff shall not be eligible to succeed themselves. No officer may serve more than one (1) full, elected (consecutive) terms in the same office.

11.6 REMOVAL OF ELECTED OFFICER

Removal of a Medical Staff officer for cause may be initiated by a two-thirds (2/3) majority vote of the active Medical Staff or the MEC. If initiated by the MEC, it must be approved by a two-thirds (2/3) majority vote of the active Medical Staff.

11.7 VACANCIES IN ELECTED OFFICE

Vacancy of an office during the medical staff year, except for the Chief of Staff, shall be filled by the MEC. If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff shall serve out the remainder of the term of the vacancy. A vacancy in the office of the Vice Chief of Staff shall be filled by the Secretary-Treasurer of the Medical Staff. If necessary a special election may be held to fill a vacant office.

11.8 RESPONSIBILITIES AND AUTHORITY OF OFFICERS

11.8-1 CHIEF OF STAFF

As the primary medical staff officer, the chief administrative officer of the staff and staff's representative in its relationships to others, the chief of

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staff has the following responsibilities and authority:

- a) To call and preside at all General Staff and Executive Committee meetings and shall be an ex-officio member of all committees.
- b) He shall present the views, policies, needs and grievances of the medical staff to the Governing Body and the Administrator.
- c) He shall interpret to the Governing Body the performance and maintenance of the medical staff's responsibility for providing quality medical care.
- d) To enforce the Medical Staff Bylaws, Rules and Regulations.
- e) To act as spokesman for the Medical Staff's professional public relations.
- f) He shall participate on a continuing basis in the administration of the medical staff, the Executive Committee and the program of medical services offered by the Hospital. It shall be the Chief of Staff's duty to maintain contact with the heads of each Department/Division or Committee on a continuing basis and oversee that the medical care rendered meets the standards of the community.
- g) As Chief of Staff he may call in a consultant on any patient if necessary.
- h) He shall serve as a member of the board with vote, chairman of the Medical Executive Committee with tie breaking voting privileges only, and as an ex-officio member without vote on all other Department, Division or Committee meetings.
- (i) The Chief of Staff, either in conjunction with or subject to ratification by the Medical Executive Committee, may establish ad hoc committees and appoint the members of such ad hoc committees.
- (j) Represent and act on behalf of the medical staff in intervals between medical staff meetings, subject to such limitations as may be imposed by the medical staff bylaws.

11.8-2 VICE CHIEF OF STAFF

The Vice Chief of Staff, in the absence of the Chief of Staff, shall assume all his duties and have all his authority. He shall be expected to perform such duties of supervision as may be assigned him by the Chief of Staff. He shall assume the duties of the Chief of Staff for any unexpired term should the office be vacated.

11.8-3 SECRETARY-TREASURER OF STAFF

The Secretary-Treasurer shall determine whether a quorum is present at all medical staff meetings, keep accurate and complete minutes of all meetings, call meetings on order of the Chief of Staff, attend to his correspondence and perform such other duties as ordinarily pertain to his office. The Executive Committee shall appoint a member of the Active Medical Staff to fill a vacated office of Secretary-Treasurer of Staff. He shall be responsible for and maintain the accounts of all funds related to the medical staff and present a report of funds at the annual general staff meeting.

11.8-4 PAST CHIEF OF STAFF/CHAIRMAN

The immediate past Chief of Staff shall serve on the Executive Committee for the ensuing year. All past chairmen of each of the various clinical departments and medical staff committees shall serve as a member of that same department/committee for the ensuing year.

11.9 APPOINTMENT OF DEPARTMENT OFFICIALS

The incoming officers shall meet with outgoing officers to assure continuity. At this meeting, recommendations may be made as to possible candidates for Department and Committee Chair positions.

11.9-1 QUALIFICATION OF DEPARTMENT CHAIRS AND VICE CHAIRS

Each department chair and vice chair must be a member of the active staff, shall have demonstrated ability in the clinical area covered by the department and shall be willing, able and eligible to discharge faithfully, the functions of their office. Department chairs must be certified by an appropriate specialty board or must demonstrate comparable competence (defined as those qualifications that allow the member to be on the Active Staff).

11.9-2 SELECTION OF DEPARTMENT CHAIRS/VICE CHAIRS

Two months prior to the meeting of the election, a notice requesting nominations shall be sent to all members of the department. It is understood that only Active members may be nominated. Active members may also nominate themselves. Each nominee may submit a short statement not to exceed five lines of his/her qualifications. Nominations will be closed one month prior to the election. A nominee may not run for both chair and vice chair. A list of nominees for chair and vice chair shall be sent to each Active member. In the event there are no nominations, the incumbent chair shall nominate one or more candidates for the office of Department Chair and vice Chair. Along with the list of nominees, each Active member of the department will be mailed a ballot. Ballots shall be mailed to the Active members via certified mail, return receipt, with a double return envelope system enclosed. Ballots shall be considered invalid if returned in an unsigned "return envelope". A nominee shall be elected upon receiving a majority of the valid votes cast. If no nominee for an office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two (2) candidates receiving the highest number of votes, following the same mail balloting process. If there is a tie in the runoff election, the Medical Executive Committee shall appoint one of the two candidates as the Department Chair.

Action of the election of the department chair and vice chair shall be determined by a majority vote (by written ballot) of the Active Medical Staff members present at the department meeting provided there is a quorum. Voting by a signed proxy of Active Staff members will be accepted at the time of the election. IF nominees for the offices are running unopposed, after the slate of nominations is sent to the Active Staff, a unanimous decision is assumed and no ballots will be required. Election of such department chair and vice chair is subject to ratification by the Executive Committee.

11.9-3 TERM OF OFFICE

Each department chair and vice chair shall serve a two year (2) term which coincides with the Medical Staff year or until their successors are chosen, unless they shall sooner resign, be removed from office, or lose their Medical Staff membership or clinical privileges in that department. Each department chair and vice chair is eligible to succeed themselves and serve unlimited terms of office, if so elected by their respective departments.

11.9-4 REMOVAL

After election and ratification, removal of department chairs and vice chairs from office may occur for cause by a two-thirds vote of the Medical Executive Committee and a two-thirds vote of the department members eligible to vote on departmental matters who cast votes. Removal may be based upon failure to perform the duties of the office held as described in these bylaws or by serious acts of moral turpitude.

11.9-5 RESPONSIBILITIES AND AUTHORITY OF DEPARTMENT CHAIRS

In assuring the accomplishment of the functions of the department as provided in the medical staff bylaws and in meeting their responsibility for professional and administrative activities within the department, a department chair has the following responsibilities and authority:

- a) Participate on a continuous basis in managing the department through cooperation and coordination with nursing and other patient care services and hospital management on all matters affecting patient care, including the integration of the department/service into the primary functions of the organization, the coordination and integration of interdepartmental and intradepartmental services; the development and implementation of policies and procedures that guide and support the provision of services.
- b) Participate in planning with respect to the department's personnel, equipment, facilities, services and budget, space and other resources.
- c) Assessing and recommending to the relevant hospital authority offsite sources for the needed patient care services not provided by the department or the organization.
- d) Communicate and implement within the department actions taken by the MEC and the Board.
- e) Unless otherwise provided, serve on the MEC, give guidance on the overall medical policies of the hospital, and make specific recommendations and suggestions regarding the department to the MEC and hospital management.
- f) Participate in the development and implementation of mechanisms designed to assure the uniform performance of patient care processes throughout the organization.
- g) Assist in developing and implementing relevant medical staff components of the Process Improvement program, as required in these Bylaws and in

cooperation with the Process Improvement Committee Chair and MEC, and other relevant staff committees to assure the continuous assessment and improvement of the quality and appropriateness of patient care and services provided within the department.

- h) Assist in developing programs to promote the recruitment, retention, development of all staff members; assist in developing, implementing, supervising, coordinating and evaluating in conjunction with other appropriate officials, committees or clinical units of the staff, education and research programs for the members of the department.
- i) Maintain continuing review of patient care and the professional performance of LIPs and AHPs with clinical privileges or specified services in the department and present written reports to the MEC and other staff or hospital committees when appropriate or required.
- j) 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.
- k) Prepare and transmit to the appropriate authorities as required by the staff bylaws recommendations concerning appointment, reappointment, delineation of clinical privileges, and corrective action with respect to LIPs in the department.
- l) Enforce the hospital and medical staff bylaws, rules, policies, including initiating corrective action and investigation of clinical performance and ordering consultations to be provided or sought when necessary.
- m) Unless otherwise provided, appoint department committees as necessary to perform the functions of the department and designate a chairman of each.
- n) Perform such other duties commensurate with the office as are set forth in the medical staff bylaws, quality improvement plan or any of the related manuals and, as may from time to time be reasonably requested by the chief of staff, MEC, or the Board.

11.9-6 DEPARTMENT VICE CHAIRS

In the temporary or permanent absence of a department chairman, the department vice chairman shall assume all duties, responsibilities, and the authority of and become the department chairman for the remainder of the term.

ARTICLE 12 COMMITTEES AND COMMITTEE FUNCTIONS

12.1 COMMITTEES OF THE MEDICAL STAFF

12.1-1 APPOINTMENT TO THE MEDICAL STAFF COMMITTEES

The Committees described in this Article, shall be the standing committees of the medical staff. Except for the Medical Staff Executive Committee and unless otherwise specified in these bylaws the chairpersons of these committees shall be appointed by the Chief of Staff. Vice chairs are appointed by the committee chair, following consultation with the Chief of Staff. Except for the Medical Executive Committee and unless otherwise specified in these bylaws, committee members shall be appointed by the committee chair. Administrative staff appointees are selected subject to approval of the administrator.

The Chief of Staff, the Administrator, and administrative staff appointees shall serve as ex-officio members, without vote, of all committees, unless otherwise expressly provided.

12.1-2 TERM AND PRIOR REMOVAL

Unless otherwise specifically provided, a medical staff committee member shall continue as such until the end of their period of appointment and until their successor is elected or appointed, unless they resign or are removed from the committee. A Medical Staff committee member, other than one serving ex-officio, may be removed by a majority vote of the Medical Staff Executive Committee.

12.1-3 VACANCIES

Unless otherwise specifically provided, vacancies on any staff committee shall be filled in the same manner in which the original appointment to such committee is made.

12.2 MEDICAL EXECUTIVE COMMITTEE (MEC)

12.2-1 COMPOSITION AND MEETINGS

The MEC shall be composed of the officers of the Medical Staff, the chair of each clinical department, the chairs of the following committees of the medical staff: Process Improvement, Utilization Review, Credentials, Bylaws, Infection Control/Pharmacy Therapeutics and Medical Education. The chair shall have the prerogative to invite others to the Executive Committee as he deems appropriate.

All members of the Active Medical Staff are eligible to participate on the MEC.

No Active Medical Staff member is ineligible based on his/her discipline or specialty. No individual may hold more than one voting position on the Medical Executive Committee nor concurrently run for election for more than one elected position that is on the Medical Executive Committee.

The chair of the Medical Executive Committee shall be the Chief of Staff.

The Medical Executive Committee shall meet monthly (a minimum of ten (10) meetings a year), and maintain a permanent record of its proceedings and actions.

12.2-2 DUTIES AND RESPONSIBILITIES

The duties and responsibilities of the MEC shall be to:

- a) Represent and act on behalf of the medical staff, subject to such limitations as may be imposed by the medical Staff bylaws.
- b) Coordinate the activities of and policies adopted by the staff, departments

and committees.

- c) Recommend to the Board all matters relating to appointment, reappointments, staff category, department assignments, clinical privileges and corrective action, and appointment of medical staff officers.
- d) Make recommendations on medico-administrative, hospital planning and hospital management matters, when necessary.
- e) Direct the review and maintenance of hospital accreditation and inform the medical staff of the JCAHO accreditation program and the accreditation status of the hospital. The MEC shall identify areas of substantial non-compliance with the JCAHO accreditation standards and shall make appropriate recommendations to the Board and/or Administrator for appropriate action.
- f) Provide liaison between the medical staff, the administrator and board.
- g) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of staff members, including initiating and conducting investigations and initiating and pursuing corrective action, when warranted.
- h) Participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs.
- i) Submit recommendations to the Board for changes in the medical staff bylaws, and the rules, regulations and other organizational documents pertaining to the medical staff.
- j) Participate in continuing education programs, which inform the medical staff of significant new developments and new skills in medicine and are responsive to findings of the Quality Improvement Program.
- k) Report at general meetings of the medical staff. Integrate and coordinate Quality Improvement Program activities with existing hospital and Medical Staff review and assessment mechanisms.
- m) Assure the comprehensiveness and integration of the overall quality of care and risk management activities of the hospital, and the mechanism for assuring the accountability of the professional staff for the quality of care they provide.
- n) Develop, review annually, and revise as needed a Quality Improvement Plan that is appropriate to the hospital and medical staff, and meets the requirements of Joint Commission on the Accreditation of Healthcare Organizations.
- o) To provide a format for reappraisal of the Quality Improvement Program at least annually with summary documentation of program activities demonstrating relevant findings, actions, and program impact on improving clinical performance, patient care, and employee, visitor and patient safety. Mechanism(s) for such reappraisal shall be as defined in the Process Improvement Plan.
- p) Process Improvement findings, recommendation and actions are reported monthly to the Administrator and the Governing Board, through the MEC.
- q) The MEC may establish a staff sub-committee to perform one or more staff functions.
- r) Establish a mechanism for dispute resolution between medical staff members (including limited license LIPs) involving the care of a patient.

12.2-3 MEDICAL STAFF EXECUTIVE COMMITTEE - GOVERNING BOARD JOINT COMMITTEE

Whenever a Governing Board decision is not in accordance with the last recommendation or action of the MEC, the matter shall be resolved as follows.

The Governing Board shall submit the matter to a Joint Committee for review and recommendation. Such Committee, unless otherwise required by law or the Medical Staff bylaws, shall consist of three (3) MEC members (who are not on the Governing Board) chosen by the Chief of Staff and three (3) Governing Board members chosen by the Chairman of the Governing Board. Such committee shall make its review and recommendation to the Governing Board within 45 days. Thereafter, the Governing Board's decision in the matter shall be final and shall be communicated to the MEC and any directly affected LIP which may be involved, consistent with the Medical Staff bylaws. Notwithstanding the foregoing, if the matter is not resolved by the Joint Committee and is a dispute relating to self-governance as set forth in California Business and Professions Code Section 2282.5, the dispute shall be referred to the Ad Hoc Dispute Resolution Committee.

12.2-4 Patient Safety Committee

1. Composition and Meetings

The Patient Safety Committee shall be a standing committee of the medical staff and shall consist of the Chief of Staff, The Vice Chief of Staff, the Immediate Past Chief of Staff and the Patient Safety Officer as an ex-officio member who shall vote. At least 50% of the composition of the Committee's voting members shall be physician members of the medical staff. Individuals from either the medical staff, hospital staff or external sources may be appointed by the Committee Chair to serve as ad hoc members of the Committee, with or without vote, as deemed appropriate from time-to-time to provide additional expertise or as matters relate to their departments, specialty or responsibilities.

The Patient Safety Committee shall meet as often as necessary to accomplish its functions, but at least quarterly. It shall maintain records which document that it has fulfilled the responsibilities described above and shall report its activities to the Medical Executive Committee.

2. Duties and Responsibilities

The Patient Safety Committee shall implement a coordinated and collaborative approach to improving patient safety, seeking input from and distributing information to departments and disciplines to establish and assess processes and systems that may impact patient safety. To fulfill this function, the Committee shall:

- a) review and evaluate the Patient Safety Plan and related policies and procedures and make recommendations to the Medical Executive Committee (MEC) for their revision and/or approval;
- b) assist the Patient Safety Officer in the annual evaluation of the effectiveness of the Patient Safety Plan;
- c) develop a confidential numbering system or other identification system that permits reference to near misses, adverse occurrences, sentinel events, patients, Medical Staff members, Allied Health Professionals and hospital staff without identifying individuals;
- d) receive reports of adverse occurrences, sentinel events or near misses which materially impacted a patient's plan of care or had the potential to materially impact a patient's plan of care, and the action (if any) which was taken, and make recommendations for

- further action, or education as appropriate;
- e) establish and assess processes and systems that may impact patient safety at the hospital;
  - f) assist the Patient Safety Officer in formulating educational programs for staff, patients and families regarding patient safety issues and the patient safety plan
  - g) ensure that patients, family members, hospital staff, medical staff and allied health professionals are periodically surveyed regarding their opinions, needs and perceptions of risks to patients;
  - h) Ensure the distribution of all sentinel event alerts issued by JCAHO to all organizational departments and to the medical staff;
  - i) at least quarterly, review and evaluate reports from:
    - 1. The Patient Safety Officer pertaining to relevant patient safety day from internal and external sources. The report shall include information relating to the type, severity, frequency and impact of adverse occurrences, sentinel events, near misses, and hazardous conditions, indications of any trends, and any remedial actions taken.
  - j) at least annually;
    - 1) select at least one high-risk patient safety process (identified in the Sentinel Event Alerts or identified by the Patient Safety Officer) and conduct a proactive risk assessment including:
      - a) assessment of the process to identify specific steps in the process where there is, or may be, undesirable variation
      - b) identification of the possible effects of the undesirable variation on patients, and the severity of the possible effects
      - c) review confidential and legally privileged data
      - d) Prepare a Failure Mode and Effects Analysis to determine why undesirable variations may occur
      - e) Perform a literature search to assist in the assessment and redesign of the process
      - f) redesign as required, the process and/or underlying systems to minimize the risk to patients
      - g) implement a test pilot of the redesigned process
      - h) identification and implementation of measurement strategies to assess the effectiveness of the redesigned process.
    - 2) Consider data obtained from the hospital's Information Management Needs Assessment, ensure that hospital staff and Medical Staff are queried regarding their willingness to report medical/health care errors; and

seek comments from hospital and Medical Staff on improving patient safety.

12.2-5 Medical Staff Conflicts Resolution Committee

a. Petition for Appointment of Medical Staff Conflicts Resolution Committee

If members of the medical staff object to specific actions taken by the Medical Executive Committee other than decisions about individual practitioners taken pursuant to the bylaws, rules, regulations or policies, the members may submit a petition to the Medical Executive Committee. The petition must be signed by at least fifty percent (50%) of the active staff, describe the actions that are objected to, demand the Medical Executive Committee appoint a Conflict Resolution Committee to discuss the matters identified in the petition and nominate at least three (3) active staff who have agreed to be members of the Conflict Resolution Committee.

b. Appointment of Conflicts Resolution Committee  
Within sixty (60) days after receipt of the petition described in Section 12.2-5a, the Medical Executive Committee will appoint a Conflicts Resolution Committee to address the issues identified in the petition. The Conflicts Resolution Committee voting members will include an equal number of members of the Medical Executive Committee and members who were nominated in the Petition, and a non-voting Chair. The Conflicts Resolution Committee will discuss and attempt to resolve the conflict that was described in the petition. The Conflicts Resolution Committee Chair will report the results of the committee's efforts back to the Medical Executive Committee not more than sixty (60) days after the Conflicts Resolution Committee was appointed. Unless a majority of the Conflicts Resolution Committee's voting members requests continuation of the Conflicts Resolution Committee's deliberations and the request is approved by the Medical Executive Committee, the Conflicts Resolution Committee will dissolve thirty (30) days after its Chair reported the results of the committee's efforts to the Medical Executive Committee.

ARTICLE 13 MEETINGS

13.1 GENERAL STAFF MEETINGS

Regular meetings of the staff ("general staff meetings") shall be one (1) time per year.

13.1-1 ORDER OF BUSINESS AND AGENDA

The order of business at a general staff meeting shall be determined by the Chief of Staff. The recommended agenda shall be:

- a) Reading and acceptance of the minutes of the last general staff meeting and of any special meetings held since the last regular meeting.
- b) Administrative reports, if any, from the Administrator, Chief of Staff, Departments, and Committees.
- c) Election of officers, when required by these Bylaws.
- d) Reports on the overall findings and results of the quality improvement program. Reports on changes in hospital policies that affect the Medical Staff.
- e) New business.

13.2-2 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Chief of Staff, the Board, the MEC or by a written request from at least ten (10) members of the Active Medical Staff to the Chief of Staff. Notice of such a special meeting shall be given and shall specify the purpose for the meeting and shall designate the date, time and place for the meeting.

13.2 COMMITTEE AND CLINICAL DEPARTMENT MEETINGS

13.2-1 REGULAR MEETINGS

Committees and departments may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required. The frequency of such meetings shall be as required by these Bylaws.

13.2-2 SPECIAL MEETINGS

A special meeting of any committee or department may be called by, or at the request of, the Chairman or Chief of thereof, the Board, the Chief of Staff, MEC or by a written request of at least five (5) members of the Active Medical Staff.

13.3 NOTICE OF MEETINGS

Written notice stating the place, day and hour of any general staff meeting, of any special meeting, or of any regular committee or department meeting, not held pursuant to resolution, shall be delivered either personally or by mail to each person entitled to be present there at not less than five (5) days nor more than thirty (30) days before the date of meeting. Notice of department or committee meetings may be given orally. If mailed, the notice of the meeting shall be delivered 72 hours after deposited, postage paid, in the United States mail addressed to each person entitled to such notice at his/her address as it appears on the records of the hospital. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

13.4 QUORUM AND ACTION

13.4-1 GENERAL STAFF MEETINGS

The presence of fifty percent (50%) of the voting members of the Active Medical Staff at any regular or special meeting shall constitute a quorum for the purpose of transacting business. In the event that a quorum is not present at any regular or special meeting those members present may meet as a committee of the whole. Any action taken by those present, acting as a committee of the whole, shall be referred for ratification purposes to the next regular or special meeting called for that purpose at which a quorum is present.

13.4-2 CLINICAL DEPARTMENT AND COMMITTEE MEETINGS

Twenty-five percent (25%) of the voting members of a department or committee, but not less than three (3) members, shall constitute a quorum.

13.5 MINUTES

Minutes of all meetings shall be prepared by the secretary of the meeting and shall include a report of attendance, discussion, activities and action taken on the matter. A permanent file of the minutes of each meeting shall be maintained. Approval of minutes of a meeting shall be obtained by consensus at the next regularly scheduled meeting.

13.6 ABSENCE FROM MEETINGS

Any member who is compelled to be absent from any Medical Staff Department or Committee meeting shall promptly provide to the presiding officer thereof the reason for such absence. Unless excused for scheduled long vacation or illness, failure to meet the attendance requirements may be grounds for any of the corrective actions specified in Article 8.

13.7 SPECIAL ATTENDANCE REQUIREMENTS

If the general medical staff, a committee or department is reviewing the conduct of care of a LIP and the general medical staff, committee or department meeting has elected to require the LIP's attendance at a meeting, the LIP shall be so notified in writing by the chair of the meeting at least ten (10) days prior to the meeting. The notification shall state the time and place of the meeting, a statement of the issue(s) involved and that the LIP's appearance is mandatory. Failure of a LIP to attend any meeting with respect to which he was given notice that his attendance was mandatory, shall, unless excused by the Executive Committee upon a showing of good cause, result in an automatic suspension of all or such portion of the LIP's clinical privileges as the Executive Committee may direct. Such suspension shall remain in effect until the LIP meets with the general medical staff, committee or department, or the matter is resolved by subsequent action of the Executive Committee. The LIP shall not be entitled to the hearing and appeals rights set forth in Article 9 as a result of action taken pursuant to this Section 13.7 unless the Chief of Staff, on behalf of the Executive Committee, determines the suspension was based on a medical disciplinary cause or reason.

13.8 CONFLICT OF INTEREST

At the discretion of the Chair of the meeting or a majority of those members in attendance, an individual who has a direct personal or financial interest in the outcome of a decision or whose care, conduct or qualifications is a subject under discussion at the meeting, may be required to leave the meeting while the members complete their discussion and vote on the matter. If the Chair is the subject of the matter, the Vice Chair shall act in the Chair's behalf in determining whether the Chair should be excused and then chairing the meeting during the Chair's absence.

ARTICLE 14 CONFIDENTIALITY, IMMUNITY AND RELEASES

14.1 SPECIAL DEFINITIONS

For the purposes of this Article, the following definitions shall apply:

- a) INFORMATION means record of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions, actions, data and other disclosures or communications whether in written or oral form relating to any of the subject matters specified in Section 5.
- b) LIP means a staff member or applicant or an allied health professional.
- c) REPRESENTATIVE means a board of a hospital and any director or committee thereof, a hospital administrator or their designee, registered nurses and other employees of a hospital, a medical staff organization and any member, office, clinical unit or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering, analysis, use or disseminating functions.
- d) THIRD PARTIES means both individuals and organizations providing information to any representative.

14.2 AUTHORIZATION AND CONDITIONS

By submitting an application for staff membership or by applying for or exercising clinical privileges or providing specified patient care services in this hospital, a LIP:

- a) Authorizes representatives of the hospital and the medical staff to solicit, provide and act upon information bearing on their professional ability and qualifications.
- b) Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article.
- c) Acknowledges that the provisions of this Article are express conditions to their application for, or acceptance of, staff membership and the continuation of such membership and to their exercise of clinical privileges or provision of specified patient services at this hospital.

14.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any LIP submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating and improving the quality and efficiency of patient care, reducing morbidity and mortality, contributing teaching or clinical research, determining that health care services are professionally indicated or were performed in compliance with the applicable standard of care or establishing and enforcing guidelines to keep health care costs within reasonable bounds shall, to the fullest extent permitted by laws, be confidential and shall not be disseminated to anyone except as provided herein or except as otherwise required or authorized by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any patient's record.

14.4 IMMUNITY FROM LIABILITY

14.4-1 FOR ACTION TAKEN

State and Federal regulations govern immunity from liability of members of the

medical committees for any act or proceeding undertaken or performed in reviewing the quality of services rendered by a LIP. Based on and in addition to the provisions of applicable regulations, no representative of the hospital or medical staff shall be liable to a LIP for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of their duties as a representative, if such representative acts in good faith without malice after reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the decision, opinion, action, statement or recommendation is warranted by such facts.

#### 14.4-2 FOR PROVIDING INFORMATION

State and Federal regulations govern immunity from liability of all persons for communication and information on evaluation of a LIP. Based on said section, no representative of the hospital or medical staff and no third party shall be liable to a LIP for damages or other relief by reason of providing information, including otherwise privileges or confidential information, to a representative of this hospital or medical staff or to any other health care facility or organization of health professional concerning a LIP who is or has been an applicant to or member of the staff or who did or does exercise clinical privileges or provide specified services at this hospital, provided that such representative or third party acts in good faith and without malice and provided further that such information is related to the performance of the duties and function of the recipient and is reported in a factual manner.

#### 14.5 ACTIVITIES AND INFORMATION COVERED

##### 14.5-1 ACTIVITIES

The confidentiality and immunity provided by this Article applies to all acts, communications, proceedings, interviews, reports, records, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

- a) Application for appointment, clinical privileges or specified services.
- b) Periodic reappraisals for reappointment, clinical privileges or specified services.
- c) Corrective or disciplinary action.
- d) Hearings and appellate reviews.
- e) Quality improvement program activities.
- f) Utilization reviews.
- g) Claims reviews.
- h) Profiles and profile analysis.
- i) Malpractice loss prevention.
- j) Other hospital, and staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

##### 14.5-2 INFORMATION

The information referred to in this Article also relates to a LIP's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might

directly or indirectly affect patient care.

#### 14.6 RELEASES

Each LIP shall upon request of the hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those in good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State. Execution of such releases is not a prerequisite to the effectiveness of this Article.

#### 14.7 CUMULATIVE EFFECT

Provisions in these Bylaws and on application forms relating to authorizations, confidentiality of information and immunities from liability are in addition to the protections provided by law and not in limitation, thereof.

#### 14.8 CREDENTIALS

##### 14.8-1 MAINTENANCE OF CREDENTIALS FILES

- a) A separate confidential credentials file shall be kept for each medical staff member and each allied health professional.

The file shall include the following:

- 1) The completed and verified application for medical staff membership including information on training, experience, references, current licensure and Drug Enforcement Act (DEA) registration, and a request for clinical privileges;
- 2) Evidence that the medical staff actually evaluated and acted upon the above information;
- 3) Evidence of proctoring for membership and additional privileges;
- 4) Specific and current clinical privileges recommended by the medical staff and approved by the Governing Body;
- 5) Data pertinent to reappraisal and reappointment, including current licensure, DEA registration, continuing medical education, attendance at required meetings, CPR qualifications and health status; and
- 6) Evidence that the medical staff critically evaluated the above information and assessed the current clinical competence for privileges requested, as well as evidence that appropriate action was taken on reappointment and renewal of privileges;
- 7) Evidence of action taken as a result of peer review activities, hearings or appellate reviews.
- 8) The credentials files shall be maintained in a secured location in the Medical Staff Office and the Director of Medical Staff Services shall be the designated custodian of the files, who will assure that the files are kept in accordance with these Bylaws.

##### 14.8-2 ACCESS TO CREDENTIALS FILES

- a) Access to credentials files shall be limited to duly appointed officers and committees of the Medical Staff for the sole purpose of discharging medical staff responsibilities and subject to the requirement that

confidentiality be maintained.

- b) Information shall be disclosed to the Governing Body by the hospital or its representative in order that the Governing Body may discharge its lawful obligations and responsibilities. Disclosed information shall be maintained by that body as confidential.
- c) An applicant or staff member may inspect only his own credentials file and may review only those documents or correspondence that applicant or member personally prepared and submitted. This includes the medical license, DEA registration and CPR certification. Exception: The applicant or member may review his/her quality improvement profile, professional liability claims history and National Practitioner Data Bank Report.
- d) The following information shall be provided to other institutions at which a staff member may be applying for medical staff membership/privileges:
  - 1) Dates of membership
  - 2) Department/Sub-specialty
  - 3) Staff category
  - 4) Indication of whether member is in good standing

Any other information will be provided in writing, only upon receipt of a consent for release of information signed by the Medical Staff member.

- e) Legal advice to determine protection afforded by state and federal laws shall be obtained from legal counsel prior to response to a subpoena for such records.

#### 14.8-3 CONTROL OF ACCESS

- a) Review of an individual credentials file by the respective applicant or staff member shall be granted upon receipt of a written request from the applicant or member twenty-four (24) hours prior to the review.

The review of the record shall be conducted in the presence of the custodian during normal hours, and shall not be removed from the Medical Staff Office.

### 14.9 CONFIDENTIAL PEER REVIEW/QUALITY ASSESSMENT FILE

#### 14.9-1 MAINTENANCE OF FILE

A separate confidential file containing information on: profile and trending data information pertinent to the reappraisal process, i.e., peer review data (record of all charts evaluated and outcome of each review), and working file for disciplinary actions taken or contemplated shall be maintained in the Quality Assessment Office and shall be maintained under the custody of the Director of Quality Assessment.

Files shall be maintained in such a manner as to increase the likelihood of confidentiality afforded Medical Staff committee records and proceedings by state and federal laws.

#### 14.9-2 ACCESS TO FILES

- a) Access shall be limited to duly appointed officers and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.
- b) Information shall be disclosed to the Governing Body of the hospital or its representative in order that the Governing Body may discharge its lawful obligations and responsibilities. Disclosed information shall be

maintained by that body as confidential.

ARTICLE 15 GENERAL PROVISIONS

15.1 STAFF RULES AND REGULATIONS

15.1-1 Subject to approval by the MEC and the Board, and after consideration of the advice of the Bylaws Committee, the Medical Staff shall adopt such rules and regulations which shall embody the level of practice that is required of each LIP or allied health professional in the hospital. Such rules and regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice, or at any special meeting on notice, by a two-thirds (2/3) vote of those present and eligible to vote. Such changes shall become effective when approved by the Board.

15.1-2 Notwithstanding Section 15.1-1, if an urgent amendment to the rules and regulations is necessary to comply with law or regulation, the Medical Executive Committee and Governing Board may provisionally approve an amendment without prior notification to the medical staff. If an urgent amendment is adopted without prior approval of the Medical Staff, the medical staff will be notified of the amendment after it is approved and given thirty (30) days to submit comments. After reviewing any comments received, the Medical Executive Committee may approve revisions to the amendment to address the issues raised.

15.1-3 Members of the Active Staff may submit a petition to amend the Rules following the processes described in Section 16.4.

15. 2 CLINICAL DEPARTMENT RULES AND POLICIES AND PROCEDURES

Subject to approval of the MEC and the Board, each clinical department shall formulate its own rules and policies and procedures for the conduct of its affairs and the discharge of its responsibilities. Such shall not be inconsistent with these Bylaws or the general rules and regulations of the Medical Staff, or hospital policies that have been approved by the Medical Staff.

15.3 MEDICAL STAFF POLICIES

The Medical Executive Committee may adopt and amend Medical Staff policies to implement the Medical Staffs Bylaws and Rules and Regulations. Within thirty (30) days after voting to amend or adopt a Medical Staff policy, the Medical Executive Committee shall notify the active, courtesy and provisional staff of the new or revised policy in such manner as determined by the Medical Executive Committee, which may be by either mail, e-mail, fax, posting in the doctors' dining area and/or posting on the medical staff intranet. Members of the Active Staff may submit a petition to amend Medical Staff policies following the processes described in Section 16.4.

15.4 BOARD ACTION

Whenever these Bylaws require or authorize action by the Board, such action may be taken by a committee of the Board to which the Board has delegated the responsibility and authority to act for it on the particular subject matter, activity or function involved.

15.5 MEDICAL STAFF SELF-GOVERNANCE

All policies, procedures, protocols, criteria, standards or guidelines related to Medical Staff self-governance activities shall be set forth in the bylaws, rules and regulations of the Medical Staff or other documents which shall be deemed to be a part of the bylaws, rules and regulations upon approval by the Medical Executive Committee and Governing Board. Such self-governance activities include, but are not limited to, standards and criteria for Medical Staff membership, standards and criteria for clinical privileges, procedures for enforcement of such standards and criteria, quality improvement, utilization management, and review and analysis of

patient medical records.

ARTICLE 16

ADOPTION AND AMENDMENT OF BYLAWS

16.1 NO UNILATERAL AMENDMENT

Neither the Medical Staff or the Governing Board may unilaterally amend the Bylaws.

16.2 EFFECT OF BYLAWS

Upon adoption and approval as provided in Article 16, in consideration of the mutual promises and agreements contained in these bylaws, the hospital and the medical staff, intending to be legally bound, agree that these bylaws shall constitute part of the contractual relationship existing between the hospital and the medical staff members, both individually and collectively.

16.3 AMENDMENT

- a) Amendment of these Bylaws may be initiated by action of the Medical Staff Bylaws Committee or by the Medical Executive Committee, or by the Governing Board.
- b) A review of these Bylaws, will be conducted at least annually by the Bylaws Committee to determine the need for amendments.

16.3 AMENDMENTS TO BYLAWS

16.3-1 ALTERNATIVE PROCESSES TO AMEND BYLAWS

- a) Amendment of these Bylaws may be initiated by action of the Medical Staff Bylaws Committee, by the Medical Executive Committee, by the Governing Board or by a petition from the members of the Active Staff, following the processes described in Sections 16.3 and 16.4. In addition, members may at any time submit to the Bylaws Committee proposed revisions that will be considered by the Bylaws Committee.
- b) A review of these Bylaws will be conducted at least annually by the Bylaws Committee to determine the need for amendments.

16.3-2 AMENDMENTS TO BYLAWS INITIATED BY THE BYLAWS COMMITTEE

- a) During its annual review or upon receipt of proposed revisions from the Medical Staff, the Bylaws Committee will present its recommendations to the Medical Executive Committee for review.
- b) Upon approval of the Medical Executive Committee, the proposed amendments shall be submitted to the members of the Active Staff by ballot mailed to those members in accordance with Section 16.5.
- c) Upon affirmative vote of the majority of the voting Active Staff, the proposed amendments shall be submitted to the Governing Board, who shall review such amendment within sixty (60) days of submission to it. The Governing Board shall give great weight to the proposed amendment and shall not unreasonably withhold its approval. If the Governing Board fails to approve or reject a proposed amendment within sixty (60) days, and does not refer the dispute to a resolution process as described in Section 12.2-3 within such time, the Governing Board shall be deemed to have approved the proposed amendments.

16.3-3 AMENDMENTS TO THE BYLAWS INITIATED BY THE MEDICAL EXECUTIVE COMMITTEE

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a) Amendments to the Bylaws may be initiated by the MEC following an affirmative vote of a majority of the voting Medical Executive Committee members.

b) Upon approval of the Medical Executive Committee, the process shall be as described in Sections 16.3-2 b) and c).

16.3-4 AMENDMENTS TO BYLAWS INITIATED BY THE GOVERNING BOARD

a) Amendments to the Bylaws may be initiated by the Governing Board following an affirmative vote of the majority of the Governing Board. The Governing Board shall present its proposed amendments to the Medical Executive Committee.

b) Upon approval of proposed amendments by the MEC, the process shall be as described in Sections 16.3-2 b) and c).

16.4 AMENDMENTS TO BYLAWS THE MEDICAL STAFF

a) Amendments to the Bylaws may be proposed by written petition of fifty percent (50%) of the members of the Active Staff. The Medical Executive Committee shall review a petition received pursuant to this Section 16.4 within sixty (60) days of its receipt. Amendments may address any provisions of the bylaws, including but not limited to changes in the Medical Executive Committee's delegated authority. Within thirty (30) days after the Medical Executive Committee meeting that reviews a petition to amend the Bylaws, rules and regulations or policies, the Medical Executive Committee shall either (1) send to the active staff, in the manner described in Section 16.5 of the Bylaws, the proposed amendment with any comments from the Medical Executive Committee and a ballot, or (2) notify each member of the active staff who signed the petition of the Medical Executive Committee's questions or concerns with the proposed language (e.g. language is unclear or inconsistent, violates applicable law, regulation or accreditation standards).

b) If petitioners are notified pursuant to Section 16.4 a) above that there are concerns with the proposed language, the petitioners shall have thirty(30) days to submit a written request for a meeting with the Medical Executive Committee to discuss and try to resolve the concerns raised by the Medical Executive Committee. The Medical Executive Committee shall schedule a meeting for this purpose within sixty (60) days after receipt of the meeting request. All active staff who signed the petition shall be notified of the meeting and invited to attend.

c) After meeting with Medical Executive Committee to address the Medical Executive Committee's concerns, the petitioners shall have thirty (30)days to submit a second petition signed by at least fifty percent (50%) of the active staff to the Medical Executive Committee. The second petition shall either (i) submit revised amendments the bylaws, rules and regulations or policies to address the concerns that were raised by the Medical Executive Committee or (ii) explain why the petitioners reject the Medical Executive Committee's concerns and request that the originally submitted revisions be submitted to the active staff for vote. The Medical Executive Committee shall review the second petition at its next regular meeting and, within thirty (30) days after that meeting, send to the active staff, in the manner described in Section 16.5 of the Bylaws, the proposed amendment with any comments from the Medical Executive Committee and a ballot.

d) If the Medical Staff approves the amendment, the proposed amendment and the Medical Executive Committee's concerns, if any, will be sent to the Governing Board, to be reviewed in accordance with Section 16.3-2 c).

16.5 BALLOTING PROCESS

The Medical Executive Committee shall determine whether proposed amendments shall be sent by mail, e-mail or facsimile. Proposed amendments to the Bylaws shall be sent within thirty (30) days after the proposed changes are approved by the Medical Executive Committee or after completion of the process described in Section 16.4 c).

The exact wording of the proposed amendment(s) shall be included with a secret written ballot. In order to be counted, a ballot must be received to the Medical Staff Office no later than thirty (30) days after the date the ballots were mailed, e-mailed or sent by facsimile. The Chief of Staff and the Director of Medical Staff Services shall count the ballots. The affirmative vote of the majority of the voting members casting valid ballots shall be required for staff approval of the amendment(s).

#### 16.6 SUCCESSOR IN INTEREST

These Bylaws, and privileges of individual members of the medical staff accorded under these bylaws, will be binding upon the medical staff, and the Governing Board of any successor in interest in this hospital.

#### 16.7 AFFILIATIONS

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