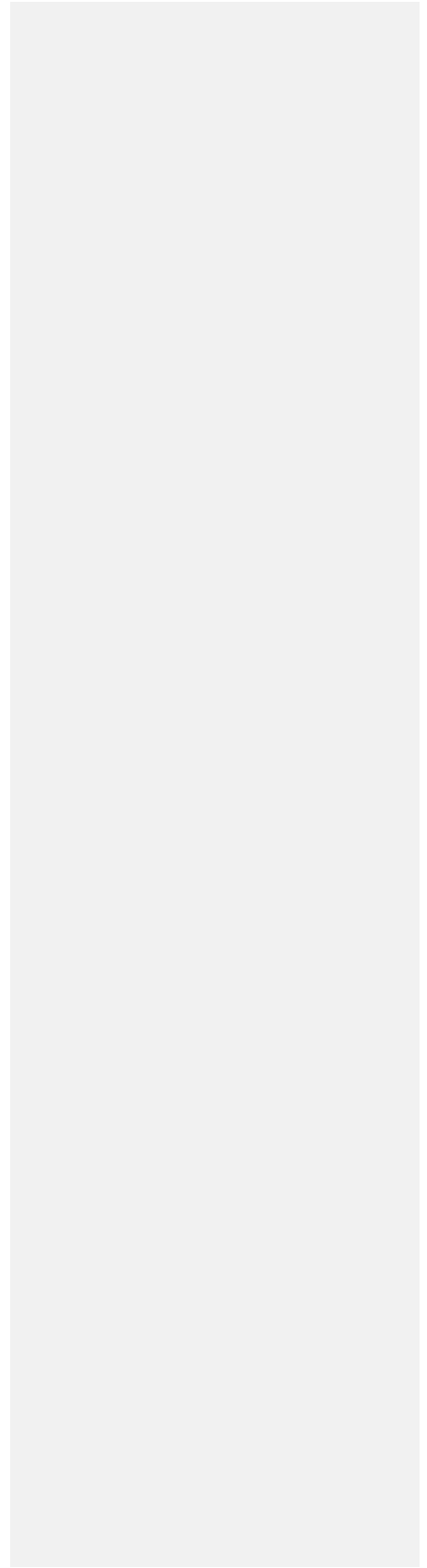


**SUTTER MEDICAL CENTER, SACRAMENTO**

**MEDICAL STAFF BYLAWS**

**September 12, 2011**



**Sutter Medical Center, Sacramento – Medical Staff Bylaws**

**TABLE OF CONTENTS**

	<u>PAGE</u>
PREAMBLE .....	11
DEFINITIONS.....	12
ARTICLE I .....	14
NAME.....	14
ARTICLE II.....	14
PURPOSES AND RELATIONSHIP TO HOSPITAL'S GOALS .....	14
2.01 THE MEDICAL STAFF'S PURPOSES AND RESPONSIBILITIES .....	14
2.01-1 Medical Staff's Purposes .....	14
2.01-2 Medical Staff's Rights and Responsibilities.....	14
2.01-2 Medical Staff's Right of Self-Governance .....	15
2.01-3 Dispute Resolution.....	16
2.02 RELATIONSHIP TO HOSPITAL'S GOALS.....	16
2.03 ACKNOWLEDGMENT OF AND ADAPTATION TO FACILITIES' RANGE OF SERVICES.....	16
2.04 COOPERATIVE PEER REVIEW .....	16
2.04-1 Sharing Credentialing and Peer Review Information .....	16
2.04-2 Confidentiality .....	16
2.05 HEALTH SYSTEM AFFILIATION.....	16
2.05-1 Credentialing.....	17
2.05-2 Peer Review .....	17
2.05-3 Corrective Action.....	17
2.05-4 Joint Hearings and Appeals .....	17
ARTICLE III.....	17
MEDICAL STAFF MEMBERSHIP .....	17
3.01 NATURE OF MEDICAL STAFF MEMBERSHIP .....	17
3.02 QUALIFICATIONS FOR MEMBERSHIP .....	17
3.02-1 General Qualifications .....	17
3.02-2 Particular Qualifications .....	19
3.02-3 Waiver of Qualifications.....	19
3.02-4 Effect of Other Affiliations.....	20
3.02-5 Nondiscrimination .....	20
3.03 ADMINISTRATIVE AND CONTRACT PRACTITIONERS.....	20
3.03-1 Contractors With no Clinical Duties.....	20
3.03-2 Contractors Who Have Clinical Duties .....	20
3.04 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP .....	20
3.05 DURATION OF APPOINTMENT .....	22
3.06 LEAVES OF ABSENCE AND MODIFICATION OF STAFF RESPONSIBILITIES .....	22
3.07 HARASSMENT PROHIBITED.....	22
3.08 HIPAA .....	23

**Sutter Medical Center, Sacramento – Medical Staff Bylaws**

ARTICLE IV ..... 23

CATEGORIES OF THE MEDICAL STAFF ..... 23

    4.01 CATEGORIES..... 23

    4.02 HONORARY STAFF ..... 23

        4.02-1 Qualifications..... 23

        4.02-2 Prerogatives ..... 23

    4.03 ACTIVE STAFF..... 23

        4.03-1 Qualifications..... 23

        4.03-2 Prerogatives ..... 24

    4.04 PROVISIONAL STAFF..... 24

        4.04-1 Qualifications..... 24

        4.04-2 Prerogatives ..... 24

        4.04-3 Observation of Provisional Staff Members ..... 25

        4.04-4 Term of Provisional Staff Status..... 25

    4.05 COURTESY STAFF ..... 25

        4.05-1 Qualifications..... 25

        4.05-2 Prerogatives ..... 25

    4.06 CONSULTING STAFF ..... 26

        4.06-1 Qualifications..... 26

        4.06-2 Prerogatives ..... 26

    4.07 OFFICE BASED STAFF ..... 26

        4.07-1 Qualifications..... 26

        4.07-2 Prerogatives ..... 27

    4.08 TELEMEDICINE AFFILIATE STAFF..... 28

        4.08-1 Qualifications..... 28

        4.08-2 Prerogatives ..... 28

ARTICLE V ..... 28

PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT ..... 28

    5.01 GENERAL..... 28

    5.02 APPLICANT'S BURDEN ..... 28

    5.03 APPOINTMENT AUTHORITY ..... 29

    5.04 APPLICATION FOR INITIAL APPOINTMENT..... 29

        5.04-1 Application Form..... 29

        5.04-2 Effect of Application ..... 30

        5.04-3 Applicant's Responsibility to Produce Complete Information..... 31

        5.04-4 Submission of Application and Verification of Information ..... 31

        5.04-5 Department Action..... 31

        5.04-6 Credentials Committee Action..... 32

        5.04-7 Medical Executive Committee Action..... 32

        5.04-8 Effect of Medical Executive Committee Action..... 32

        5.04-9 Action on Application..... 32

        5.04-10 Notice of Final Decision ..... 33

        5.04-11 Reapplication After Adverse Action..... 33

        5.04-12 Date When the Action Becomes Final..... 33

        5.04-13 Effect of the Waiting Period ..... 34

        5.04-14 Timely Processing of Applications..... 34

        5.04-15 Expedited Review ..... 34

**Sutter Medical Center, Sacramento – Medical Staff Bylaws**

5.05 REAPPOINTMENT AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES ..... 35

    5.07-1 Application for Reappointment ..... 35

    5.07-2 Effect of Application ..... 36

    5.07-3 Standards of Procedures for Review ..... 36

    5.07-4 Failure to File Reappointment Application ..... 36

    5.07-5 Leave Status ..... 36

    5.07-6 Termination of Leave ..... 37

    5.07-7 Failure to Request Reinstatement ..... 37

    5.07-8 Request for Reinstatement After Voluntary Resignation ..... 37

5.08 CONFIDENTIALITY; IMPARTIALITY ..... 37

5.09 SYSTEMWIDE COOPERATION ..... 37

ARTICLE VI ..... 37

DETERMINATION OF CLINICAL PRIVILEGES ..... 37

    6.01 EXERCISE OF PRIVILEGES ..... 37

    6.02 CRITERIA FOR GENERAL COMPETENCIES ..... 38

    6.03 DEVELOPMENT OF CRITERIA FOR CLINICAL PRIVILEGES ..... 38

    6.04 DELINEATION OF PRIVILEGES IN GENERAL ..... 38

        6.04-1 Requests ..... 38

        6.04-2 Bases for Privileges Determinations ..... 38

    6.05 CONDITIONS FOR PRIVILEGES OF NON-PHYSICIAN PRACTITIONERS ..... 39

        6.05-1 Admissions ..... 39

        6.05-2 Surgery ..... 39

        6.05-3 Medical Appraisal ..... 39

    6.06 EFFECT OF EXCLUSIVE CONTRACT ..... 39

    6.07 CONSULTATIONS ..... 39

        6.08 CREDENTIALING OF ALLIED HEALTH PROFESSIONALS ..... 40

            6.08-1 Categories ..... 40

            6.08-2 Privileges and Responsibilities ..... 40

            6.08-3 Procedural Rights of Allied Health Professionals ..... 40

            6.08-4 Automatic Suspension ..... 41

    6.09 CONFIDENTIALITY; IMPARTIALITY ..... 41

    6.10 TEMPORARY PRIVILEGES AND LOCUM TENENS ..... 41

        6.10-1 Circumstances ..... 41

        6.10-2 Application and Review ..... 41

        6.10-3 General Conditions and Termination ..... 42

    6.11 EMERGENCY PRIVILEGES ..... 42

    6.12 DISASTER PLAN CREDENTIALING FOR VOLUNTEERS ..... 42

    6.13 PROCTORING ..... 43

        6.13-1 When Proctoring May Be Imposed ..... 43

        6.13-2 Completion of Proctoring ..... 43

        6.13-3 Effect of Failure to Complete Proctoring ..... 43

ARTICLE VII ..... 44

CORRECTIVE ACTION ..... 44

    7.01 ROUTINE MONITORING AND EDUCATION ..... 44

    7.02 ROUTINE CORRECTIVE ACTION ..... 44

**Sutter Medical Center, Sacramento – Medical Staff Bylaws**

7.02-1	Criteria for Initiation.....	44
7.02-2	Requests for Investigation and Corrective Action.....	44
7.02-3	Expedited Initial Review .....	45
7.02-4	Investigation.....	45
7.02-5	Medical Executive Committee Action.....	45
7.02-6	Subsequent Action .....	46
7.02-6	Procedural Rights.....	46
7.02-7	Other Action .....	46
7.02-8	Board Initiation of Action.....	46
7.03	SUMMARY SUSPENSION.....	47
7.03-1	Criteria and Initiation.....	47
7.03-2	Written Notice of Summary Suspension .....	47
7.03-3	Medical Executive Committee Action.....	48
7.03-4	Procedural Rights.....	48
7.03-5	Initiation by Board of Directors.....	48
7.04	AUTOMATIC SUSPENSION AND TERMINATION.....	48
7.04-1	License .....	49
7.04-2	Controlled Drug Number .....	49
7.04-3	Medical Records .....	49
7.04-4	Liability Insurance .....	49
7.04-5	Failure to Comply with Government and Other Third Party Payor Requirements .....	49
7.04-6	Failure to Satisfy Special Appearance Requirement .....	50
7.04-7	Failure to Report .....	50
7.04-8	Failure to Pay Dues/Assessments .....	50
7.04-9	Disruptive Conduct .....	50
7.04-10	Automatic termination .....	50
7.04-11	Procedural Rights Associated with Automatic Actions.....	50
7.05	PRIVILEGES OF PHYSICIANS WHO ARE UNDER CONTRACT TO THE HOSPITAL .....	51
7.05-1	Medical Disciplinary Rights .....	51
7.05-2	Effect of Contract.....	51
7.05-3	Termination of Contracts .....	51
7.06	SYSTEMWIDE CORRECTIVE ACTION .....	51
7.06-1	Notice of Pending Investigations/Joint Investigations.....	51
7.06-2	Notice of Actions .....	51
7.06-3	Effect of Actions Taken by Other Entities.....	52
7.07	CONFIDENTIALITY; IMPARTIALITY .....	52
ARTICLE VIII.....		52
INTERVIEWS, HEARINGS AND APPELLATE REVIEW - FAIR HEARING PLAN .....		52
8.01	INTERVIEWS.....	52
8.02	HEARINGS AND APPELLATE REVIEW.....	53
8.02-1	Review Philosophy .....	53
8.02-2	Adverse Medical Executive Committee Recommendation .....	53
8.02-3	Exceptions.....	53
8.02-4	Adverse Board Decision .....	53
8.03	EXHAUSTION OF REMEDIES.....	54

**Sutter Medical Center, Sacramento – Medical Staff Bylaws**

8.04	HEARING AND APPEAL PROCEDURES.....	54
8.04-1	Grounds for Hearing.....	54
8.04-2	When Deemed Adverse.....	55
8.04-3	Notice of Adverse Recommendation or Action.....	55
8.04-4	Request for Hearing.....	55
8.04-5	Waiver by Failure to Request a Hearing.....	55
8.05	HEARING PREREQUISITES; NOTICE; EXCHANGE OF WITNESS LISTS; PRODUCTION OF DOCUMENTS; PREHEARING MOTIONS.....	56
8.05-1	Notice of Time and Place for Hearing; Notice of Charges.....	56
8.05-2	Witness Lists.....	56
8.05-3	Amendments to Notice of Charges/Witness Lists.....	56
8.05-4	Appointment of Hearing Committee.....	56
8.05-5	Voir Dire.....	57
8.05-6	Authority.....	57
8.05-7	Discovery Rights.....	57
8.05-8	Documents to be Introduced at Hearing.....	57
8.05-9	Prehearing Motions and Procedural Disputes.....	57
8.05-10	Timely Completion of Process.....	58
8.05-11	Continuance or Postponement of the Hearing.....	58
8.06	HEARING PROCEDURE.....	58
8.06-1	Personal Presence.....	58
8.06-2	Presiding Officer.....	58
8.06-3	Representation.....	59
8.06-4	Rights of Parties.....	59
8.06-5	Evidence.....	59
8.06-6	Official Notice.....	59
8.06-7	Burden of Producing Evidence; Burden of Proof.....	60
8.06-8	Record of Hearing.....	60
8.06-9	Continuances; Completion of the Hearing.....	60
8.06-10	Presence of Hearing Committee Members and Vote.....	60
8.06-11	Recesses and Adjournment.....	60
8.07	HEARING COMMITTEE REPORT AND FURTHER ACTION.....	61
8.07-1	Hearing Committee Report.....	61
8.07-2	Report.....	61
8.07-3	Request for Appeal.....	61
8.07-4	No Appeal.....	61
8.07-5	Appeals.....	61
8.08	INITIATION AND PREREQUISITES OF APPELLATE REVIEW.....	61
8.08-1	Request for Appellate Review.....	61
8.08-2	Grounds for Appeal.....	61
8.08-3	Waiver by Failure to Request Appellate Review.....	61
8.08-4	Notice of Time and Place for Appellate Review.....	62
8.08-5	Appellate Review Body.....	62
8.08-6	Presiding Officer.....	62
8.09	APPELLATE REVIEW PROCEDURE.....	62
8.09-1	Nature of Proceedings.....	62
8.09-2	Written Statements.....	62
8.09-3	Appearance.....	63

**Sutter Medical Center, Sacramento – Medical Staff Bylaws**

8.09-4	Consideration of New or Additional Matters .....	63
8.09-5	Powers.....	63
8.09-6	Recesses and Adjournment .....	63
8.09-7	Burden of Proof, Action by the Appellate Review Body .....	63
8.09-8	Conclusion .....	63
8.10	FINAL DECISION OF THE BOARD .....	63
8.11	GENERAL PROVISIONS .....	64
8.11-1	Hearing Officer Appointment and Duties.....	64
8.11-2	Waiver.....	64
8.11-3	Number of Reviews .....	64
8.11-4	Confidentiality; Impartiality .....	64
8.11-5	Release .....	64
8.12	BOARD COMMITTEES .....	64
8.13	PEER REVIEW BODIES .....	64
8.14	JOINT HEARINGS AND APPEALS .....	65
8.14-1	Joint Hearings .....	65
8.14-2	Joint Appeals.....	65
8.14-3	Effect of Joint Hearings/Appeals .....	65
8.14-4	Provision for Separate Hearing.....	65
ARTICLE IX .....		65
REVIEW OF BYLAWS, RULES AND REGULATIONS, AND MEDICAL STAFF POLICIES ...		65
9.01	REQUEST FOR REVIEW .....	65
9.02	BYLAWS COMMITTEE OR DEPARTMENT REVIEW .....	66
9.03	MEDICAL EXECUTIVE COMMITTEE ACTION .....	66
9.04	LIMITATION ON FREQUENCY OF REVIEW .....	66
9.05	TIMEFRAMES .....	66
ARTICLE X.....		67
MEDICAL STAFF OFFICERS.....		67
10.01	MEDICAL STAFF OFFICERS - GENERAL PROVISIONS .....	67
10.01-1	Identification .....	67
10.01-2	Qualifications.....	67
10.01-3	Disclosure of Conflict of Interest.....	67
10.01-4	Method of Selection .....	68
10.01-5	Term of Office .....	68
10.01-6	Recall of Officers.....	68
10.01-7	Filling Vacancies .....	68
10.02	THE ROLE OF THE CHIEF OF STAFF.....	68
10.02- 1	Duties .....	69
10.02-2	Authority .....	69
10.02-3	Accountability and Relationships .....	70
10.03	ROLE OF THE VICE CHIEF OF STAFF (VICE CHIEF).....	70
10.03-1	Duties .....	70
10.03-2	Authority .....	70
10.03-3	Accountability and Relationships .....	70
10.04	SECRETARY-TREASURER .....	71
10.04-1	Duties .....	71

**Sutter Medical Center, Sacramento – Medical Staff Bylaws**

10.04-2 Authority .....	71
10.04-3 Accountability and Relationships .....	71
ARTICLE XI .....	72
COMMITTEES AND TEAMS .....	72
11.01 GENERAL .....	72
11.01-1 Designation .....	72
11.01-2 Appointment of Members .....	72
11.01-3 Representation on Hospital Committees and Participation in Hospital Deliberations .....	72
11.01-4 <i>Ex Officio</i> Members.....	73
11.01-5 Action Through Subcommittees .....	73
11.01-6 Terms and Removal of Committee Members .....	73
11.01-7 Vacancies .....	73
11.01-8 Conduct and Records of Meetings.....	73
11.01-9 Attendance of Nonmembers .....	73
11.02 JOINT CONFERENCE COMMITTEE .....	73
11.02-1 Composition.....	73
11.02-2 Purpose, Responsibilities and Authority.....	73
11.02-4 Other .....	74
11.03 MEDICAL EXECUTIVE COMMITTEE .....	74
11.03-1 Composition.....	74
11.03-2 Purpose.....	74
11.03-3 Duties .....	74
ARTICLE XII .....	76
DEPARTMENTS AND CLINICAL SECTIONS .....	76
12.01 ORGANIZATION OF DEPARTMENTS .....	76
12.02 DESIGNATION .....	76
12.02-1 Current Designation .....	76
12.02-2 Future Departments.....	76
12.03 ASSIGNMENT TO DEPARTMENTS .....	76
12.04 FUNCTIONS OF DEPARTMENTS .....	76
12.05 DEPARTMENT CHIEF, VICE CHIEF AND SECRETARY .....	77
12.05-1 Qualifications.....	77
12.05-2 Selection.....	77
12.05-3 Term of Office .....	77
12.05-4 Removal .....	77
12.05-5 Roles and Responsibilities of Department Officers.....	77
12.06 CLINICAL SECTIONS .....	79
12.06-1 Formal Sections .....	79
12.06-2 Informal Sections .....	79
ARTICLE XIII .....	79
MEETINGS .....	79
13.01 GENERAL STAFF MEETINGS.....	79
13.01-1 Staff Meetings.....	79
13.01-2 Special Meetings.....	79

**Sutter Medical Center, Sacramento – Medical Staff Bylaws**

13.01-3 Combined Medical Staffs Meeting .....	80
13.02 COMMITTEE, TEAM, AND DEPARTMENT MEETINGS.....	80
13.02-1 Regular Meetings .....	80
13.02-2 Special Meetings.....	80
13.02-3 Combined Department Meetings .....	80
13.03 NOTICE OF MEETINGS .....	80
13.04 QUORUM.....	80
13.04-1 General Staff Meetings .....	80
13.04-2 Department, Team, and Committee Meetings .....	80
13.05 MANNER OF ACTION .....	80
13.06 MINUTES.....	81
13.07 MEETING ATTENDANCE.....	81
13.07-1 Regular Attendance.....	81
13.07-2 Special Appearance.....	81
ARTICLE XIV .....	81
IMMUNITY AND RELEASES .....	81
14.01 CONFIDENTIALITY, IMMUNITY AND RELEASES .....	81
14.01-1 General.....	81
14.01-2 Breach of Confidentiality.....	81
14.02 IMMUNITY FROM LIABILITY .....	82
14.03 ACTIVITIES AND INFORMATION COVERED .....	82
14.03-1 Activities .....	82
14.03-2 Information .....	82
14.04 RELEASES.....	82
14.05 CUMULATIVE EFFECT.....	82
14.06 INDEMNIFICATION .....	83
ARTICLE XV.....	83
GENERAL PROVISIONS .....	83
15.01 MEDICAL STAFF RULES.....	83
15.01-1 Proposal by Medical Executive Committee.....	83
15.01-2 Urgent Need for Legal/Regulatory Compliance .....	83
15.02 DEPARTMENTAL RULES.....	84
15.03 SECTION RULES .....	84
15.04 MEDICAL STAFF POLICIES.....	84
15.05 DIRECT MEDICAL STAFF PROPOSAL TO BOARD OF DIRECTORS – ADOPTION AND AMENDMENTS TO RULES AND POLICIES .....	84
15.06 CONFLICT MANAGEMENT .....	85
15.07 MEDICAL STAFF PARTICIPATION IN HOSPITAL DELIBERATIONS .....	86
15.05-1 General.....	86
15.05-2 Exclusive Contracting Decisions .....	86
15.08 MEDICAL STAFF DUES.....	86
15.09 MEDICAL STAFF LEGAL COUNSEL.....	86
15.10 FORMS.....	86
15.11 AUTHORITY TO ACT.....	86
15.12 DIVISION OF FEES .....	86
15.13 WAIVER OF BYLAWS OR RULES .....	87

**Sutter Medical Center, Sacramento – Medical Staff Bylaws**

15.14 DISCLOSURE OF INTEREST ..... 87

15.15 MEDICAL STAFF CREDENTIALS FILES. .... 87

    15.15-1 Insertion of Adverse Information ..... 87

    15.15-2 Confidentiality ..... 88

    15.15-3 Member’s Opportunity to Request Correction/Deletion of and to Make  
        Addition to Information File..... 88

15.16 REQUIREMENTS FOR COMPLETING AND DOCUMENTING MEDICAL  
HISTORY AND PHYSICAL EXAMINATIONS ..... 89

    15.16-1 Responsibility for Completion of History and Physical..... 89

    15.16-2 Timeliness ..... 89

ARTICLE XVI ..... 89

ADOPTION AND AMENDMENT OF BYLAWS ..... 89

    16.01 MEDICAL STAFF RESPONSIBILITY AND AUTHORITY ..... 89

    16.02 METHODOLOGY ..... 89

    16.03 TECHNICAL AND EDITORIAL AMENDMENTS..... 90

    16.04 PRESERVATION OF BYLAWS ..... 90

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **PREAMBLE**

The Medical Staff recognizes and acknowledges that providing quality medical care in the Hospital depends on the mutual accountability, interdependence and responsibility of the Medical Staff and the Governing Body for the proper performance of their respective obligations. These Medical Staff Bylaws are adopted in order to provide for the organization of the Medical Staff of Sutter Medical Center, Sacramento and to provide a framework for self-government and certain rights and are intended to assure an organization of the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes, and account to the Board of Directors for the effective performance of Medical Staff responsibilities. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Directors, and relations with applicants to and Members of the Medical Staff.

Accordingly, these Bylaws address the Medical Staff's responsibility to establish criteria and standards for Medical Staff membership and Privileges as well as criteria and standards for Allied Health Professional status and Privileges. The Bylaws also address the Medical Staff's right and responsibility to enforce those criteria and standards, to establish clinical criteria and standards to oversee and manage quality management, utilization review, and other Medical Staff activities; they describe the standards and procedures for selecting and removing Medical Staff Officers; and they address the respective rights and responsibilities of the Medical Staff and the Board of Directors. The Bylaws also codify a process for the Medical Staff and Board of Directors to meet and confer in good faith regarding any disputes that may arise.

In adopting these Bylaws, the Medical Staff acknowledges the Board of Directors' duty and responsibility to act to protect the quality of medical care provided and the competency of the Medical Staff to ensure the responsible governance of the Hospital in the event that the Medical Staff fails in any of its substantive duties and responsibilities. In that regard, the Medical Staff commits to exercise its responsibilities with diligence and in good faith and the Board of Directors commits to allowing the Medical Staff independence in conducting the affairs of the Medical Staff. The final authority of the Board of Directors may be exercised for the responsible governance of the Hospital or for the conduct of the business affairs of the Hospital. However, the final authority may only be exercised with a reasonable and good faith belief that the Medical Staff has failed to fulfill a substantive duty or responsibility in matters pertaining to the quality of patient care and the Board of Directors will not assume a duty or responsibility of the Medical Staff precipitously, unreasonably, or in bad faith.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **DEFINITIONS**

1. **ADMINISTRATOR** means the individual selected by the chief executive officer to serve as the chief administrative officer of the Hospital.
2. **ALLIED HEALTH PROFESSIONAL OR AHP** means an individual, other than a licensed physician, dentist, podiatrist, or qualified clinical psychologist, who exercises independent judgment within the areas of his or her professional competence and the limits established by the Board, the Medical Staff and the applicable State Practice Acts, who is qualified to render direct or indirect care under the supervision or direction of a Medical Staff Member possessing Privileges to provide such care in the Hospital and who may be eligible to exercise practice Privileges and prerogatives in conformity with the rules adopted by the Board, these Bylaws, and the Medical Staff Rules. AHPs are not eligible for Medical Staff membership.
3. **APPELLATE REVIEW BODY** means the group designated pursuant to the Fair Hearing Plan established by these Bylaws to hear a request for appellate review properly filed and pursued by a Practitioner or the Medical Executive Committee.
4. **BOARD OF DIRECTORS or BOARD** means the Governing Body of the Hospitals and/or any committee thereof duly authorized to perform some or all of the responsibilities of the Board of Directors as set forth in these Bylaws.
5. **CHIEF OF STAFF** means the chief elected officer of the Medical Staff.
6. **CLINICAL PRIVILEGES or PRIVILEGES** means the permission granted, including temporary Privileges, to a Medical Staff Member or Allied Health Professional to render specific patient services at one or more specific hospitals.
7. **DATE OF RECEIPT** of any notice or other communication shall be deemed to be the date such notice or communication was delivered personally to the required addressee or, if sent by mail, seventy-two (72) hours after being deposited, postage prepaid, in the United States mail.
8. **DAYS** means calendar days unless otherwise specified.
9. **EX OFFICIO** means service by virtue of office or position held. An Ex Officio appointment is with vote unless specified otherwise.
10. **GOOD STANDING** means a Medical Staff Member or Allied Health Professional is in good standing when, at the time of the assessment of standing, his/her membership and/or Privileges are not voluntarily or involuntarily limited, restricted, suspended, or otherwise encumbered for medical disciplinary cause or reason (excluding medical leaves of absence and participation in a Diversion Program).
11. **HEARING COMMITTEE** means the committee appointed pursuant to the Fair Hearing Plan established by these Bylaws to hear a request for an evidentiary hearing properly filed and pursued by a Practitioner.
12. **HOSPITAL** means Sutter Memorial Hospital, Sutter General Hospital and Sutter Center for Psychiatry. Throughout these Bylaws, references to "Hospital" shall mean the three facilities collectively, except with respect to Clinical Privileges (which shall be hospital-specific) or as otherwise specified.
13. **INVESTIGATION** means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a Member or the Medical Staff and does not include the activities of the Physician's Health Committee.
14. **MEDICAL EXECUTIVE COMMITTEE or EXECUTIVE COMMITTEE** means the Executive Committee of the Medical Staff.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

15. **MEDICAL STAFF or STAFF** means those physicians (M.D. or D.O. or their equivalent (i.e. foreign)) as recognized by the Medical Board of California (MBC) or the Osteopathic Medical Board of California (OMBC) who is licensed by either the MBC or OMBC, dentists, podiatrists, and qualified clinical psychologists who have been granted recognition as Members of the Medical Staff pursuant to the terms of these Bylaws.
16. **MEDICAL STAFF YEAR** means the period from January 1 through December 31.
17. **MEMBER** means, unless otherwise expressly limited, any physician (M.D. or D.O. or their equivalent (i.e. foreign)); dentists; podiatrists and qualified clinical psychologists, holding a current license to practice within the scope of that license who is a Member of the Medical Staff.
18. **NOTICE** means a written communication delivered personally to the addressee or sent by United States Postal Service, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the Medical Staff or Hospital. Special notice means written notification sent by certified or registered mail, return receipt requested.
19. **PARTIES** mean the practitioner who requested the hearing or appellate review and the body or bodies upon whose adverse action a hearing or appellate review request is predicated.
20. **PATIENT ENCOUNTER** means admitting or attending the patient, performing a procedure on the patient (inpatient or Hospital outpatient), consulting on a patient, actively participating in the care management of the patient, as determined by the Department chair and as reflected in the Practitioner's notes in the medical record, or assisting at surgery.
21. **PHYSICIAN** means an individual with an M.D. or D.O. degree who is currently licensed to practice medicine.
22. **PRACTITIONER** means, unless otherwise expressly limited, any physician (M.D. or D.O.), dentist, podiatrist, or qualified clinical psychologist holding a current license to practice within the scope of his or her license. In the context of corrective action and fair hearings pursuant to Articles VII and VIII of these Bylaws, it shall also mean clinical psychologists credentialed as Allied Health Professionals.
23. **PRIMARY SOURCE** means the original source of a specific credential which can verify the accuracy of a qualification reported by an individual health care Practitioner.
24. **RULES** refers to the Medical Staff and/or department Rules adopted in accordance with these Bylaws unless specified otherwise.
25. **SYSTEM** means Sutter Health.
26. **SYSTEM AFFILIATE** means a facility or entity, such as an affiliated hospital, urgent care center, surgery center, foundation, or other entity, that is an affiliated member of the System.
27. **TEAM or TEAMS** means organized groups of individuals assigned to perform Medical Staff functions. Teams shall be deemed to be organized "committees" of the Medical Staff, within the meaning of California laws protecting the activities and records of Medical Staff committees.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **ARTICLE I NAME**

- 1.01 The name of this organization shall be the Medical Staff of Sutter Medical Center, Sacramento (“Medical Staff” or “Staff”).

### **ARTICLE II PURPOSES AND RELATIONSHIP TO HOSPITAL'S GOALS**

#### **2.01 THE MEDICAL STAFF'S PURPOSES AND RESPONSIBILITIES**

##### **2.01-1 Medical Staff's Purposes**

The Medical Staff's purposes shall include, but are not limited to, the following:

- (a) To assure that all patients admitted or treated in any of the Hospital's services, sub-acute facilities and outpatient clinics on the Hospital license receive care at a uniform level of quality and efficiency consistent with generally accepted standards attainable within the Hospital's means and circumstances;
- (b) To assume a leadership role in Hospital performance improvement activities to improve quality of care, treatment, services, patient safety and satisfaction;
- (c) To organize prioritize and support hospital sponsored continuing education, other professional education and community health education and support services;
- (d) To initiate, develop and maintain Bylaws and Rules and Regulations to establish a framework for self-governance of Medical Staff with respect to the professional work performed in the Hospital and establishing processes for the Medical Staff to carry out its responsibilities for the professional work performed at the Hospital, outpatient programs and facilities, or sub-acute facilities on the Hospital license, including periodic meetings of the Medical Staff to review and analyze at regular intervals their clinical experience based on review of patient medical records; and
- (e) To provide a means for the Medical Staff, Board of Directors and Administration to discuss issues of mutual concern.

##### **2.01-2 Medical Staff's Rights and Responsibilities**

The Medical Staff's rights and responsibilities shall include, but are not limited to, the following:

- (a) To provide quality patient care;
- (b) To account to the Board of Directors for the quality of patient care provided by all Members authorized to practice in the Hospital through the following measures:
  - (1) Review and evaluation of the quality of patient care provided through valid and reliable patient care evaluation procedures;
  - (2) An organizational structure and mechanisms that allow on-going monitoring of patient care practices;

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

- (3) A credentials program, including mechanisms of appointment, reappointment and the matching of Clinical Privileges to be exercised or specified services to be performed with the verified credentials and current demonstrated professional performance of the Medical Staff applicant or Member;
  - (4) A continuing education program based at least in part on needs demonstrated through the medical care evaluation program; and
  - (5) A utilization review program to provide for the appropriate use of all medical services.
- (c) To recommend to the Board of Directors action with respect to appointments, reappointments, staff category and Department assignments, Clinical Privileges and corrective action;
  - (d) To recommend to the Board of Directors for the establishment, maintenance, continuing improvement and enforcement of professional standards related to the delivery of health care within the Hospital;
  - (e) To account to the Board of Directors for the quality of patient care through regular reports and recommendations concerning the implementation, operation and results of the quality review and evaluation activities;
  - (f) To initiate and pursue corrective action with respect to Members where warranted;
  - (g) To provide a framework for cooperation with other community health facilities and/or educational institutions or efforts;
  - (h) To develop, administer and recommend amendments to and in compliance with these Bylaws, the Rules and Regulations of the Medical Staff and with Hospital policies and procedures; and
  - (i) To exercise the authority granted by these Bylaws in order to fulfill the foregoing responsibilities.

### **2.01-2 Medical Staff's Right of Self-Governance**

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

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

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **2.01-3 Dispute Resolution**

With respect to any dispute related to the Medical Staff's rights of self-governance and/or discharge of Medical Staff responsibilities, the Medical Staff and Board of Directors shall meet and confer in good faith to resolve the dispute. The forum established in these Bylaws for this meet and confer obligation is the Joint Conference Committee; however, the Medical Staff and Board of Directors can utilize additional or different forums or processes, such as mediation, so long as both the Medical Staff and Board of Directors mutually agree to the forum or process as well as any procedures that would govern the meet and confer function. Whenever any person or entity, including the Board of Directors, has engaged in, or is about to engage in, acts or practices that hinder, restrict or obstruct the Medical Staff's ability to exercise its rights, obligations or responsibilities, the Medical Staff may apply for, and the Superior Court of the County in which the Hospital is located, may issue an injunction, writ of mandate or other appropriate order. Prior to seeking judicial relief, the Medical Staff must first make a reasonable effort to resolve the dispute, including the pursuit of any reasonable administrative remedies provided in these Bylaws.

### **2.02 RELATIONSHIP TO HOSPITAL'S GOALS**

With respect to the Medical Staff, the goals of the Hospital are to maintain a highly qualified professional staff, to carefully screen and monitor applicants and Members of the Medical Staff and other professionals exercising Clinical Privileges; to continually strive to achieve higher standards of patient care; to respond to community needs; and to achieve high confidence and communication among the Medical Staff, the Hospital administration, and the Board. These Bylaws, together with Medical Staff Rules and policies and procedures, constitute the Medical Staff's articulated objectives toward achievement of these goals.

### **2.03 ACKNOWLEDGMENT OF AND ADAPTATION TO FACILITIES' RANGE OF SERVICES**

Sutter General and Memorial Hospitals are general acute care hospitals, with a full range of medical and surgical services, medical-psychiatric services, and emergency services. Sutter Center for Psychiatry is an inpatient psychiatric facility. The Medical Staff acknowledges that the differences in scope of services among these facilities may necessitate adoption of special rules, regulations, policies and procedures applicable on a facility-specific basis. However, wherever possible, the desire of the Medical Staff is to minimize duplication of efforts, to consolidate resources, to standardize policies and procedures, to operate as efficiently and effectively as possible, and to achieve a comparably high standard of care at all facilities, while at the same time accommodating the uniqueness of each facility.

### **2.04 COOPERATIVE PEER REVIEW**

#### **2.04-1 Sharing Credentialing and Peer Review Information**

The Medical Staff recognizes the value and importance of sharing credentialing and peer review information between itself and other health care entities, which perform peer review. Further, it may be beneficial for the Medical Staff to rely upon information in other health care entities' credentials and peer review files in evaluating applications for appointment and reappointment and in the conduct of peer review activities. In keeping with this, such cooperative credentialing and peer review is hereby authorized.

#### **2.04-2 Confidentiality**

Notwithstanding other provisions of these Bylaws relating to confidentiality, participation in cooperative activities described in the immediately preceding paragraph, including sharing of information with other health care entities, shall not be deemed a violation of the confidentiality requirements of these Bylaws or of another health care entity's professional staff bylaws or regulations.

### **2.05 HEALTH SYSTEM AFFILIATION**

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

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### 2.05-1 Credentialing

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

### 2.05-2 Peer Review

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

### 2.05-3 Corrective Action

The Medical Staff may work cooperatively with any other System Affiliate, at which a Medical Staff Member or Allied Health Professional holds Privileges, to develop and impose coordinated, cooperative, or joint corrective action measures, as deemed appropriate to the circumstances. This may include, but is not limited to, giving timely notice of emerging or pending problems, as well as notice of corrective actions imposed and/or reciprocal effectiveness of such corrective actions, as provided in Section 8.14 of these Bylaws.

### 2.05-4 Joint Hearings and Appeals

The Medical Staff and Board are authorized to participate in joint hearings and appeals provided the applicable procedures are substantially comparable to those set forth in the hearing and appellate review procedures established in these Bylaws.

## **ARTICLE III MEDICAL STAFF MEMBERSHIP**

### 3.01 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff and Privileges may be extended to, and may be maintained by only those professionally competent Practitioners who continuously meet the qualifications; standards and requirements set forth in these Bylaws and the Rules. A Practitioner, including one who has a contract with the Hospital to provide medical-administrative services, may admit or provide services to patients in the Hospital only if the Practitioner is a Member of the Medical Staff or has been granted temporary Privileges in accordance with these Bylaws and the Rules. Appointment to the Medical Staff shall confer only such Privileges and prerogatives, as have been granted by the Board in accordance with these Bylaws.

### 3.02 QUALIFICATIONS FOR MEMBERSHIP

Medical Staff membership (except Honorary Staff) shall be limited to qualified Licensed Independent Practitioners who are currently licensed to practice medicine, podiatry, clinical psychology or dentistry in California.

#### 3.02-1 General Qualifications

(a) Practitioners must demonstrate compliance with the standards set forth in this Section 3.02-1(a), in order to have an application for Medical Staff membership accepted for review. The Practitioner must:

(1) Have an unrestricted license from the State of California and (if practicing clinical medicine, dentistry or podiatry) have a federal DEA number.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

- (2) For clinical psychologists, hold a Ph.D. or Psy.D. degree in clinical psychology. All other practitioners must hold such degrees as necessary to qualify them for licensure by their respective licensing boards.
- (3) Be board certified or admissible in his or her field; or have completed an approved residency in his or her field; or have practiced in his or her field in a hospital accredited by the Joint Commission for ten (10) years.
- (4) Maintain in force continuous professional liability insurance, with an insurer acceptable to the Medical Executive Committee and Board of Directors, in not less than the minimum amounts, if any, as from time to time may be jointly determined by the Medical Executive Committee and the Board of Directors. Continuous coverage means current professional liability coverage, as well as evidence of tail and nose coverage for prior periods of Medical Staff membership in the event that the Member has changed insurance carriers. The Medical Executive Committee, for good cause shown, may recommend to the Board of Directors that this requirement be waived with regard to a Practitioner, and the Board shall not grant or withhold such waiver on an arbitrary, discriminatory or capricious basis. In determining whether an individual exception is appropriate, the following facts may be considered:
- (a) Whether the Practitioner has applied for the requisite insurance;
  - (b) Whether the Practitioner has been refused insurance, and if so, the reasons for such refusal; and
  - (c) Whether insurance is reasonably available to the Practitioner and, if not, the reasons for its unavailability.
- (5) Have actively practiced for an average of at least twenty (20) hours per week in his or her field for eighteen (18) of the previous twenty-four (24) months (or have completed a twelve (12) month residency within the previous eighteen (18) months);
- (6) Except for clinical psychologists, have practiced in a Joint Commission accredited hospital or other equivalent accrediting organization at least two (2) of the previous five (5) years or completed an accredited hospital residency program within the previous two (2) years.
- (7) Be able to arrive within forty-five (45) minutes (surface travel time) of Sutter General or Sutter Memorial Hospitals (except for consulting staff applicants and physicians assigned specific times to be at the facility, i.e., Emergency Room physicians).
- (8) Document compliance with certain infectious disease screening requirements such as Physician's tuberculosis screening.
- (9) Must not be excluded from participating in Medicare, Medicaid, or any other federal healthcare program when such exclusion has been imposed by government enforcement authorities, or accepted by Practitioner, as a sanction for unlawful conduct.
- (b) Except for applicants for the Honorary Staff, a Practitioner who does not meet these basic standards is ineligible to apply for Medical Staff membership and the application shall not be accepted for review.

If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in these Bylaws, but may submit comments and a request for reconsideration of the specific standards which adversely affected such Practitioner. Those comments and requests shall be reviewed by the Medical Executive Committee and the Board, which shall have sole discretion to decide whether to consider any changes in the basic standards or to grant a waiver as allowed by Section 3.02-3.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **3.02-2 Particular Qualifications**

In addition to meeting the general qualifications set forth above, the Practitioner must:

- (a) Document (i) adequate experience, education, and training in the requested Clinical Privileges; (ii) current professional competence; (iii) good judgment; and (iv) adequate physical and mental health status (subject to any necessary reasonable accommodation) to demonstrate to the satisfaction of the Medical Staff that he or she is professionally and ethically competent so that patients can reasonably expect to receive the generally recognized high professional level of quality of care for this community.
- (b) Be determined (1) to adhere to the lawful ethics of his or her profession, (2) to be able to work cooperatively with others in the hospital setting so as not to adversely affect patient care or jeopardize the ability of the treatment team to provide quality patient care, as determined by the Medical Executive Committee, (3) to keep as confidential, as required by law, all information or records received in the physician-patient relationship, (4) pay dues in such amounts as determined by the Medical Executive Committee and (5) to be willing to participate in and properly discharge Medical Staff responsibilities, including peer review; and
- (c) If applying for clinical psychologist membership in the Medical Staff, meet the following criteria:
  - (1) Two (2) years of professional experience, at least one (1) year of which must be in a multidisciplinary health facility (as defined in the Rules). Such experience must include the equivalent of six (6) months full-time active participation in treatment planning and collaboration with a multidisciplinary team in an acute psychiatric facility or equivalent acute inpatient psychiatric treatment facility. At least fifty percent (50%) of this experience should be in direct treatment of individuals.
  - (2) Evidence of coursework and supervised experience covering evaluation and treatment of severely disturbed populations; and
  - (3) One of the following:
    - (a) Five (5) years of post-doctoral clinical experience;
    - (b) A doctoral degree from an American Psychological Association-accredited program; or
    - (c) A one (1) year internship in an American Psychological Association-accredited training site.

A Clinical Psychologist who does not meet the above requirements may apply for Privileges as an Allied Health Professional.

### **3.02-3 Waiver of Qualifications**

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

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### 3.02-4 Effect of Other Affiliations

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

### 3.02-5 Nondiscrimination

Medical Staff membership or particular Privileges shall not be denied on the basis of sex, sexual orientation, race, creed, color, national origin, or any physical or mental impairment that, after any necessary reasonable accommodation, does not pose a threat to the quality of patient care or preclude compliance with the Medical Staff Bylaws or Rules or Hospital policies.

## 3.03 ADMINISTRATIVE AND CONTRACT PRACTITIONERS

### 3.03-1 Contractors With no Clinical Duties

A Practitioner employed by or contracting with the Hospital in a purely administrative capacity with no clinical duties or Privileges is subject to the terms of his or her contract or other conditions of employment and need not be a Member of the Medical Staff.

### 3.03-2 Contractors Who Have Clinical Duties

- (a) A Practitioner with whom the Hospital contracts to provide services, which involve duties or Privileges, must be a Member of the Medical Staff, achieving his or her status by the procedures described in these Bylaws.
- (b) Contracts between Practitioners and the Hospital shall prevail over these Bylaws and the Rules, except that the contracts may not reduce any hearing rights granted when an action will be taken that must be reported to the Medical Board of California or the federal National Practitioner Data Bank.

## 3.04 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

Each Member of the Medical Staff shall:

- (a) Provide his or her patients with care of the generally recognized professional level of quality and efficiency.
- (b) Abide by applicable laws and regulations (whether federal, state, and/or local), the Medical Staff Bylaws and Rules, and lawful bylaws, standards, policies, and rules of the Hospital or the Medical Staff, and comply with applicable standards of The Joint Commission.
- (c) Discharge such Staff, department, service, and committee functions for which he or she is responsible by appointment, election, or otherwise.
- (d) Prepare and complete in a timely manner the medical and other required records for all patients he or she admits or in any way provides care to in the Hospital, including completion of history and physical examination no more than thirty (30) days before or twenty-four (24) hours after admission and all required updates by a Physician in accordance with the Medical Staff Rules and Regulations.
- (e) Abide by the ethical principles of his or her profession.
- (f) Refrain from fee splitting or other inducements relating to patient referral.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

- (g) Provide for continuous care of his or her hospitalized patients, without regard for the patient's age, sex, religion, race, creed, color, health status, ability to pay, or source of payment.
- (h) Refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a Practitioner who is not qualified to undertake this responsibility and who is not adequately supervised.
- (i) Coordinate individual patient's care, treatment and services with other Practitioners and Hospital personnel, including, but not limited to, seeking consultation as required in the Rules, or whenever warranted by the patient's condition.
- (j) Provide adequate twenty-four (24) hour coverage for his or her patients.
- (k) Provide information to appropriate department heads or Medical Staff officers when he or she obtains reasonable information that a fellow Medical Staff Member may have engaged in unprofessional or unethical conduct or may have a health condition which poses a significant risk to the well-being or care of patients, and then cooperate as reasonably necessary toward the appropriate resolution of any such matter.
- (l) Accept responsibility for emergency care and for support of the Emergency Rooms, including consultation and/or admission as may be necessary. This obligation shall apply, regardless of the facility at which the Medical Staff Member primarily practices. Availability and assignment shall be in accordance with the Rules and with regulations formulated by the departments.
- (m) Accept responsibility for proctoring. Availability and assignment shall be in accordance with the Rules and with regulations formulated by the departments.
- (n) Participate in Continuing Medical Education programs that are appropriate to his or her specialty and that meet all licensing requirements.
- (o) Work cooperatively with Members, nurses, Hospital administration and others so as not to adversely affect patient care or Hospital operations.
- (p) Continuously meet the qualifications for membership as set forth in these Bylaws. Members shall cooperate in any physical or mental health evaluation and any other information deemed necessary by the Medical Executive Committee to enable an adequate evaluation of their qualifications.
- (q) Promptly notify the Chief of Staff any reduction, restriction, suspension or revocation of his/her Medical Staff membership and/or Clinical Privileges, for medical disciplinary cause or reason, at another hospital or surgicenter, or any termination, reduction or suspension for medical disciplinary cause or reason, of his/her status as a contracted provider for a managed care organization, or any licensing agency's accusation, action or settlement.
- (r) Reporting to his/her clinical department chief any extended illness, disability, or absence which will prevent him/her from participating in Hospital practice and/or Medical Staff business.
- (s) Reporting to the Chief of Staff promptly in the event of any formal action taken by government authorities to exclude the Member from participating in Medicare, Medicaid, or any other federal health care program as a sanction for unlawful conduct.
- (t) Providing information to and/or testifying on behalf of the Medical Staff or an accused Practitioner regarding any matter under an investigation pursuant to Section --, and those which are subject to hearing subject to Article IX.
- (u) Report to the Chief of Staff within five (5) calendar days any criminal conviction.
- (v) Attend department meetings as determined by the department and Medical Executive Committee.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

(w) Attending meetings of a Medical Staff peer review committee at which the Member's practice or conduct is scheduled for discussion, if the Member's attendance has been requested at least seven (7) days prior to the meeting, or responding within thirty (30) days (or as directed by the committee chair) to a written request on behalf of any such committee, identifying questions or concerns pertaining to a Member's practice or conduct and requesting that he/she review and respond to the applicable committee meeting minutes and medical records.

(x) Cooperate in responding to requests for information (including information from a patient's office medical record) as necessary to enable a full evaluation of the Member's qualifications and current professional competence.

(y) Actively participate in and regularly cooperate with the Medical Staff in assisting the Hospital to fulfill its obligations related to patient care, including but not limited to total quality improvement, peer review, utilization management, quality evaluation and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time.

### **3.05 DURATION OF APPOINTMENT**

Appropriate Rules and Medical Staff policies and procedures shall be developed to implement the following:

(a) All new Medical Staff Members shall be appointed to the Provisional Staff and subjected to a period of formal observation and review except for those appointed to the Consulting Staff. Provisional appointments are for not less than one (1) year, and a Member may serve no more than two (2) consecutive one (1) year terms as a Provisional Staff Member unless an extension is granted pursuant to Section 4.05.

(b) Reappointments to any Medical Staff category shall be for a period of two (2) years, and shall be staggered throughout the year so as to enable thorough review of each Member. Change in Staff category may be requested at any time during the reappointment period after requirements of Provisional status are met.

### **3.06 LEAVES OF ABSENCE AND MODIFICATION OF STAFF RESPONSIBILITIES**

Members may request a leave of absence in accordance with the Rules and Medical Staff policies, which must be approved by the Medical Executive Committee and cannot exceed two (2) years. Reinstatement at the end of the leave must be approved in accordance with the standards and procedures set forth in the Rules. The Member must provide information regarding his or her professional activities during the leave of absence if requested by the Medical Executive Committee. If the leave extends beyond the reappointment term of the Practitioner, a reinstatement application form must be completed and acted upon by the appropriate committees prior to the Practitioner's return to practice. During the period of the leave, the Member shall not exercise Privileges at the Hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the Medical Executive Committee. Members on leave of absence shall not be required to maintain continuous professional liability insurance, but must have appropriate "tail" coverage providing coverage for acts which occurred prior to the leave of absence and must provide evidence of such tail coverage as part of any request for a leave of absence. Any Practitioner who commences a leave of absence without providing such evidence will be deemed to have voluntarily resigned from the Medical Staff.

### **3.07 HARASSMENT PROHIBITED**

Harassment by a Medical Staff Member against any individual, e.g., against another Medical Staff Member, a Hospital employee or patient, on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender or sexual orientation, or for any other reason, 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, drawing or posters).

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

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

All allegations of harassment by a Medical Staff Member, including, but not limited to, 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.

### **3.08 HIPAA**

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

## **ARTICLE IV CATEGORIES OF THE MEDICAL STAFF**

### **4.01 CATEGORIES**

The Staff shall be divided into Honorary, Retired, Active, Provisional, Courtesy, Consulting, Affiliate, and Inactive categories. All initial appointments to the Staff shall be to the Provisional or Consulting categories. Physicians participating in Hospital-approved residency training programs may be referred to as Resident Staff members; however, Resident Staff shall not be deemed Members of the Medical Staff, shall not enjoy the rights of Medical Staff membership, and shall have only such Privileges, prerogatives and responsibilities as may be set forth in the Rules.

### **4.02 HONORARY STAFF**

#### **4.02-1 Qualifications**

(a) The Honorary Staff shall consist of retired Practitioners recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous long-standing service to the Hospital (including, but not by way of limitation, holding various offices of the Medical Staff, the departments, the teams, or the committees).

#### **4.02-2 Prerogatives**

(a) Honorary Staff Members shall not admit or attend patients. They may attend Staff, department, section, and educational meetings; but they may not vote or hold office in the Medical Staff organization, the departments, or the committees; and they need not pay dues.

### **4.03 ACTIVE STAFF**

#### **4.03-1 Qualifications**

The Active Staff shall consist of Members who:

(a) Meet the general qualifications for membership as set forth in section 3.02;

## Sutter Medical Center, Sacramento – Medical Staff Bylaws

- (b) Have offices or residences which, in the opinion of the Medical Executive Committee, are located closely enough to the Hospital to provide appropriate continuity of care;
- (c) Have eleven (11) or more Patient Encounters in two (2) years at the Hospital. Actually working the equivalent of eight (8) or more assigned eight (8) hour shifts in the Hospital in two (2) years equals eleven (11) Patient Encounters.
- (d) Pay dues to the Medical Staff;
- (e) Participate in continuing evaluation of the clinical care and adherence to the standards established by the Medical Staff; and
- (f) Except for good cause shown as determined by the Medical Executive Committee, have satisfactorily completed their designated term in the Provisional Staff category.

### 4.03-2 Prerogatives

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

- (a) Admit patients and exercise such Clinical Privileges as are granted pursuant to Article VI (i.e., the Medical Staff Bylaws provision on Clinical Privileges);
- (b) Attend and vote on matters presented at general and special meetings of the Medical Staff and the department and committees to which the Member is duly appointed; and
- (c) Hold Staff, section, or department office and serve as a voting member of committees to which the Member is duly appointed or elected by the Medical Staff or duly authorized representative thereof.

Any Active Staff Member with less than eleven (11) patient encounters in two (2) years at Sutter Medical Center, Sacramento or in any facility licensed as part of the Hospital, including outpatient facilities, will be given a two-year grace period to attain the activity level that corresponds with the Staff category (s) he desires. If at the end of the two-year grace period the Member has not met the minimum activity requirements, the Member must transfer to the Office Based or Courtesy Staff as appropriate.

## 4.04 PROVISIONAL STAFF

### 4.04-1 Qualifications

The Provisional Staff shall consist of Members who:

- (a) Meet the general Medical Staff membership qualifications set forth in Section 3.02;
- (b) Practitioners who are newly appointed to the Medical Staff and immediately prior to their application and appointment were not Members (or were no longer Members) in Good Standing of this Medical Staff; and
- (c) Pay dues to the Medical Staff.

### 4.04-2 Prerogatives

The Provisional Staff Member shall be entitled to:

- (a) Admit patients and exercise such Clinical Privileges as are granted pursuant to Article VI (i.e., the Medical Staff Bylaws provision on Clinical Privileges).
- (b) Attend Staff meetings as stated under Section 13.07-1, and they may serve on Staff and department teams and committees but may not vote.

## Sutter Medical Center, Sacramento – Medical Staff Bylaws

Provisional Staff Members may not vote at any general or special meeting of the Medical Staff. They may not serve as a general Medical Staff officer, a department Chief, a committee Chair, or a team Leader.

### 4.04-3 Observation of Provisional Staff Members

Each Provisional Member shall be assigned to a department where a specific program of proctoring will be established. (Proctoring requirements for Consulting Staff shall be as specified in the Rules.) A Member remains in Provisional status until he or she meets all the qualifications and has successfully completed his or her supervision and observation program. The purpose of the observation shall be to evaluate the Member's (1) proficiency in the exercise of Clinical Privileges initially granted, and (2) overall eligibility for continued Medical Staff membership and advancement within Staff categories. Appropriate observation records shall be maintained and the results of the observation shall be communicated in writing to the Department chairpersons and to the Credentials Committee.

### 4.04-4 Term of Provisional Staff Status

Provisional appointments are for not less than one year, and a Member may serve no more than two consecutive one-year terms as a Provisional Staff Member unless an extension has been granted. Extensions may be requested by those Practitioners who admit, treat, or consult in the Hospital on an infrequent basis. Such extensions shall only be granted upon the concurrence of the department and the approval of the Medical Executive Committee and the Board. The Chief of the department shall certify satisfactory completion of the Provisional period in accordance with the Rules.

If at the end of the first year, there is insufficient activity to advance to another Staff category, the Staff Member will be notified (s) he must complete proctoring within the next year in order to go to Active or to Courtesy Staff. If proctoring is not completed by the end of the second year, the Member shall be deemed to have voluntarily withdrawn his or her request for membership or the relevant Privileges in accordance with Section 6.09-3 of these Bylaws.

## 4.05 COURTESY STAFF

### 4.05-1 Qualifications

The Courtesy Staff shall consist of Practitioners who:

- (a) Meet the general qualifications for membership set forth in Section 3.02;
- (b) Have offices or residences, which in the opinion of the Medical Executive Committee, are located closely enough to the Hospital to provide appropriate continuity of quality of care;
- (c) Pay dues to the Medical Staff;
- (d) Do not have more than ten Patient Encounters in two (2) years in the Hospitals or in any facility licensed as part of the Hospital, including outpatient facilities;
- (e) Are members in Good Standing of the active medical staff of another hospital licensed in the state of California and accredited by The Joint Commission or other equivalent accrediting organization where each is subject to a patient care audit program and other quality maintenance activities similar to those required by the Active Staff of this Hospital. If a Member exceeds the ten (10) patients in two (2) years, the Member will be automatically advanced to Active Staff.

### 4.05-2 Prerogatives

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

- (a) Admit patients to the Hospital with the limitations of Section 4.06-1(d) and exercise such Clinical Privileges as are granted pursuant to Article VI (i.e., the Medical Staff Bylaws provisions on Clinical Privileges); and

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

- (b) Attend meetings of the Medical Staff and the department or service of which he or she is a Member, and may attend any Staff or Hospital education programs.

Courtesy Members are not eligible to vote or to hold office in the Medical Staff organization, the departments, the teams, or the committees.

### **4.06 CONSULTING STAFF**

#### **4.06-1 Qualifications**

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

- (a) Are not otherwise Members of the Medical Staff, who possess special expertise in their field of medicine that is not adequately represented on the Medical Staff, and who meet the general qualifications set forth in Section 3.02, except that this requirement shall not preclude an out of state Practitioner from appointment as may be permitted by law if that Practitioner is otherwise deemed qualified by the Medical Executive Committee;
- (b) Possess qualifications for Medical Staff membership and adequate clinical and professional credentials in an expertise which the Medical Executive Committee determines is under represented on the Medical Staff;
- (c) Shall be a member in Good Standing of the active medical staff of another Joint Commission (or equivalent) accredited acute care hospital acceptable to the Medical Executive Committee, although exceptions to this requirement may be made by the Medical Executive Committee for good cause; and
- (d) Shall have satisfactorily have completed appointment in the Provisional Staff category. At the time of application, Practitioners seeking appointment to the Consulting Staff must provide documentation that he or she has satisfactorily completed a proctoring program at their primary hospital. Such documentation may be accepted in lieu of actual observation and or other proctor program requirement, at the discretion of the chairperson of the department to which the Practitioner is assigned.
- (e) Pay dues to the Medical Staff.

#### **4.06-2 Prerogatives**

The Consulting Staff Member shall be entitled to:

- (a) Exercise such Clinical Privileges as are granted pursuant to Article VI (i.e., the Medical Staff Bylaws provisions on Clinical Privileges); and
- (b) Be appointed to a specific department, be eligible to serve on specific committees when appointed and vote on matters before such committees. They may attend Medical Staff meetings, including open committee meetings and educational programs, and meetings of the department to which the Practitioner is assigned but shall have not right to vote at such meetings.

Consulting Staff Members may not admit patients to the Hospital or act as the primary care provider but may function as the attending practitioner in his/her specialty. Each Consulting Staff Member shall be assigned to a department and are subject to the same proctoring requirements as a Provisional Staff Member. Consulting Staff Members are not eligible to vote or hold office in the Medical Staff organization, the departments, the teams, or the committees. Consulting Staff Members are not required to pay dues.

### **4.07 OFFICE BASED STAFF**

#### **4.07-1 Qualifications**

## Sutter Medical Center, Sacramento – Medical Staff Bylaws

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

- (a) Have met all the requirements set forth in Section 3.02-1 to qualify for Medical Staff Membership except for the requirement that the applicants have practiced in the applicant's intended field of practice in a Joint Commission (or equivalent) accredited acute care hospital for two (2) of the previous five (5) years. Office Based Members must be involved in the care of outpatients at least twenty (20) hours per week in the outpatient or office based setting. Office Based Members shall not be granted Clinical Privileges or be allowed to write orders. An applicant may be appointed directly to the Office Based Category.

### 4.07-2 Prerogatives

- (a) Office Based Staff Members may attend meetings of the Medical Staff and the Department and/or Section to which that person is assigned, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.
- (b) Office Based Staff Members shall not be eligible to hold office in the Medical Staff organization, but may serve on committees, as appointed by the Department Chief, Chief of Staff or Medical Executive Committee.
- (c) Office Based Members shall pay dues.
- (d) Office Based Staff Members who wish to apply for Clinical Privileges must demonstrate current competence in the care of acute inpatients and to exercise the specific Privileges requested as recommended by the appropriate clinical department, the Credentials Committee and the Medical Executive Committee. This required demonstration will likely require the Practitioner to obtain recent education and training from a program approved by the appropriate clinical Department, the Credentials Committee and the Medical Executive Committee and which is specifically designed to enable the Practitioner to demonstrate current competence in the care of acute inpatients. Office Based Staff Members applying for Clinical Privileges may be required to have an interview with the Credentials Committee.
- (e) Office Based Staff Members must provide documentation identifying a Medical Staff Member who shall be responsible for admitting and managing the care of the Office Based Staff Member's patients who present to the Hospital for admission.
- (f) At the time of reappointment, Practitioners seeking reappointment to the Office Based Staff must provide documentation acceptable to the Credential Committee and Medical Executive Committee that he or she has been involved in the care of outpatients at least twenty (20) hours per week in the outpatient or office based setting. Additionally the Practitioner must present evidence of successful completion of Board Certification, recertification or maintenance of specialty certification the preceding two (2) years or objective, written evidence that adequate and satisfactory peer review has been performed on Practitioner's outpatient practice by an entity or agency acceptable to the Medical Executive committee and that Practitioners who cannot satisfy this requirement shall then be required to submit at least eight (8) complete office charts spanning a two (2) year period for review by either the Department Chair or his or her designee, or by and out side review, as determined by the Medical Executive Committee. The costs of such review shall be the responsibility of the Practitioner. The Department Chief may, any time, within his or her discretion, request the Practitioner to produce complete copies of office charts for patients admitted to the Hospital so that the Department Chief, or his or her designee, can assess, or cause to be assessed, the quality and appropriateness of care provided in the office based setting.

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## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **4.08 TELEMEDICINE AFFILIATE STAFF**

#### **4.08-1 Qualifications**

The Telemedicine Affiliate Staff shall consist of Physicians who meet the basic and particular qualifications for Medical Staff membership and who provide diagnostic or treatment services to Hospital patients via Telemedicine devices (i.e., interactive [involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information] audio, video, or data communications (but not to include telephone or electronic mail communications) between Physician and patient.

#### **4.08-2 Prerogatives**

- (a) Telemedicine Affiliate Staff Members may not admit patients to the Hospital or exercise Clinical Privileges whatsoever in the Hospital. Members of this staff category may only provide patient care services from a Distant Site.
- (b) Telemedicine Affiliate Staff Members may attend meetings of the Medical Staff and Department meetings, including open committees meetings and educational programs. However, they may not vote at Department or general Medical Staff meetings or hold any office in the Medical Staff organization. Telemedicine Affiliate Staff Members may, however, be appointed by the Medical Executive Committee to serve on committees and they may vote in those committees if the right to vote is specified at the time of appointment.
- (c) Telemedicine Affiliate Staff Members shall pay dues.

## **ARTICLE V PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT**

### **5.01 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, is granted temporary Privileges as set forth in these Bylaws, or, with respect to Allied Health Professionals, has been granted Privileges under applicable Medical Staff Bylaws, Rules and Regulations and policies. The Medical Staff shall consider each application for appointment, reappointment and Privileges, and each request for modification of Staff category, using the procedure and the standards set forth in the Bylaws and the Rules. The Medical Staff shall investigate each applicant before recommending action to the Board. The Board shall ultimately be responsible for granting membership and Privileges. The Medical Staff shall perform this function also for Practitioners who seek temporary Privileges and for AHPs. By applying to the Medical Staff for appointment or reappointment (or by accepting Honorary Staff appointment), the applicant agrees that regardless of whether he or she is appointed or granted the requested Privileges, he or she will comply with the responsibilities of Medical Staff membership and with the Medical Staff Bylaws and the Rules as they exist and as they may be modified from time to time.

### **5.02 APPLICANT'S BURDEN**

All applicants shall have the burden of producing accurate and adequate information for a proper evaluation of the applicant's qualifications and suitability for the requested status or Privileges, resolving any reasonable doubts about these matters, and satisfying requests for information. The provision of information containing significant misrepresentations or omissions and/or a failure to sustain the burden of producing information shall be grounds for denying an application or request. This burden may include submission to a medical or psychological examination upon request of the Medical Executive Committee or the Board.

## Sutter Medical Center, Sacramento – Medical Staff Bylaws

### 5.03 APPOINTMENT AUTHORITY

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

### 5.04 APPLICATION FOR INITIAL APPOINTMENT

New applicants must meet the threshold criteria (see Section 5.05 above) in order for an application to be accepted. If a new applicant fails to satisfy the threshold criteria, the application will not be processed and will be returned to the applicant.

#### 5.04-1 Application Form

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

- (a) The applicant's qualifications, including, but limited to, professional training and experience, current licensure (verified with the Primary Source at the time of initial granting, renewal and revision of Privileges, and at the time of license expiration), current DEA registration (if applicable), and continuing medical education information related to the Clinical Privileges to be exercised by the applicant;
- (b) Peer reference letters (minimum of three (3)), preferably from the applicant's specialty area and preferably not including relatives, current partners or associates in practice. If possible, at least one peer reference letter should be from one Member from the Medical Staff of the facility at which the applicant requests Privileges. All peer reference letters must be from individuals who are directly familiar with the applicant's professional competence in the care of patients in the hospital and ethical character, either through direct clinical observation or through close working relationships;
- (c) Current government issued photograph (e.g., passport, driver's license, military identification) sufficient to verify that the applicant requesting approval is the same individual identified in the application and credentialing documents;
- (d) Application fee;
- (e) Verified plans to provide continuous coverage for the Practitioner's patients, subject to approval of the Medical Executive Committee;
- (f) Written clarification of any lapse in time, (subsequent to graduation from medical school) exceeding sixty (60) days;
- (g) Requests for membership categories, departments and Clinical Privileges;
- (h) Past or pending professional disciplinary action, voluntary or involuntary denial, revocation, suspension, restriction, or reduction or relinquishment of Medical Staff membership or Clinical Privileges, or any licensure or registration, termination of participating provider status in any managed care organization for medical disciplinary cause or reason, and related matters;
- (i) Information detailing any prior or pending government agency or third party payor, investigation, proceeding, or litigation challenging or sanctioning the Practitioner's patient admission, treatment, discharge, charging, collection, or utilization practices, including, but not limited to, Medicare or Medical fraud and abuse proceedings or convictions;
- (j) Current physical and mental health status, including a completed Physician Tuberculosis Surveillance Affidavit and, for initial applications only, a completed Infectious Disease Surveillance form (for Measles, Mumps, Rubella, Varicella and Hepatitis B screening);

### **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

- (k) Final judgments or settlements or other awards rendered in or outside the United States made against the applicant in professional liability cases, and any open or closed malpractice lawsuits filed in or outside the United States;
- (l) Professional liability coverage;
- (m) Completion of such certifications or statements as required by law, the Joint Commission, Medicare, Medi-Cal or other government payor or bond financing programs; and
- (n) Signed releases and authorizations necessary to complete a criminal background check.

Each application for initial appointment to the Medical Staff shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), dated and signed by the applicant. A complete application is one which provides responsive information reasonably necessary to enable the Medical Staff to make a sound recommendation regarding the application. Unresolved disciplinary action or malpractice litigation or the inability to verify information may render an application incomplete. When an applicant requests an application form, that person shall be given a copy of these Bylaws, the Medical Staff Rules and Regulations, and, as deemed appropriate by the Medical Executive Committee, copies of summaries of any other applicable Medical Staff policies relating to clinical practice at the Hospital.

#### 5.04-2 Effect of Application

In addition to the matters set forth in Section 5.01, by applying for appointment to the Medical Staff each applicant:

- (a) Signifies a willingness to appear for interviews in regard to the application;
- (b) Authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications, and performance, and authorizes such individuals and organizations to candidly provide all such information;
- (c) Consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out Clinical Privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;
- (d) Certifies that he/she will report to the Medical Executive Committee any changes in the information submitted on the application form which may subsequently occur;
- (e) Releases from any liability, to the fullest extent permitted by law, the Hospital and all other persons for their acts performed in connection with investigating and evaluating the applicant;
- (f) Releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;
- (g) Consents to the disclosure to other hospitals, medical associations, licensing boards, health care service plans, managed care organizations, and to other similar organizations as authorized by law, any information regarding the applicant's professional or ethical standing that the Hospital or Medical Staff may have, and releases the Medical Staff and the Hospital from liability for so doing to the fullest extent permitted by law;
- (h) Agrees that the Hospital and Medical Staff may share information with a representative or agent of any other affiliated hospital or affiliated medical group, skilled nursing facility or outpatient clinic, including information obtained from other sources, and releases each person and each entity who received the information from any and all liability, including any claims of violations of any federal or state laws, including laws regarding restraints of trade, and agrees that the person or entity to whom the information is disclosed may act upon such information;

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

- (i) Consents to undergo and to release the results of a medical, psychiatric, or psychological examination by a practitioner acceptable to the Medical Executive Committee, at the applicant's expense, if deemed necessary by the Medical Executive Committee;
- (j) If a requirement then exists for Medical Staff dues, acknowledges responsibility for timely payment (see Section 2.2-2(e));
- (k) Pledges to provide for continuous quality care for patients;
- (l) Pledges to maintain an ethical practice, including refraining from illegal inducements for patient referrals, providing continuous care of his or her patients, seeking consultation whenever necessary, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners;
- (m) Pledges to be bound by the Medical Staff Bylaws, Rules and Regulations and policies; and
- (n) Agrees to execute the releases and/or authorizations necessary for the Medical Staff to conduct, or cause to be conducted, a criminal background check.

### **5.04-3 Applicant's Responsibility to Produce Complete Information**

The applicant shall have the burden of producing adequate and complete information in a timely fashion for a proper evaluation of his/her competence, character, ethics, and other basic qualifications for membership. Only complete applications will receive consideration. An application which is not deemed complete in accordance with Section 5.04-1 shall not be considered. An application which remains incomplete after one hundred twenty (120) days, unless an exception is made for good cause by the Credentials Committee, will be deemed to have been withdrawn. The failure to consider applications deemed incomplete shall not entitle the applicant to due process rights pursuant to Article VIII. Applicants whose license to practice in the State of California is restricted or encumbered by the Medical Board of California, the Osteopathic Medical Board of California or any other licensing agency, shall not be considered for initial appointment to the Medical Staff.

### **5.04-4 Submission of Application and Verification of Information**

The applicant shall deliver a completed, signed, and dated application and supporting documents to the Medical Staff Office along with an advance payment of the application fee. The Medical Staff Office shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The Medical Staff Office shall query the Medical Board of California and the National Practitioner Data Bank regarding the applicant and submit any resulting information for inclusion with the applicant's or Member's credentials file. The Medical Staff Office may verify licensure and DEA certification status on-line, but in any event shall verify licensure, in writing, with the Primary Source. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain any reasonably requested information. When collection and verification of information is accomplished, the application shall be considered complete and shall be processed as described below.

### **5.04-5 Department Action**

The completed application and all supporting materials shall be transmitted to the Chairperson of the appropriate Department of the Hospital. The Chairperson or designee shall review the application and supporting documentation, and may conduct a personal interview with the applicant at the Chairperson's or designee's discretion. The Department Chairperson or designee shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of Privileges requested, and the applicant's participation in relevant continuing education, and shall transmit to the Credentials Committee a written report and recommendation as to appointment and, if appointment is recommended, as to membership category, Department affiliation, Clinical Privileges to be granted, and any special conditions to be attached. The chair may also request of the Credentials Committee that further action on the application be deferred for good cause.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### 5.04-6 Credentials Committee Action

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

### 5.04-7 Medical Executive Committee Action

At its next regular meeting (or as soon thereafter as is practicable) after receipt of the Credentials Committee report (including a complete application file) and recommendation and the Department report and recommendation, the Medical Executive Committee shall consider the reports and recommendations and any other relevant information. The Medical Executive Committee may request additional information, return the matter to the Credentials Committee or Department for further investigation, and/or elect to interview the applicant. The Medical Executive Committee shall forward to the Board of Directors, a written report and recommendation as to Medical Staff appointment and, if appointment is recommended, as to membership category, Department affiliation(s), Clinical Privileges to be granted, and any special conditions to be attached to the appointment. The Medical Executive Committee may also defer action on the application. The reasons for each recommendation shall be stated. All requests for Privileges by an applicant shall go to the Medical Executive Committee.

### 5.04-8 Effect of Medical Executive Committee Action

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

### 5.04-9 Action on Application

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

- (a) If the Medical Executive Committee issues a favorable recommendation, the Board of Directors shall affirm the recommendation of the Medical Executive Committee if the Medical Executive Committee's decision is supported by substantial evidence.
  - (1) If the Board of Directors concurs in that recommendation, the decision of the Board of Directors shall be deemed final action.
  - (2) If the tentative final action of the Board of Directors 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 set forth in Article VIII. If procedural rights are waived by the applicant, the decision of the Board of Directors shall be deemed final action.
- (b) In the event the recommendation of the Medical Executive Committee, or any significant part of it, is unfavorable to the applicant, the procedural rights set forth in Article VIII shall apply.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

(1) If procedural rights are waived by the applicant, the recommendations of the Medical Executive Committee shall be forwarded to the Board of Directors for final action, which shall affirm the recommendation of the Medical Executive Committee if the Medical Executive Committee's decision is supported by substantial evidence.

(2) If the applicant requests a hearing following the adverse Medical Executive Committee recommendation pursuant to Section 5.06-8 (b) or an adverse Board of Directors tentative final action pursuant to Section 5.06-9 (a)(2), the Board of Directors shall take final action only after the applicant has exhausted all procedural rights as established in Article VIII, the Board of Directors shall make a final decision and shall affirm the decision of the Judicial Review Committee if the Judicial Review Committee's decision is supported by substantial evidence, following a fair procedure. The Board of Director's decision shall be in writing and shall specify the reasons for the action taken.

### 5.04-10 Notice of Final Decision

- (a) Notice of final decision shall be given to the Chief of Staff and Medical Executive Committee, the applicant, and the Hospital 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 has been assigned;
  - (3) The Clinical Privileges granted; and
  - (4) Any special conditions attached to the appointment.

### 5.04-11 Reapplication After Adverse Action

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

- (a) An applicant who (1) has received a final adverse decision regarding appointment or (2) withdrew his or her application or request for membership or Privileges following an adverse recommendation by the Medical Executive Committee or the Board;
- (b) A former Member who has (1) received a final adverse decision resulting in termination of Medical Staff membership and/or Privileges or (2) resigned from the Medical Staff following the Medical Executive Committee or Board issuing an adverse recommendation; or
- (c) A Member who has received a final adverse decision resulting in termination or restriction of his or her Privileges.

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

### 5.04-12 Date When the Action Becomes Final

The action is considered final on the latest date on which the application or request was withdrawn, a Member's resignation became effective, or upon completion of: (i) all Medical Staff and Hospital hearings and appellate reviews and (ii) all judicial proceedings pertinent to the action served within two years after the completion of the Hospital proceedings.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### 5.04-13 Effect of the Waiting Period

Practitioners subject to waiting periods cannot reapply for Medical Staff membership or the Privileges affected by the adverse action for at least twenty-four (24) months after the action became final. After the waiting period, the Practitioner may reapply. The application will be processed like an initial application or request, plus the Practitioner shall document that the basis for the adverse action no longer exists, that he or she has corrected any problems that prompted the adverse action, and/or he or she has complied with any specific training or other conditions that were imposed.

### 5.04-14 Timely Processing of Applications

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

- (a) Evaluation, review, and verification of application and all supporting documents by the Central Verification Unit: forty-five (45) days from receipt of all necessary documentation;
- (b) Review and recommendation by all departments to which the applicant has applied for Privileges: thirty (30) days after receipt of all necessary documentation from the Central Verification Unit and Medical Staff Office;
- (c) Review and recommendation by Credentials Committee: thirty (30) days after receipt of all Department(s) report(s) and recommendation(s), or at its next meeting;
- (d) Review and recommendation by the Medical Executive Committee: thirty (30) days after receipt of all necessary documentation from the Credentials Committee, or at its next meeting; and
- (e) Final action: thirty (30) days after receipt of recommendation from the Medical Executive Committee or seven (7) days after conclusion of hearings.

Best efforts will be made to expedite a completed and verified application and applicant presented to the Credentials Committee within thirty (30) days when there is an urgent need to do so, as determined by the Medical Executive Committee.

### 5.04-15 Expedited Review

The Board of Directors may use an expedited process for appointment, reappointment or when granting Privileges when criteria for that process are met. The Board of Directors may delegate this authority to a committee of the Board; however, any final decision of the committee must be subject to ratification by the full Board of Directors at its next regularly scheduled meeting. Expedited processing is usually not available if:

- (a) The applicant or Member submits an incomplete application;
- (b) The Medical Executive Committee's recommendation is adverse in any respect;
- (c) There is a current challenge or a previously successful challenge to the applicant's licensure or registration;
- (d) The applicant has received an involuntary termination of Medical Staff membership or some or all Privileges at another organization;
- (e) There has been a final judgment adverse to the applicant in a professional liability action.

## Sutter Medical Center, Sacramento – Medical Staff Bylaws

### 5.05 REAPPOINTMENT AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

#### 5.07-1 Application for Reappointment

(a) At least six (6) months prior to the expiration date of the current staff appointment (except for temporary appointments), a reapplication form developed by the Credentials Committee and approved by the Medical Executive Committee shall be mailed or delivered to the Member. If an application for reappointment is not received at least one hundred fifty (150) days prior to the expiration date, written notice shall be promptly sent to the applicant advising that the application has not been received and that the Member will have only an additional thirty (30) days to submit it. At least one hundred twenty (120) days prior to the expiration date, each Medical Staff Member shall submit to the Medical Staff Office the completed application form with supporting or requested documentation for renewal of appointment to the staff for the coming year and for renewal or modification of Clinical Privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 5.06-1, as well as other relevant matters. Should the Member's tardiness result in the Medical Staff's inability to process the application through all the evaluation and approval levels up to and including final action by the Board of Directors, automatic suspension will occur as set forth in Section 5.07-5. Upon receipt of the application, the information shall be processed as set forth commencing at Section 5.06-4. The information requested may include, but not be limited to, the following:

- (1) Professional and clinical performance, including his/her patterns of practice, based at least in part on the findings of performance improvement measures, such as peer review, utilization management, infection control activities, tissue review, medical record review, and pharmacy and therapeutics activities;
- (2) Current Privileges and the basis for any requested modifications;
- (3) Health status (subject to any necessary reasonable accommodation), including a completed Physician Tuberculosis Surveillance Affidavit;
- (4) Evidence of participation in continuing education programs relevant to the applicant's field of practice;
- (5) Service on Medical Staff and Hospital Committees;
- (6) Timely completion of medical records;
- (7) Compliance with applicable Hospital policies and with Medical Staff Bylaws, Rules and Regulations and policies;
- (8) The recommendations of any Department or Section to which the Member has been assigned or in which the Member exercises Privileges;
- (9) Peer reference letters [minimum of three (3)], preferably not including relatives, current partners or associates in practice. All peer reference letters must be from individuals who are directly familiar with the applicant's professional competence in the care of patients in the hospital and ethical character, either through direct clinical observation or through close working relationships;
- (10) Current California Medical license;
- (11) Current continuous professional liability insurance, as defined in previous sections;
- (12) Current DEA registration, if applicable;
- (13) Radiography X-ray Supervisor's and Operator's Permit, if applicable;
- (14) Reports from Medical Board of California and National Practitioner Data Bank inquiries;

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

- (15) Judgments, settlements, other awards rendered in or outside the United States since previous appointment; malpractice lawsuits filed in or outside the United States since previous appointment; and other matters as set forth in section 5.06-1(j) and (k), updated from previous appointment;
- (16) Letter from Primary Hospital (in case of Courtesy Staff members) or letter from other area facility (in case of Active Staff members);
- (17) Completion of such other certifications or statements as required by law, the Joint Commission, Medicare, Medi-Cal or other government payor or bond financing programs; and
- (18) Signed releases and authorizations necessary to complete a criminal background check.

Upon receipt of the application for reappointment and supporting data, the application shall be processed as set forth commencing at Section 5.06-4, et seq.

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

### **5.07-2 Effect of Application**

The effect of an application for reappointment or modification of staff status of Privileges is the same as set forth in Section 5.06-2.

### **5.07-3 Standards of Procedures for Review**

When a Medical Staff Member submits the first application for reappointment, and every two years thereafter, or when the Member submits an application for modification of staff status or Clinical Privileges, the Member shall be subject to an in-depth review generally following the procedures set forth in Sections 5.06-3 through 5.06-10.

### **5.07-4 Failure to File Reappointment Application**

Failure without good cause to file, on or before the date specified by the Medical Staff Office, a completed application for reappointment shall result in the automatic suspension of the Member's admitting privileges. Such failure shall also result in expiration of other practice Privileges and prerogatives at the end of the current staff appointment period. Failure to submit a completed application for reappointment with all supporting or requested documentation by the expiration of the current appointment period shall result in the automatic termination of the Member's Medical Staff membership and Clinical Privileges. In the event membership terminates for the reasons set forth herein, this will not be considered an adverse decision regarding reappointment, the procedures set forth in Article VII shall not apply. A Member who requests reappointment to the Medical Staff within sixty (60) days following an automatic termination under this Section shall not be required to complete a new application form.

### **5.07-5 Leave Status**

At the discretion of the Medical Executive Committee, a Medical Staff Member may obtain a voluntary leave of absence from the Staff upon submitting a written request to the Medical Executive Committee or its designee stating the approximate period of leave desired, which may not exceed two (2) years. The member should also state the reasons for the leave of absence. During the period of the leave, the Member shall not exercise clinical privileges at the Hospital, and Membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any shall continue, unless waived by the Medical Staff. Unless accompanied by a reportable restriction of privileges, in the discretion of the Medical Executive Committee, the leave shall not be deemed to be for a medical disciplinary cause or reason and shall not be reportable to the National Practitioner Data Bank. Reactivation of membership and clinical privileges following a leave of absence may be granted subject to monitoring and/or proctoring as determined by the Medical Executive Committee or its designee.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **5.07-6 Termination of Leave**

At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff Member may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee. The Staff Member shall submit a summary of relevant activities during the leave, if the Medical Executive Committee so requests. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the Member's privileges and prerogatives, and the procedure provided in Section 5.07-1 shall be followed.

### **5.07-7 Failure to Request Reinstatement**

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

### **5.07-8 Request for Reinstatement After Voluntary Resignation**

A Practitioner who requests reinstatement after voluntary resignation shall not be required to complete a new application form if the request is received within sixty (60) days of the effective date of the resignation. However, the Practitioner will be expected to respond to requests for additional information, if any, from the Medical Staff relative to the request for reinstatement.

### **5.08 CONFIDENTIALITY; IMPARTIALITY**

To maintain confidentiality, and to assure the unbiased performance of appointment and reappointment functions, participants in the credentialing process shall limit their discussion of the matters involved to the formal avenues provided in the Bylaws and Rules for processing applications for appointment and reappointment.

### **5.09 SYSTEMWIDE COOPERATION**

The Medical Staff may develop, in cooperation with other facilities or entities in the System, a consolidated appointment, reappointment, proctoring, and peer review process that includes, but is not limited to, one application form that will be shared by the facilities, a single investigation and verification of information resulting in information that will be shared by the facilities, sharing of information among the facilities and entities about applicants and Members, and joint review of applications. The results of the application review and investigation shall be reported to this Medical Staff's committee responsible for credentialing for processing in accordance with these Bylaws and the Rules.

## **ARTICLE VI DETERMINATION OF CLINICAL PRIVILEGES**

### **6.01 EXERCISE OF PRIVILEGES**

Except as otherwise provided in these Bylaws or the Medical Staff Rules, every Practitioner or AHP providing direct clinical services at this Hospital shall be entitled to exercise only those Privileges or services specifically granted to him or her and that define the scope of patient care services they may provide independently in the hospital. Said Privileges and services must be granted on a hospital specific basis, within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to the rules and regulations of the clinical Department and the authority of the Department chair and the Medical Staff. Medical Staff Privileges may be granted, continued, modified or terminated by the Board of Directors of the Hospital based upon recommendation of the Medical Staff, only for reasons directly related to the quality of patient care and other provisions of the Medical Staff Bylaws, and only following the procedures outlined in these Bylaws.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **6.02 CRITERIA FOR GENERAL COMPETENCIES**

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

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

Subject to approval of the Medical Executive Committee and the Board of Directors, each Department will be responsible for developing criteria for granting Clinical Privileges. The criteria shall be designed to facilitate uniform quality patient care, treatment and services. Insofar as feasible, affected categories of Allied Health Professionals shall participate in developing the criteria for Privileges to be exercised by Allied Health Professionals. Each Department’s approved criteria for granting Privileges shall be included in the Department’s rules.

### **6.04 DELINEATION OF PRIVILEGES IN GENERAL**

#### **6.04-1 Requests**

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific Privileges desired by the applicant. A request by a Staff Member for a modification of Privileges must be supported by documentation of training and/or experience supportive of the request. Privileges are hospital specific and are based on the Practitioner’s demonstrated current competence. The Medical Staff Office or Central Verification Unit shall query the National Practitioner Data Bank whenever the Practitioner seeks to expand Privileges or add new Privileges. Approval for each Privilege shall not exceed two (2) years.

Each Department will be responsible for developing criteria for granting Privileges.

#### **6.04-2 Bases for Privileges Determinations**

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

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

## Sutter Medical Center, Sacramento – Medical Staff Bylaws

### 6.05 CONDITIONS FOR PRIVILEGES OF NON-PHYSICIAN PRACTITIONERS

#### 6.05-1 Admissions

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

(b) General history and physical examinations for class I and II anesthesia risk patients may be performed by qualified Oral/Maxillofacial Surgeons, who have been granted history and physical privileges, in accordance with the Section's privilege criteria.

(c) General history and physical examinations for class I and II anesthesia risk patients may be performed by qualified Podiatric Surgeons, who have been granted history and physical privileges, in accordance with the Section's privilege criteria.

#### 6.05-2 Surgery

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

#### 6.05-3 Medical Appraisal

All patients admitted for care at the Hospital by a dentist, oral surgeon, or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and the dentists, oral surgeons, and podiatrists 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 development of a new medical problem. Consultation shall be obtained for circumstances defined by the Medical Staff. Where a dispute exists regarding proposed treatment between a Physician Member and a limited license Practitioner based upon medical or surgical factors outside the scope of the licensure of the limited license Practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate Department(s).

### 6.06 EFFECT OF EXCLUSIVE CONTRACT

Certain Hospital services are provided through exclusive contracts. When this is the case, only Practitioners who are members of the contracting group, and who are otherwise qualified by training and experience, shall be entitled to exercise "primary Privileges." Primary Privileges shall mean the Privileges to render the official first opinion and/or perform the procedure. Practitioners who are not members of the contracting group, but who are otherwise qualified by training or experience, shall be entitled to provide consulting services in the nature of "second opinions." Practitioners who depart an exclusive contract group, or whose group contract is terminated and then awarded to another group shall have their Privileges automatically converted to the second category of Privileges (i.e., consulting second opinions). Such privilege determinations are deemed administrative actions, and shall not entitle the practitioner to the procedural rights described in Article VIII. The foregoing shall not be deemed to deprive a practitioner of procedural rights when a denial, loss or restriction of Privileges is due to action of the Medical Executive Committee or the Board of Directors for reasons other than the existence of the exclusive contract (e.g., denial of Privileges due to lack of qualifications, or removal or restriction of Privileges pursuant to the corrective action procedures described in these Bylaws).

### 6.07 CONSULTATIONS

Consultations may be required at the discretion of the Chief of Staff or the department Chiefs or in accordance with the Rules.

## Sutter Medical Center, Sacramento – Medical Staff Bylaws

### 6.08 CREDENTIALING OF ALLIED HEALTH PROFESSIONALS

#### 6.08-1 Categories

Subject to approval by the Board, the Medical Executive Committee shall determine those categories of Allied Health Professionals that shall be eligible to exercise Privileges in the Hospital. Such Allied Health Professionals shall be subject to the supervision requirements developed in each department and approved by the Interdisciplinary Practices Subcommittee, the Medical Executive Committee and the Board.

#### 6.08-2 Privileges and Responsibilities

- (a) AHPs may exercise only those Privileges specifically granted them by the Board. The range of Privileges for which each AHP may apply and any special limitations or conditions to the exercise of such Privileges shall be based on recommendations of the Interdisciplinary Practice Subcommittee, subject to approval by the Medical Executive Committee and the Board.
- (b) Applications for initial granting of AHP Privileges and biennial renewal thereof shall be submitted and processed in a parallel manner to that provided for Practitioners, unless otherwise specified in the Rules.
- (c) Each AHP shall be assigned to the department or departments appropriate to his or her occupational or professional training and, unless otherwise specified in these Bylaws or the Rules, shall be subject to terms and conditions paralleling those specified for Practitioners as they may logically be applied to AHPs and appropriately tailored to the particular AHP's profession. Each AHP may attend department meetings and serve on Medical Staff and department committees as permitted by the department and the Rules.

#### 6.08-3 Procedural Rights of Allied Health Professionals

- (a) Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an AHP to the procedural rights set forth in Article VIII (except when an action is taken against a clinical psychologist that must be reported to the state licensing board).
- (b) A non-employee AHP shall have a right to informal hearing and appeal proceedings to challenge any action that would constitute grounds for a hearing under Section 8.04 of the Bylaws by filing a written grievance with the Medical Executive Committee within fifteen (15) days of such action. Upon receipt of such a grievance, the Medical Executive Committee shall authorize the Administrator to arrange an informal hearing to be conducted by one or more persons to be appointed by the Administrator. The hearing committee may, but need not, be comprised of AHPs or Members of the Medical Staff, however, in cases involving clinical competency or clinical performance, and subject to feasibility, the Administrator should attempt to include at least one individual who is a professional peer of the affected AHP. This informal hearing need not be conducted in accordance with the provisions of Article VIII. Rather, the following provisions shall apply: The AHP shall be informed of the general nature and circumstances giving rise to the action and the AHP may present information relevant thereto at the informal hearing. Evidence in support of the adverse recommendation will be presented by an authorized representative of either the Medical Executive Committee, the Credentials Committee, or the Interdisciplinary Practices Subcommittee (as determined by the Chief of Staff). A record of the proceeding shall be made. The resulting findings and recommendation shall be reported to the AHP and Medical Executive Committee, and shall be appealable to an appeal committee appointed by or consisting of the Medical Affairs Committee of the Board of Directors.
- (c) Appeals shall be based solely upon the record of the informal hearing, plus such oral or written statements and/or new evidence as the appeal committee, in its sole discretion, may permit. The recommendation of the appeal committee shall be forwarded to the Board (or authorized committee thereof) for final action.
- (d) The rights afforded by this Section shall not apply to any decision regarding whether a category of AHP shall or shall not be eligible for AHP Privileges and the terms, prerogatives, or conditions of such decision.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### 6.08-4 Automatic Suspension

An AHP's Privileges shall be automatically suspended, without review pursuant to Section 6.13-3 or any other section of these Bylaws, in the event:

- (a) The Medical Staff membership of the supervising Practitioner is terminated, whether such termination is voluntary or involuntary; or
- (b) The supervising Practitioner no longer agrees to act as the supervising Practitioner for any reason, or the relationship between the AHP and the supervising Practitioner is otherwise terminated, regardless of the reason.

The AHP will have thirty (30) days from the date of the automatic suspension to submit notice of new supervising Practitioner, to include appropriate documentation, or the AHP's Privileges shall be automatically terminated, without review pursuant to Section 6.13-3 or any other section of these Bylaws.

### 6.09 CONFIDENTIALITY; IMPARTIALITY

To maintain confidentiality, and to ensure the unbiased performance of Privilege review functions, Medical Staff Members participating in the credentialing process shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws and the Rules for processing applications for Privileges.

### 6.10 TEMPORARY PRIVILEGES AND LOCUM TENENS

#### 6.10-1 Circumstances

Temporary Privileges may be granted in two circumstances. First to meet an important patient care need and only after the Medical Staff verifies current licensure and current competence. Secondly, temporary Privileges may be granted when a new applicant with a complete application that raises no concerns is awaiting review and approval by the Credentials Committee, the Medical Executive Committee and the Board of Directors. Temporary Privileges may be granted:

- (a) For a period not to exceed 120 days.
- (b) For Practitioners who will serve as locum tenens for a Medical Staff Member or in the case of a undue hardship for the medical center or in cases of a documented important patient care need, for a period not to exceed three months and not less than two weeks' duration; can be renewed one time as long as the renewal begins within two months of the expiration of the original locums.
- (c) Other: Notwithstanding any other provision contained herein, when there is a significant need for the granting of temporary Privileges, the Administrator, the Chief of Staff, and the involved department Chief may grant such Privileges. All individuals with temporary Privileges granted under this paragraph shall be under the supervision of the department Chief or his or her designee.

#### 6.10-2 Application and Review

- (a) Temporary Privileges may be granted by the Administrator (or his or her designee) on the recommendation of the Chief of Staff after the Practitioner completes the application procedure and the Medical Staff completes the review process described in Section 5.06 of these Bylaws.
- (b) There is no right to temporary Privileges. Accordingly, temporary Privileges should not be granted unless the available information supports, with reasonable certainty, a favorable determination regarding the requesting Practitioner's or AHP's qualifications, ability, current competency and judgment to exercise the Privileges requested and only after the Practitioner or AHP has demonstrated compliance with the Rule on professional liability insurance.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

(c) If the available information is inconsistent or casts any reasonable doubts on the applicant's qualifications, action on the request for temporary Privileges shall be deferred until the doubts have been satisfactorily resolved.

(d) A determination to grant temporary Privileges shall not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff.

### **6.10-3 General Conditions and Termination**

(a) Practitioners granted temporary Privileges shall be subject to the proctoring and supervision specified in the Rules.

(b) Temporary Privileges shall automatically terminate at the end of the designated period, unless earlier terminated under this Section 6.11-3 or affirmatively renewed following the procedures set forth in the Rules.

(c) Temporary Privileges may be terminated with or without cause at any time by the Chief of Staff, the responsible department Chief, or the Administrator after conferring with the Chief of Staff or the responsible department Chief.

(d) Whenever temporary Privileges are terminated, the appropriate department Chief or, in the Chief's absence, the Chief of Staff shall assign a Member to assume responsibility for the care of the Practitioner's patient(s). The wishes of the patient and affected Practitioner shall be considered in the choice of a replacement Member.

(e) A person shall be entitled to the procedural rights afforded by Article VIII only if a request for temporary Privileges is refused based upon, or if all or any portion of temporary Privileges are terminated or suspended for, a medical disciplinary cause or reason. In all other cases (including a deferral in acting on a request for temporary Privileges), the Practitioner shall not be entitled to any procedural rights based upon any adverse action involving temporary Privileges.

(f) All persons requesting or receiving temporary Privileges shall be bound by the Bylaws and the Rules.

### **6.11 EMERGENCY PRIVILEGES**

In the case of an emergency, any Member of the Medical Staff, to the degree permitted by the scope of the Member's license and regardless of Department, Staff status or Clinical Privileges, or other professional or person shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The Member or other person shall promptly yield such care to a qualified Member when one becomes reasonably available.

### **6.12 DISASTER PLAN CREDENTIALING FOR VOLUNTEERS**

The Hospital Administrator or Chief of Staff, or their respective designees, may grant specialty-specific and time limited disaster Privileges to physicians and other licensed independent practitioners who volunteer their services during a disaster but who are not Members of the Medical Staff. Similarly, the Hospital Administrator or Chief of Staff may assign disaster responsibilities to other volunteers (e.g. volunteer nurses). The individuals covered by this section shall be collectively referred to as "Volunteers." Disaster plan credentialing and the assignment of disaster responsibilities to Volunteers shall only be available when (i) the Hospital's Disaster Plan is activated, and (ii) the Hospital is unable to meet the immediate patient care needs. The granting of such Privileges and/or responsibilities shall be in accordance with the Policy for Disaster Credentialing approved by the Medical Executive Committee and the Board of Directors, which shall comply with Joint Commission requirements, as they may be amended from time to time. The persons designated above who are authorized to grant disaster Privileges and/or responsibilities to Volunteers are not required to grant disaster Privileges or responsibilities to any person and will make such decisions on a case-by-case basis at his or her discretion. Any Privileges and/or responsibilities granted pursuant to this section shall exist only for the duration of the disaster as determined by the Hospital.

## Sutter Medical Center, Sacramento – Medical Staff Bylaws

### 6.13 PROCTORING

#### 6.13-1 When Proctoring May Be Imposed

Except as otherwise determined by the Medical Executive Committee and Board, all initial appointees to any category of the Medical Staff and all Members granted new Privileges shall be subject to a period of proctoring in accordance with the Rules. 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 as to make assessment of current competence difficult or unreliable). Finally, proctoring may be implemented whenever the Medical Executive Committee determines that additional information is needed to assess a Practitioner's performance. Proctoring is not viewed as a disciplinary measure, but rather is an information gathering measure. Therefore, it should be imposed only for such period (or number of cases) as is reasonably necessary to enable such assessment and its imposition does not give rise to the procedural rights described in Article VIII.

#### 6.13-2 Completion of Proctoring

Proctoring shall be deemed successfully completed when the Practitioner completes the required number of proctored cases/shifts within the time frame established in the Bylaws and the Rules and the Practitioner's professional performance in the cases is determined to have met the standard of care of the Hospital.

#### 6.13-3 Effect of Failure to Complete Proctoring

##### (a) Failure to Complete Necessary Volume

Any initial appointee or 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 Section 7.04-8 or Article VIII. However, the department has the discretion to extend the time for completion of proctoring in appropriate cases subject to ratification by the Medical Executive Committee.

##### (b) Failure to Satisfactorily Complete Proctoring

If a practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring, he or she may be terminated (or the relevant Privileges may be revoked) but he or she shall be afforded the procedural rights as provided in Article VIII, subject to the following:

- (1) If the practitioner is an initial appointee or a Member who has been granted new Privileges, his or her procedural rights shall be those of an applicant.
- (2) If the practitioner is a Member who has been subjected to proctoring due to reasons related to insufficient use or to investigate potential problems, his or her procedural rights shall be those of a Staff Member.

The failure to complete proctoring for any specific Privilege shall not, by itself, preclude advancement from Provisional Staff. If advancement is approved prior to completion of proctoring, the proctoring will continue for the specified Privileges. The specific Privileges may be voluntarily relinquished or terminated if proctoring is not completed thereafter within a reasonable time.

## Sutter Medical Center, Sacramento – Medical Staff Bylaws

### ARTICLE VII CORRECTIVE ACTION

#### 7.01 ROUTINE MONITORING AND EDUCATION

The departments and committees are responsible for carrying out delegated review and quality improvement functions. They may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent proctoring or monitoring in the course of carrying out their duties, without initiating formal corrective action. Comments, suggestions, and warnings may be issued orally or in writing. The Practitioner shall be given an opportunity to respond in writing and may be given an opportunity to meet with the department or committee. Any such informal actions shall be documented in the Member's file. Medical Executive Committee approval is not required for such actions, although the actions shall be reported to the Medical Executive Committee. The actions shall not constitute a restriction of Privileges, nor shall they be grounds for any hearing or appeal rights under Article VIII.

#### 7.02 ROUTINE CORRECTIVE ACTION

##### 7.02-1 Criteria for Initiation

(a) In addition to the specific requirements of Sections 3.03 (k) and 7.02-1 (b), any person may provide information to the Medical Staff about the conduct, performance, or competence of its Members. When reliable information indicates a Member may have exhibited acts, demeanor, or conduct either within or outside of the Hospital, that is reasonably likely to be:

- (1) detrimental to patient safety or to the delivery of quality patient care within the Hospital;
- (2) unethical;
- (3) contrary to the Medical Staff Bylaws or Rules;
- (4) below applicable professional standards;
- (5) disruptive of Medical Staff or Hospital operations,
- (6) an improper utilization of Hospital resources as determined by the Medical Staff, or
- (7) the Member has sustained a summary suspension or limitation of Privileges at another hospital, for medical disciplinary cause or reason.

A request for an investigation of or action against such Member should be brought to the attention of the Chief of Staff, any other officer of the Medical Staff, any department Chief, the Chair of any standing committee of the Medical Staff, the Administrator, or the Board, as appropriate.

(b) A recommendation for corrective action may also be initiated by any Medical Staff or department committee, with respect to activities, conduct, or performance within the scope of authority of that committee. Such recommendation shall be recorded in the minutes of that committee, and shall be reported to the Chief of Staff and the Medical Executive Committee through the committee's chair and/or the minutes.

##### 7.02-2 Requests for Investigation and Corrective Action

Whenever activities or conduct described in Section 7.02-1 are brought to the attention of any official named in that section, the Chief of Staff shall be notified. The Chief of Staff shall notify the Administrator, or his or her designee in his or her absence, and the Medical Executive Committee and shall continue to keep them fully informed of all action taken. In addition, the Chief of Staff shall immediately forward all necessary information to the investigating body, as described in Section 7.02-4; provided, however, that the Chief of Staff or Medical Executive Committee may dispense with further investigation of matters deemed to have been adequately investigated by a committee, pursuant to Section 7.02-1(b) or otherwise.

## Sutter Medical Center, Sacramento – Medical Staff Bylaws

### 7.02-3 Expedited Initial Review

- (a) Whenever information suggests that corrective action may be warranted, the Chief of Staff or his or her designee shall inform the department Chief, and may, on behalf of the Medical Executive Committee, immediately investigate and conduct whatever interviews may be indicated. The information developed during this initial review shall be presented to the Medical Executive Committee, which shall decide whether to initiate a corrective action investigation.
- (b) In cases of complaints of harassment or discrimination involving a Medical Staff Member, an expedited review shall be conducted by the Chief of Staff, or his or her designee, together with representatives of Administration. Such an initial review shall not be a Medical Staff proceeding. The information gathered from that review may be referred to the Medical Executive Committee if it is determined that corrective action may be indicated against a Medical Staff Member, and all further review would be conducted as Medical Staff proceedings.

### 7.02-4 Investigation

If the Medical Executive Committee concludes that an investigation is warranted, it shall direct an investigation to be undertaken. The investigation shall be conducted promptly by the Medical Executive Committee, the appropriate Medical Staff officer, department chief, the appropriate Peer Review Committee or by an ad hoc committee appointed by the Medical Executive Committee, the Chief of Staff, the department Chief, or the appropriate Peer Review Committee; and within 30 days after completion of the investigation, a written report of the investigation shall be forwarded, together with any recommendations, to the appointing body and the Chief of Staff. If additional time is needed to complete the investigation, an interim report shall be forwarded, which should include a specific request for additional time to complete the investigation. The Member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a “hearing” as that term is used in Article VIII, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary restriction or suspension, termination of the investigative process or other action.

### 7.02-5 Medical Executive Committee Action

Within 30 days following the Chief of Staff's receipt of the investigative report, the Medical Executive Committee shall consider the report, and, where appropriate shall take action, to include, without limitation:

- (a) Determining that no corrective action should be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, clearly documenting those findings in the Practitioner's file.
- (b) Deferring action for a reasonable time.
- (c) Providing for proctors and ongoing review in accordance with Section 6.09.
- (d) Issuing a warning, or a letter of admonition or reprimand (although nothing herein shall be deemed to preclude department or committee Chairs from issuing informal written or oral warnings outside of the mechanism for corrective action). In the event such letters are issued, the affected Practitioner may make a written response, which shall be placed in his or her file.
- (e) Recommending terms of probation or special limitation upon continued Medical Staff membership or exercise of Clinical Privileges, including without limitation, requirements for co-admission, mandatory consultation, or monitoring.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

- (f) Recommending reduction, suspension or revocation of Clinical Privileges. If suspension is recommended, the terms and duration of the suspension and the conditions that must be met before the suspension is ended shall be stated.
- (g) Recommending reduction of Staff category or limitation of any Staff prerogatives directly related to patient care.
- (h) Recommending suspension or revocation of Staff membership. If suspension is recommended, the duration and terms of suspension, as well as the conditions precedent to its termination, shall be stated.
- (i) Recommending other remedial actions as deemed necessary and appropriate under the circumstances.

Insofar as possible, considering the size and composition of the Medical Staff, the Medical Executive Committee members who have participated in investigating or formulating department or committee recommendations should not participate in the Medical Executive Committee's deliberations or vote on the matter; however, such members may be in attendance at the Medical Executive Committee meeting, may present the report and any related recommendations, and may answer questions posed by the Medical Executive Committee.

### **7.02-6 Subsequent Action**

- (a) If the Medical Executive Committee's recommended action is to recommend no corrective action, such recommendation, together with such supporting documentation as may be required by the Board of Directors shall be transmitted thereto.
- (b) If corrective action as set forth in Section -- is recommended by the Medical Executive Committee, that recommendation shall be transmitted to the Board of Directors. So long as the recommendation is supported by substantial evidence the recommendation of the Medical Executive Committee shall be adopted by the Board of Directors as final action unless the Member requests a hearing, in which case the final decision shall be determined as set forth in Article VIII.
- (c) If the Medical Executive Committee recommends an action that constitutes grounds for a hearing under Section --, the Chief of Staff shall give the Practitioner Special Notice of the adverse recommendation and of the right to request a hearing. The Board of Directors may be informed of the recommendation, but shall take no action until the Practitioner has either waived his or her right to a hearing or completed the hearing.

### **7.02-6 Procedural Rights**

Subject to the provisions of Section 7.03-3 (if applicable), any action by the Medical Executive Committee pursuant to Section 7.02-5(e), (f), (g), or (h), or any other action which must be reported to the Medical Board of California pursuant to Business and Professions Code Section 805, shall entitle the Practitioner to the procedural rights as provided in Article VIII, except that consultations imposed by rules or regulations or imposed by the Chief of Staff or department Chief on a case-by-case basis do not give rise to procedural rights.

### **7.02-7 Other Action**

If the Medical Executive Committee's recommended action is as provided in Section 7.02-5(a), (b), or (c), such recommendation, together with all supporting documentation shall be transmitted to the Board of Trustees. Thereafter, the procedure shall be as provided in the Rules, as applicable.

### **7.02-8 Board Initiation of Action**

- (a) In those instances in which the Medical Executive Committee's failure to investigate or initiate disciplinary action is contrary to the weight of the evidence, the Board shall, after consultation with the Medical Executive Committee, have the authority to direct the Medical Executive Committee to initiate an investigation or corrective action, including specific adverse action as deemed necessary by the Board.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

(b) If the Medical Executive Committee fails to take action in response to a direction from the Board, the Board shall have the authority to take action against such Practitioner. Such action shall only be taken after written notice to the Medical Executive Committee, and shall give rise to the procedural rights described in Article VIII.

### **7.03 SUMMARY SUSPENSION**

#### **7.03-1 Criteria and Initiation**

Whenever a Practitioner's conduct is such that a failure to take action may result in imminent danger to the health of any individual (whether identified or prospective) or result in a severe disruption of Medical Staff or Hospital operations of a type that might result in a danger to the health of an individual, the Medical Executive Committee hereby authorizes the Chief of Staff to summarily suspend or restrict the Medical Staff status or Clinical Privileges of such Practitioner. The head of the department or the chair of the section in which the Practitioner holds Privileges shall be authorized to summarily suspend or restrict the Medical Staff Privileges of such Practitioner, but should first consult with the Chief of Staff, if circumstances permit. The Board or Administrator may summarily suspend or restrict privileges of a Practitioner, under the same circumstances, when no person authorized by the Medical Staff is available, provided the Board or Administrator has made reasonable attempts to contact the persons so authorized. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible therefore shall promptly give written notice of the suspension to the Practitioner which fully complies with Section 7.03-2 below, as well as the Board, Medical Executive Committee and Administrator. The summary restriction or suspension may be limited in duration in order to permit an investigation to be conducted. Unless otherwise indicated by the terms of the summary restriction or suspension, the Practitioner's patients shall be promptly assigned to another practitioner by the department Chief or by the Chief of Staff, considering, where feasible, the wishes of the patient in the choice of a substitute Practitioner.

#### **7.03-2 Written Notice of Summary Suspension**

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

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **7.03-3 Medical Executive Committee Action**

In those cases where the Medical Executive Committee did not impose the initial summary action, a meeting of the Medical Executive Committee shall be convened as soon as possible, but no later than fourteen (14) days after such summary suspension, to review the action taken; provided, however, that if the suspension was effected by the Board or Administrator, the Medical Executive Committee must meet within two working days, excluding weekends and holidays. Failure of the Medical Executive Committee to ratify the suspension within this time frame shall result in automatic termination of the suspension and reinstatement of the Practitioner. Upon request, the Member may attend that meeting and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee shall impose, although in no event shall any meeting of the Medical Executive Committee, with or without the Member, constitute a hearing within the meaning of Article VIII, and none of the procedural rules shall apply. In those cases in which the Medical Executive Committee imposed the initial summary action, the Member may request a meeting with the Medical Executive Committee for the same purposes and on the same terms and conditions as described above. The Medical Executive Committee shall hold such meeting within one (1) week of receipt of the request. The Medical Executive Committee may recommend modification, continuation or termination of the summary suspension, as well as, without limitation, any action described in Section 7.02-5. Whenever suspension is sustained, the Medical Executive Committee shall delineate the duration and terms of the suspension, and the conditions of reinstatement or other permanent action. In addition, the Medical Executive Committee shall provide the Practitioner with a general statement of the basis of its determination that a failure to take action may result in an imminent danger to the health of any individual.

### **7.03-4 Procedural Rights**

Unless the Medical Executive Committee recommends immediate termination of the suspension or restriction and cessation of all further corrective action (or a suspension imposed by the Board is terminated through lack of Medical Executive Committee ratification within the time frame specified in Section 7.03-3), the Practitioner shall be entitled to the procedural rights as provided in Article VIII. The terms of the summary suspension as sustained or as modified by the Medical Executive Committee shall remain in effect pending satisfaction of any conditions of reinstatement or a final decision by the Board. There shall be no procedural rights associated with any suspension or restriction of fourteen days or less that is rescinded or not ratified by the Medical Executive Committee.

### **7.03-5 Initiation by Board of Directors**

If the Chief of Staff, the Medical Executive Committee and the Chair of the Department, (or Vice Chair if the Chair is unavailable), in which the Member holds Privileges are not available to summarily restrict or suspend the Member's membership or Clinical Privileges, the Board of Directors (or designee) may immediately suspend a Member's Privileges if a failure to suspend those Privileges is likely to result in an imminent danger to the health of any patient, prospective patient, or other person, provided that the Board of Directors (or designee) made reasonable attempts to contact the Chief of Staff, the Medical Executive Committee, and the Chair of the Department (or Vice Chair, if the Chair is unavailable) before the suspension.

Such a suspension is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two (2) working days, excluding weekends and holidays, the summary suspension shall terminate automatically. If the Medical Executive Committee does ratify the summary suspension, all other provisions under Section 7.03 of these Bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the Medical Executive Committee for purposes of compliance with notice and hearing requirements.

## **7.04 AUTOMATIC SUSPENSION AND TERMINATION**

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

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **7.04-1 License**

A Staff Member or Allied Health Professional whose California license to practice expires, or is revoked or suspended shall immediately and automatically be suspended from practicing in the Hospital. In addition, whenever restrictions have been placed on a Staff Member's or AHP's license, corresponding restrictions shall automatically be placed on the Member's or AHP's Privileges in the Hospital. In the case of restrictions of licensure, or at the time a Practitioner or AHP seeks reinstatement following suspension or revocation (and reinstatement) of a license, the department will consider the facts under which the license was revoked, suspended or restricted and shall forward its recommendation to the Medical Executive Committee which shall convene to review and consider the recommendation. The Medical Executive Committee may then take such further corrective action as is appropriate to the facts disclosed in the investigation.

Whenever a Member or AHP is placed on probation by the applicable licensing or certifying authority, membership status and Clinical Privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

### **7.04-2 Controlled Drug Number**

A Staff Member or Allied Health Professional whose permit to prescribe or administer narcotics and dangerous drugs is revoked or suspended shall immediately and automatically be divested of his or her right to prescribe medications covered by such permit. In addition, whenever restrictions have been placed on a Staff Member's or AHP's permit, corresponding restrictions shall automatically be placed on the Member's or AHP's prescribing privileges in the Hospital. The department administrative committee will consider the facts under which the permit was revoked, suspended, or restricted and shall forward its recommendation to the Medical Executive Committee, which shall convene to review and consider the recommendation. The Medical Executive Committee may then take such further corrective action as is appropriate to the facts disclosed in the review.

### **7.04-3 Medical Records**

After warning of delinquency, an automatic suspension from Staff membership shall be imposed for failure to complete medical records as specified in the Medical Staff Rules. Such suspension shall apply to the Staff Member's right to admit, treat or provide services to new patients in the Hospital, but shall not affect his or her right to continue to care for a patient already admitted by or being treated by the affected Staff Member. Following suspension, failure to complete medical records within the time frames provided in the Medical Staff Rules shall result in automatic termination of the Member's Staff membership in accordance with those Rules.

### **7.04-4 Liability Insurance**

Automatic suspensions from Staff membership shall be imposed for failure to maintain current and continuous professional liability insurance in accordance with the Rules. In addition, failure to maintain professional liability insurance for certain procedures shall result in automatic suspension of Clinical Privileges to perform those specific procedures. The suspension shall be effective until appropriate coverage is reinstated, including coverage of any acts or potential liabilities that may have occurred or arisen involving Hospital patients during the period of any lapse in coverage. If the Member does not provide evidence of required professional liability insurance within thirty (30) days after written warnings of the delinquency, the Member's membership will be automatically terminated.

### **7.04-5 Failure to Comply with Government and Other Third Party Payor Requirements**

The Medical Executive Committee shall be empowered to determine that certain specific rules and requirements of third party payors, government agencies, and professional review organizations are of a nature that compliance with such requirements by Medical Staff Members and Allied Health Professionals is essential to Hospital and/or Medical Staff operations and that compliance with such requirements can be objectively determined. Thereafter, upon general notice to the Medical Staff or specific notice to the affected Practitioner, a Practitioner may be automatically suspended for failure to comply with such requirements. The suspension shall be effective until he or she complies with such requirements.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### 7.04-6 Failure to Satisfy Special Appearance Requirement

A practitioner who fails without good cause to appear and satisfy the requirements of Section 13.07-2 (special appearances) shall automatically be suspended from exercising his or her Clinical Privileges, for a period of at least two weeks, or such longer period as the Medical Executive Committee shall determine. A suspension for two weeks shall, in all cases, be deemed administrative and not "medical disciplinary," regardless of the facts giving rise to the special appearance requirements; suspensions in excess of two weeks may or may not be "medical disciplinary," depending upon the facts and circumstances.

### 7.04-7 Failure to Report

Failure to report, as required in Section 3.04 (q) and (u), within five (5) days will result in an automatic suspension of Privileges.

### 7.04-8 Failure to Pay Dues/Assessments

Failure without good cause as determined by the Medical Executive Committee, to pay dues or assessments, as required under Section 3.02-2 (b), shall be grounds for automatic suspension of a Member's Clinical Privileges, and if within sixty (60) days after written warnings of the delinquency the Member does not pay the required dues or assessments, the Member's membership shall be automatically terminated.

### 7.04-9 Disruptive Conduct

In accordance with Medical Staff policy, a Practitioner may be automatically suspended for a cumulative total of up to fourteen (14) days in any twelve (12) month period for inappropriate, disruptive, or unprofessional conduct as determined by the Medical Executive Committee. This provision does not preclude the imposition of other lesser or greater corrective actions that may be necessitated by the circumstances.

### 7.04-10 Automatic termination

Except as provided in the Rules for automatic termination based upon delinquent medical records, if after six (6) months the Practitioner remains suspended, his or her membership shall be automatically terminated. In addition, membership or Privileges shall also be automatically terminated in the event a Practitioner fails to complete proctoring requirements, as further described at Section 6.09-3. Thereafter, reinstatement to the Medical Staff shall require application and compliance with Section 5.04.

### 7.04-11 Procedural Rights Associated with Automatic Actions

(a) Whenever the automatic suspension is required to be reported to the Medical Board of California, the Practitioner shall be entitled to a hearing pursuant to Article VIII.

(b) In all other cases (i.e., whenever a Medical Board of California report is not required), anyone whose membership has been automatically suspended or terminated shall be entitled at his or her request to meet with the Medical Executive Committee to review the action. The review must be requested within ten (10) days after notification of action; must be conducted within ninety (90) days of such notification; and shall be limited to whether or not the conditions described in these sections had in fact occurred. There shall be a right to only one MEC review of the reasons for suspension and termination; if there is a review conducted after a suspension, there shall be no right of additional review in the event a suspended practitioner is later terminated pursuant to Section 7.04-10. The formal hearing procedures described at Article VIII shall not apply, and the decision of the Medical Executive Committee shall then become and remain effective pending the final decision of the Board.

## Sutter Medical Center, Sacramento – Medical Staff Bylaws

### 7.05 PRIVILEGES OF PHYSICIANS WHO ARE UNDER CONTRACT TO THE HOSPITAL

#### 7.05-1 Medical Disciplinary Rights

Any Practitioner whose engagement by the Hospital requires membership on the Medical Staff shall not have his or her Medical Staff Privileges terminated for any "medical disciplinary" cause or reason without the same fair procedure provisions which are provided for other Medical Staff Members pursuant to these Bylaws.

#### 7.05-2 Effect of Contract

Privileges of Practitioners who are under contract to the Hospital shall depend on the nature of the contract. If the contract is an exclusive contract, and the affected Practitioner or Practitioners are no longer members of the contracting group, then those Privileges covered by the exclusive contract shall be automatically relinquished, subject to the provisions of Sections 6.06 and 7.05-3. Otherwise, their Privileges shall not be altered or suspended when their contract with the Hospital is terminated.

#### 7.05-3 Termination of Contracts

Termination of Hospital contracts shall be the sole province of the Hospital's administration; provided, however, that if the reason for a Practitioner's contract termination or his or her departure from the contracting group is based on a "medical disciplinary" cause or reason, as determined by the Medical Executive Committee, the Practitioner shall be entitled to the procedural rights specified in Article VIII.

### 7.06 SYSTEMWIDE CORRECTIVE ACTION

#### 7.06-1 Notice of Pending Investigations/Joint Investigations

- (a) The Chief of Staff has the discretion to notify his or her counterpart officers at other System Affiliates whenever a request for corrective action has been received.
- (b) In addition, the Medical Executive Committee may authorize a coordinated investigation and may appoint other System Affiliates' medical staff members to assist in the coordinated investigation.
- (c) The Chief of Staff is authorized to disclose to another System Affiliate's peer review body (or an authorized representative of that body) information from Hospital and Medical Staff records to assist in the other System Affiliate's independent or joint investigation of any practitioner.
- (d) The results of any joint investigation shall be reported to peer review body of each System Affiliate who participated in the joint investigation for its independent determination of what, if any, corrective action should be taken.

#### 7.06-2 Notice of Actions

- (a) In addition to the discretionary reporting and joint investigation provisions set forth at Section 7.06-1, the Chief of Staff (or the Administrator at the request of the Chief of Staff) is authorized to inform his or her counterpart officer at any other System Affiliate where the Practitioner is known to hold privileges whenever any of the following actions has been taken:
  - (1) Summary suspension of Clinical Privileges should be reported promptly upon imposition (other than automatic suspensions of less than 14 days for failure to complete medical records).
  - (2) Other corrective actions may be reported at any time the Chief of Staff determines such a report to be appropriate, and should be reported promptly upon final action by the Board of Directors.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

(b) The effect of such action on the involved Practitioner's Privileges at another System Affiliate shall be determined by the Medical Staff bylaws or other applicable policies of that other System Affiliate; or if there are no applicable bylaws or policies, the information shall be deemed transmitted for the receiving System Affiliate's independent review and action.

(c) The Chief of Staff and Administrator are authorized to disclose to another System Affiliate's peer review body (or an authorized representative of that body) information from the Hospital and Medical Staff records regarding such Practitioner or AHP.

### **7.06-3 Effect of Actions Taken by Other Entities**

Except as provided at Section 7.06-1, above, whenever the Chief of Staff or Medical Executive Committee receives information about an action taken at another System Affiliate and involving a Practitioner or AHP holding Privileges at the Hospital, the Chief of Staff or Medical Executive Committee shall, if time permits, independently assess the facts and circumstances to ascertain whether to take comparable action. However, when the Practitioner or AHP was summarily suspended or restricted at the other System Affiliate, the Chief of Staff, Vice Chief of Staff (or the Administrator if neither the Chief or Vice Chief is available) is authorized to immediately impose a comparable suspension or restriction at this Hospital, subject to review by the Medical Executive Committee in accordance with the provisions of Section 7.03.

### **7.07 CONFIDENTIALITY; IMPARTIALITY**

To maintain confidentiality, and to ensure the unbiased pursuit of all Medical Staff disciplinary actions, Staff Members participating in the corrective action process shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws for peer review and discipline. Members of the committees, and Staff Members shall avoid further discussing the case outside of the committees appointed to investigate or review Medical Staff disciplinary matters.

## **ARTICLE VIII INTERVIEWS, HEARINGS AND APPELLATE REVIEW - FAIR HEARING PLAN**

### **8.01 INTERVIEWS**

(a) Except as provided in Section 8.01(b), if a committee is going to make a negative recommendation to the Medical Executive Committee regarding a Practitioner, the committee Chair shall notify the Practitioner of the pending adverse recommendation as outlined in Section 8.04-1 (b) through (n) and of Section 8.01 of the Medical Staff Bylaws and shall afford the Practitioner an interview before the issue is forwarded to the Medical Executive Committee. At such interview he or she shall be informed of the specific nature of the investigation, and be asked to discuss, explain or refute the matters at issue. Such interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules set forth in Article VIII shall apply.

(b) The foregoing provision for Practitioner interview may be dispensed with if, in the sole discretion of the investigating body, notice to the Practitioner might reasonably be expected to jeopardize the investigation; however, if such interview is not conducted by the investigating body, the Practitioner must be afforded an interview by the Medical Executive Committee prior to finalizing its recommendation.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

(c) When the Medical Executive Committee receives or is considering initiating an adverse recommendation concerning a Practitioner, the Practitioner may be afforded an informal interview with the Medical Executive Committee at the discretion of the Medical Executive Committee; provided, however, that if the Practitioner was not afforded an interview by the investigating body (per Section 8.01(b)), then the Medical Executive Committee shall afford such an interview. The interview shall not constitute a hearing, shall be preliminary in nature, and need not be conducted according to the procedural rules applicable to hearings. At such interview, the Practitioner will be informed of the general nature of the circumstances and may present relevant information. A record of any such interview shall be made; however, such record need not be verbatim. Nothing in the foregoing shall limit the ability of any authorized individual or body to take summary action when warranted by the circumstances.

### **8.02 HEARINGS AND APPELLATE REVIEW**

#### **8.02-1 Review Philosophy**

The intent in adopting these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect applicants and Practitioners, 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 Board from carrying out peer review. Accordingly, discretion is granted to the Medical Staff and Board to create a hearing process, which provides for the least burdensome level of formality in the process, and yet still provides a fair review, and this Fair Hearing Plan shall be interpreted in this context. Further, technical, insignificant, or nonprejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken.

#### **8.02-2 Adverse Medical Executive Committee Recommendation**

When any Practitioner receives notice of an adverse recommendation of the Medical Executive Committee, he or she shall be entitled, upon request, to a hearing before an ad hoc hearing committee of the Medical Staff or arbitrator(s), as outlined at Section 8.05-4. If the recommendation following such hearing is still adverse to the Practitioner, he or she shall then be entitled, upon request, to an appellate review by a committee of the Board before a final decision is rendered by the Board.

#### **8.02-3 Exceptions**

Neither the issuance of a warning, a letter of admonition, a letter of reprimand, nor the denial, termination or reduction of temporary Privileges without medical-disciplinary cause, nor any other actions except those specified in this Fair Hearing Plan shall give rise to any right to a hearing or appellate review. Further, the fair hearing procedures described in these Bylaws are intended for the resolution of factual disputes, or to challenge whether or not the provisions of these Bylaws have been followed. The Fair Hearing Plan is not intended as a mechanism to challenge the substantive validity of the Medical Staff or Hospital Bylaws, Rules, regulations, or policies, and the Hearing Committee appointed pursuant to this Fair Hearing Plan shall not be empowered to hold quasi-legislative, notice-and-comment-type hearings, or to make quasi-legislative determinations, or determinations as to the substantive validity of bylaws, rules, regulations, or other intra-organizational legislation. Such challenges shall, instead, be made through the mechanism described at Article IX of these Bylaws.

#### **8.02-4 Adverse Board Decision**

When any Practitioner receives notice of an adverse decision by the Board taken either contrary to a favorable recommendation by the Medical Executive Committee or on the Board's own initiative, such Practitioner shall be entitled, upon request, to a hearing by a committee comprised of Medical Staff and Board members appointed by the Board, or by arbitrator(s), as outlined at Section 8.05-4(b). If such hearing results in an unfavorable recommendation, he or she shall then be entitled, upon request, to an appellate review by the Board or a committee of the Board before a final decision is rendered.

## Sutter Medical Center, Sacramento – Medical Staff Bylaws

### 8.03 EXHAUSTION OF REMEDIES

If adverse action is taken with respect to a Practitioner's Staff membership or Privileges, regardless of whether the Practitioner is an applicant or a Medical Staff Member, the Practitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action challenging the action or procedures used to arrive at the action or asserting any claim against any participants in the decision-making process.

### 8.04 HEARING AND APPEAL PROCEDURES

#### 8.04-1 Grounds for Hearing

In any case in which any Member of the Medical Staff, or applicant for such membership (both hereafter for purposes of Article VIII "Practitioner"), receives notice of a specific recommendation of the Medical Executive Committee to the Board of Directors outlined in this Section 8.04-1 which recommendation, if approved by the Board of Directors, would adversely affect Practitioner's exercise of Clinical Privileges "adverse recommendation"), or if a Practitioner is otherwise entitled by these Bylaws to a hearing and review under these Bylaws, the Practitioner shall be entitled to a hearing before a Judicial Review Committee, and if the Judicial Review Committee also makes an adverse recommendation, to an appellate review by the Board of Directors prior to its final decision on the matter.

Except as otherwise provided at Section 8.02-3, any one or more of the following recommendations or actions shall, if taken for medical disciplinary cause or reason, as defined in Business and Professions Code Section 805 or its successor statute, shall be deemed adverse and shall entitle the affected Practitioner to a hearing:

- (a) Denial of initial Staff appointment.
- (b) Denial of reappointment.
- (c) Suspension of Staff membership.
- (d) Revocation of Staff membership except as otherwise provided in Section 4.05.
- (e) Limitation of the right to admit patients.
- (f) Denial of requested Clinical Privileges.
- (g) Reduction in Clinical Privileges.
- (h) Suspension of Clinical Privileges.
- (i) Revocation of Clinical Privileges.
- (j) Requirement of consultation or other conditions of Clinical Privileges including mandatory consultation, assistants or special conditions of admission or treatment (excluding monitoring incidental to Provisional status and Section--)
- (k) Denial, reduction, suspension or termination of temporary, special or locum tenens Privileges, if undertaken for medical disciplinary cause or reason as defined in Business and Professions Code Section 805 or its successor statute;
- (l) Any other "medical disciplinary" action or recommendation that must be reported to the Medical Board of California.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### 8.04-2 When Deemed Adverse.

A recommendation or action listed in Section 8.04-1 shall be deemed adverse only when it has been:

- (a) Recommended by the Medical Executive Committee; or
- (b) Taken by the Board contrary to a favorable recommendation by the Medical Executive Committee; or
- (c) Taken by the Board on its own initiative without benefit of a prior recommendation by the Medical Executive Committee as described in the Rules.

### 8.04-3 Notice of Adverse Recommendation or Action

A Practitioner against whom adverse action has been taken shall promptly be given Special Notice of such action. Such Notice shall:

- (a) Contain a general statement of the reasons or subject matter forming the basis for the adverse recommendation or action, which is the subject of the hearing.
- (b) Advise the Practitioner of his or her right to request a hearing within thirty (30) days after receipt of the Special Notice as defined herein.
- (c) State that failure to request a hearing within the specified time period shall constitute a waiver of rights to a hearing and to an appellate review on the matter.
- (d) State that after receipt by the Hospital of his or her hearing request, the Practitioner will be notified of the date, time and place of the hearing, as well as a more specific Notice of Charges consisting of a concise statement of the Practitioner's alleged acts or omissions, a list by number of the specific or representative patient records in question and/or the other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing.
- (e) Contain a summary of the Practitioner's rights in the hearing.
- (f) Advise the Practitioner whether the action, if adopted, must be reported to the Medical Board of California or other appropriate professional licensing agency pursuant to Business and Professions Code Section 805.

### 8.04-4 Request for Hearing

A Practitioner shall have thirty (30) days following the date of receipt of Special Notice to file a written request for a hearing. Such request shall be addressed to the Medical Executive Committee with a copy to the Board of Directors and delivered to the Chief of Staff either in person or by certified or registered mail. The Practitioner shall state, in writing, his or her intentions with respect to attorney representation at the time he or she files the request for a hearing. Notwithstanding the foregoing and regardless of whether the Practitioner elects to have attorney representation at the hearing, the parties shall have the right to consult with legal counsel to prepare for a hearing or an appellate review.

### 8.04-5 Waiver by Failure to Request a Hearing

A practitioner who fails to request a hearing in the manner described above and within thirty (30) days from the date of receipt of the Special Notice, the Practitioner shall be deemed to have waived any right to such hearing and to any appellate review and to have accepted the recommendation or action involved.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **8.05 HEARING PREREQUISITES; NOTICE; EXCHANGE OF WITNESS LISTS; PRODUCTION OF DOCUMENTS; PREHEARING MOTIONS**

#### **8.05-1 Notice of Time and Place for Hearing; Notice of Charges**

(a) Upon receipt of a request for hearing, the Medical Executive Committee shall schedule a hearing and, within thirty (30) days but in no event less than ten (10) days prior to the hearing, give written notice to the Practitioner of the time, place and date of hearing, and the reasons for the proposed action or recommendation including the acts or omissions with which the Practitioner is charged and a list of the charts in question, where applicable. A supplemental Notice may be issued at any time, provided the Practitioner is given sufficient time to prepare to respond. The hearing date shall be not less than thirty (30) days, nor more than sixty (60) days from the date of receipt of the request by the Medical Executive Committee for a hearing; provided, however, that when a request is received from a Practitioner who is under a summary suspension, the hearing shall be held as soon as arrangements may reasonably be made, so long as the Practitioner has at least thirty (30) days from the date of notice of the hearing to prepare for the hearing or waives this right. The date of hearing may be delayed only upon agreement of the parties or upon written decision issued by the hearing officer pursuant to Section --.

#### **8.05-2 Witness Lists**

If known at the time of the notice of hearing, the Practitioner shall be given a list of witnesses (if any) who are expected to testify at the hearing. If either side to the hearing requests in writing a list of witnesses, within fifteen (15) days of receipt of a request, and in no event less than ten (10) days before commencement of the hearing, each party shall furnish to the other a written list of the names of anticipated witnesses. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. The failure to have provided the name of a witness at least ten (10) days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

#### **8.05-3 Amendments to Notice of Charges/Witness Lists**

The Medical Executive Committee may amend its notice of charges and/or its list of witnesses; provided, however, that such amendment shall be provided to the Practitioner as soon as reasonably possible under the circumstances; and provided, further, that the Practitioner shall be entitled to a continuance if any such amendment substantially changes the scope of the hearing or substantially affects the Practitioner's ability to adequately prepare for the hearing. The hearing officer shall determine whether any such continuance is necessary.

#### **8.05-4 Appointment of Hearing Committee**

When a hearing is requested, the Medical Executive Committee shall appoint a Hearing Committee which shall be composed of not less than three (3) Members of the Medical Staff who shall not have acted as accusers, investigators, fact finders or initial decision makers in connection with or active participants in the same matter, provided such persons shall gain no direct financial benefit from the outcome nor shall any be in direct economic competition with the Practitioner who has requested the hearing. Membership on the Hearing Committee shall consist of one Member who shall have the same healing arts licensure as the accused, and where feasible, include an individual practicing the same specialty as the Practitioner. Such appointment shall include designation of the chairman. Knowledge of the matter involved shall not preclude a Member of the Active Medical Staff from serving as a member of the Judicial Review Committee. In the event that it is not feasible to appoint a fully qualified Hearing Committee from the Medical Staff, the Medical Executive Committee may appoint qualified physicians who are not Members of the Medical Staff or the hearing may be conducted before an arbitrator or arbitrators (who need not be health professionals) selected by a process mutually acceptable to the Medical Executive Committee and the practitioner. The Medical Executive Committee shall appoint alternates who meet the standards described above and who can serve if a Hearing Committee member becomes unavailable. An alternate may attend all sessions of the hearing, and may attend and, in the discretion of the hearing officer, participate in deliberations. An alternate shall not vote unless a Hearing Committee member is absent from or otherwise unable to vote due to failure to meet the attendance requirements of Section 8.06-10.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **8.05-5 Voir Dire**

The affected Practitioner shall be notified in writing of his or her right to pose relevant questions to the Hearing Committee and the presiding officer, and to challenge the impartiality of those individuals based upon bias or conflict of interest. Any such challenge must be reasonably supported by facts.

### **8.05-6 Authority**

The Hearing Committee (or arbitrator) shall have such powers and authority as reasonably necessary to discharge its (his or her) responsibilities.

### **8.05-7 Discovery Rights**

- (a) The Practitioner shall have the right to inspect and copy, at his or her expense, any documentary information relevant to the charges which the Medical Executive Committee has in its possession or under its control, as soon as practicable after delivery of his or her request for a hearing.
- (b) The Medical Executive Committee shall have the right to inspect and copy, at its expense, any documentary information relevant to the charges which the Practitioner has in his or her possession or control, as soon as practicable after receipt of the Medical Executive Committee's request therefore.
- (c) The failure by either party to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for a continuance. Repeated failure to comply shall be good cause for the hearing officer to limit the introduction of any documents not provided to the other side in a timely manner.
- (d) The right to inspect and copy by either party does not extend to confidential information referring to individually identifiable Practitioners, other than the Practitioner under review; nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information.

### **8.05-8 Documents to be Introduced at Hearing**

At the request of either side, the parties shall exchange copies of all documents expected to be introduced at the hearing. Failure to produce such copies at least ten days before the commencement of the hearing shall constitute good cause for a continuance.

### **8.05-9 Prehearing Motions and Procedural Disputes**

- (a) The parties shall be entitled to file prehearing motions as deemed necessary to give full effect to rights established by these Bylaws, and to resolve such procedural matters as the hearing officer determines may properly be resolved outside the presence of the full Hearing Committee. It shall be the duty of the Practitioner and the Medical Executive Committee (or its representative) to exercise reasonable diligence in notifying the hearing officer of any pending or anticipated motion or procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Such motions or procedural disputes shall be raised in writing and shall specifically state the request, all relevant factual information, and any supporting authority for the motion. The requesting party shall deliver a copy to the opposing party, who shall have five (5) working days to submit a written response to the hearing officer, with a copy to the moving or complaining party.
- (b) The hearing officer shall determine whether to allow oral argument on any such motion or procedural dispute. The hearing officer's ruling shall be in writing and shall be provided to the parties promptly upon its rendering. All requests, and rulings thereon, shall be entered into the hearing record by the hearing officer. Objections to any prehearing decisions may be succinctly made at the hearing.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### 8.05-10 Timely Completion of Process

The hearing and appeal process shall be completed within a reasonable time. Unless there is good cause, the hearing process should commence within thirty (30) days from the date the Medical Executive Committee received the request for a hearing and should be completed within one (1) year from such date. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as deemed warranted by the circumstances.

### 8.05-11 Continuance or Postponement of the Hearing

The hearing officer shall use his or her best efforts and discretion to assure that the hearing is commenced as scheduled. Subject to the foregoing, continuances or postponements may be affected by agreement of the parties or by action of the hearing officer. Requests for continuance or postponement of a hearing shall be addressed to the hearing officer as soon as the need therefore is reasonably known to the party, and shall be supported with a written statement demonstrating good cause for the continuance or postponement. Such a request may be granted by the hearing officer upon a showing of good cause. The hearing officer should also consider the potential prejudice that may be caused to the party not requesting the postponement or extension. A ruling on the request shall be in writing, stating the basis for the granting or denial of the requested postponement or continuance.

## 8.06 HEARING PROCEDURE

### 8.06-1 Personal Presence

The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails, without good cause, to appear and proceed at such hearing shall be deemed to have waived his or her rights to a hearing and shall constitute voluntary acceptance of the recommendations or actions involved.

### 8.06-2 Presiding Officer

The hearing officer who shall be an attorney appointed in accordance with Section 8.11-1 shall be the presiding officer. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence in an efficient and expeditious manner. If the presiding officer determines that either party is not proceeding in an efficient and expeditious manner, the presiding officer may take such discretionary action as seems warranted by the circumstances. He or she shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence, including but not limited to:

- (a) Rulings on challenges to the impartiality of any of the Hearing Committee members. Challenges to the impartiality of the presiding officer himself or herself shall be ruled upon by the person appointing the committee.
- (b) Rulings on requests for access to information pursuant to Section 8.05-5. The hearing officer, upon the request of either side, may deny a discovery request when justified to protect peer review or justice.
- (c) In making such rulings, the presiding officer may impose any safeguards the protection of the peer review process and justice requires. Moreover, in making such rulings and determining the relevancy of the requested information, the presiding officer shall, among other factors, consider the following:
  - (1) Whether the information sought may be introduced to support or defend the charges;
  - (2) The exculpatory or inculpatory nature of the information sought, if any;
  - (3) The burden imposed on the party in possession of the information sought, if access is granted; and
  - (4) Any previous requests for access to information submitted or resisted by the parties to the same proceeding.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **8.06-3 Representation**

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on conduct, professional competency or character. Accordingly, the Practitioner requesting the hearing has a right to representation by an attorney in any phase of the hearing. In the absence of legal counsel, the Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a Member of the Medical Staff in good standing or by a member of his or her local professional society who is also not an attorney at law. The Medical Executive Committee or the Board, depending on whose recommendation or action prompted the hearing, shall appoint an individual who is not an attorney to represent it at the hearing, to present the facts in support of its adverse recommendation or action, and to examine witnesses.

### **8.06-4 Rights of Parties**

During a hearing, each of the parties shall have the right (if exercised in an efficient and expeditious manner) to:

- (a) Pose relevant questions to the hearing panel and the presiding officer, and to challenge the impartiality of any Member or the presiding officer, in accordance with Sections 8.05-4(e) and 8.06-2.
- (b) Call and examine witnesses.
- (c) Introduce relevant evidence.
- (d) Cross-examine any witness on any matter relevant to the issues.
- (e) Impeach any witness.
- (f) Rebut any relevant evidence.
- (g) To be provided with all of the evidence provided to the Hearing Committee.
- (h) To have a record made of the hearing in accordance with Section 8.06-8.
- (i) To submit memoranda concerning any issue of law or fact, including proposed findings of fact and conclusions of law, prior to, at, or within ten (10) days after the close of the hearing. Such memoranda shall become a part of the hearing record.

The Practitioner may be called and examined as if under cross-examination. These rights shall be exercised in an efficient and expeditious manner and within reasonable limitations imposed by the presiding officer.

### **8.06-5 Evidence**

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Subject to the provisions of Section 8.06-6, any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall, prior to, during or within ten (10) days after the close of the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become a part of the hearing record. The presiding officer may order that oral evidence be taken only on oath or affirmation.

### **8.06-6 Official Notice**

In reaching a decision, the Hearing Committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the State of California. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be noted in the hearing record. Any party shall be given the opportunity, on timely request, to request that a matter be officially noticed and to refute the officially noticed matters by evidence or by written or oral presentation of authority (the manner of such refutation to be determined by the hearing officer).

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **8.06-7 Burden of Producing Evidence; Burden of Proof**

(a) When a hearing relates to an adverse action or recommendation as set forth in Section 8.04-1, the body making the adverse action or recommendation shall have the initial obligation to present evidence in support of that action or recommendation. The Practitioner shall then be obligated to present evidence in response; however, Practitioners shall not be permitted to introduce information not produced upon request of the peer review body during the application process, unless the Practitioner establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(b) Thereafter:

(1) Initial applicants (including Staff Members requesting new Privileges) shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, of their qualifications by producing information, which allows for adequate evaluation and resolution of reasonable doubts concerning their current qualifications for Staff Privileges or membership.

(2) Except as provided above for initial applicants, the Medical Executive Committee shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that the action or recommendation is reasonable and warranted.

### **8.06-8 Record of Hearing**

To facilitate Board and possible judicial review, a record of the hearing (including such pre-hearing proceedings as deemed appropriate by the hearing officer) shall be made by a court reporter. The cost of the court reporter shall be borne by the Hospital and the cost of the transcript shall be borne by the requesting party.

### **8.06-9 Continuances; Completion of the Hearing**

The hearing officer shall use his or her best efforts and discretion to assure that the hearing is completed in an expeditious manner. Subject to the foregoing, continuances may be affected by agreement of the parties or by action of the hearing officer. Requests for continuance shall be processed as described in Section 8.05-8. The hearing shall be completed within a reasonable time under the circumstances unless the hearing officer issues a written decision finding that the Practitioner failed to comply with requests to produce documentary evidence, pursuant to Section 8.05-5, in a timely manner, or consented to the delay.

### **8.06-10 Presence of Hearing Committee Members and Vote**

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

### **8.06-11 Recesses and Adjournment**

The Hearing Committee may recess and reconvene the hearing, without additional notice, for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing record shall be closed. The Hearing Committee shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of its deliberations, the hearing shall be declared finally adjourned.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **8.07 HEARING COMMITTEE REPORT AND FURTHER ACTION**

#### **8.07-1 Hearing Committee Report**

Within thirty (30) days (ten (10) working days if a summary suspension is involved) after final adjournment of the hearing, the Hearing Committee shall render its decision in writing. The decision of the Hearing Committee shall be based on the evidence and written statements introduced at the hearing, including all logical and reasonable inferences from the evidence and testimony. The decision shall include the Hearing Committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached.

#### **8.07-2 Report**

The Hearing Committee report shall be sent to the parties to the hearing together with the notice of a right to appeal and a written explanation of the procedure for appealing the decision.

#### **8.07-3 Request for Appeal**

Either party may request appeal of the findings and recommendations of the Hearing Committee, as provided at Section 8.08-2, below.

#### **8.07-4 No Appeal**

If an appellate review is not requested within ten (10) days of receipt of the Hearing Committee's Report, the decision of the Hearing Committee shall be forwarded to the Board for final action. The Board shall give great weight to the decision of the Hearing Committee.

#### **8.07-5 Appeals**

Appeals shall be processed as described in Section 8.08.

### **8.08 INITIATION AND PREREQUISITES OF APPELLATE REVIEW**

#### **8.08-1 Request for Appellate Review**

The parties shall have ten (10) days following receipt of the Hearing Committee's Report as provided for in Section 8.07-2 to file a written request for an appellate review. Such request shall state the grounds for the appeal (see Section 8.08-2) and shall be delivered to the Administrator either in person or by certified or registered mail. The Practitioner may also request a copy of the report and record of the Hearing Committee and all other material, favorable or unfavorable, if not previously forwarded, that was considered by the Hearing Committee or by a subsequently reviewing body in making the adverse recommendation.

#### **8.08-2 Grounds for Appeal**

An appeal shall be based upon one or more of the following grounds:

- (a) The recommendation of the Hearing Committee is arbitrary, capricious or not supported by substantial evidence.
- (b) The substantial failure to follow the procedures outlined in the Medical Staff Bylaws.

The request for appeal shall state the specific manner in which the decision is arbitrary, capricious, or lacking in substantial basis, or in which the applicable procedures were not followed.

#### **8.08-3 Waiver by Failure to Request Appellate Review**

A party who fails to request an appellate review within the time and in the manner specified above waives any right to such review. Such waiver shall have the same force and effect as provided above for failure to request a hearing.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### 8.08-4 Notice of Time and Place for Appellate Review

Upon receipt of a timely request for appellate review, the Administrator shall deliver the request to the Board. As soon as practicable, the Board shall schedule an appellate review which shall be held not less than thirty (30) days nor more than sixty (60) days from the date of receipt of the request; however, an appellate review for a Practitioner who is under a suspension then in effect shall be held as soon as the arrangements may reasonably be made, but not later than thirty (30) days from the date of receipt of the request. At least fifteen (15) days prior to the appellate review, the Administrator shall send the Practitioner Special Notice of the time, place and date of the review. The time for the appellate review may be extended by the presiding officer for good cause and if the request for extension is made as soon as is reasonably practical; provided that the appellate review shall be held as promptly thereafter as possible under the circumstances.

### 8.08-5 Appellate Review Body

The Board shall determine whether an appeal shall be conducted by:

- (a) The Board as a whole, with or without the assistance of an appellate hearing officer; or
- (b) An appellate hearing officer only.

Whenever members of the Board have had prior involvement, such as initiating, investigating, or reporting on matters at issue in the appeal, such members shall be excluded from serving on the appellate review body, or an appellate hearing officer should be appointed. If an appellate hearing officer is appointed to hear the appeal by himself or herself, references throughout Sections 8.08 and 8.09 to an "Appellate Review Body" shall be deemed to mean "appellate hearing officer."

### 8.08-6 Presiding Officer

The chair of the Appellate Review Body or a hearing officer shall be the presiding officer. In the discretion of the chair of the Appellate Review Body, a hearing officer may also be engaged to assist the Appellate Review Body by serving (in lieu of the chair) as the presiding officer of the appellate review. The presiding officer shall determine the order of procedure during the review, make all required rulings, and maintain decorum, and shall endeavor to assure that the appeal is conducted in an efficient and expeditious manner. If the presiding officer determines that either party is not proceeding in an efficient and expeditious manner, the presiding officer may take such discretionary action as seems warranted by the circumstances.

## 8.09 APPELLATE REVIEW PROCEDURE

### 8.09-1 Nature of Proceedings

The proceedings by the review body shall be in the nature of an appellate review based upon the record of the Hearing Committee, that committee's report, the written statements, if any, submitted as provided below, and such other material as may be presented and accepted within the terms of this Plan.

### 8.09-2 Written Statements

The party seeking the review may submit a written statement detailing the findings, conclusions and procedural matters with which he or she or it disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the Appellate Review Body and the opposing party through the Administrator at least ten days prior to the scheduled date of the appellate review, or later if this time limit is waived by the presiding officer of the Appellate Review Body. A written statement in reply may be submitted by the opposing party and if submitted, the Administrator shall provide a copy to the appealing party at least three days prior to the appellate review.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **8.09-3 Appearance**

The parties or their representatives shall have the right to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be expected to answer questions put to him by any member of the Appellate Review Body.

### **8.09-4 Consideration of New or Additional Matters**

Except for new material provided pursuant to Section 8.08-1, new or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review level only in the discretion of the Appellate Review Body, following a foundational showing that such evidence could not have been made available in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the hearing.

Alternatively, the Appellate Review Body may remand the matter to the Hearing Committee for the taking of further evidence and a reconsidered decision in light of such further evidence.

### **8.09-5 Powers**

The Appellate Review Body and presiding officer shall have all powers granted to the Hearing Committee and hearing officer, and such additional powers as are reasonably appropriate to the discharge of their responsibilities.

### **8.09-6 Recesses and Adjournment**

The Appellate Review Body may recess and reconvene the review proceedings, without additional notice, for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements and submission of any written statements within the time frame established by the presiding officer, the appellate review record shall be closed. The Appellate Review Body shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned.

### **8.09-7 Burden of Proof, Action by the Appellate Review Body**

The Appellate Review Body shall sustain the decision of the Hearing Committee unless it finds that the decision is not supported by substantial evidence, that it is arbitrary, unreasonable, or capricious; or that there has been a substantial failure to follow the procedures outlined in the Bylaws. If the decision is not sustained, the Appellate Review Body may recommend that the Board modify or reverse the recommendation of the Hearing Committee or, in its discretion, the Appellate Review Body may refer the matter back to a Hearing Committee for further review and recommendation to be returned to it within thirty (30) days (fifteen (15) days if summary suspension is involved) and in accordance with its instructions. Within ten (10) days (five (5) days if summary suspension is involved) after receipt of a recommendation after referral, the Appellate Review Body shall make its recommendation to the Board. The Appellate Review Body's recommendation shall be in writing, shall include findings of fact and a conclusion articulating the connection between the evidence produced during the hearing and appeal process and the decision reached, and shall be provided to the Board and the parties.

### **8.09-8 Conclusion**

The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Plan have been completed or waived.

## **8.10 FINAL DECISION OF THE BOARD**

Within thirty (30) days (fifteen (15) days if summary suspension is involved) after the conclusion of the appellate review, the Board shall render its final decision in writing. The decision shall include the Board's findings of fact and a conclusion articulating the connection between the evidence produced during the hearing and appeal process and the decision ultimately reached. The Administrator shall send notice of the decision of the Board to the Practitioner (by Special Notice), to the Chief of Staff, and to the Medical Executive Committee. This decision shall be immediately effective and final.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **8.11 GENERAL PROVISIONS**

#### **8.11-1 Hearing Officer Appointment and Duties**

The use of a hearing officer to preside at a hearing is mandatory. The appointment of such officer shall be by the Chief of Staff after consultation with the Administrator. A hearing officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, but an attorney regularly utilized by the Hospital for legal advice regarding its affairs and activities shall not be eligible to serve as hearing officer. (The foregoing shall not be construed to prevent using the same hearing officer from hearing to hearing so long as that individual does not regularly render other legal service to the Hospital.) The hearing officer shall act in an impartial manner as the presiding officer of the hearing. The hearing officer shall gain no direct financial benefit from the outcome of the hearing, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote.

#### **8.11-2 Waiver**

If at any time after receipt of Special Notice of an adverse recommendation or action, a Practitioner fails to make a required appearance or otherwise fails to proceed or to comply with this Fair Hearing Plan, he or she shall be deemed to have consented to such adverse recommendation or action and to have voluntarily waived all rights to which he or she might otherwise have been entitled under the Medical Staff Bylaws or under this Fair Hearing Plan.

#### **8.11-3 Number of Reviews**

No Practitioner shall be entitled as a right to more than one (1) evidentiary hearing and appellate review with respect to an adverse recommendation or action.

#### **8.11-4 Confidentiality; Impartiality**

To maintain confidentiality, and to ensure the unbiased performance of peer review, disciplinary, and credentialing functions, Medical Staff Members participating in any stages of the fair hearing process shall limit their discussion of the matters involved to the formal avenues provided in the Medical Staff Bylaws and this Fair Hearing Plan.

#### **8.11-5 Release**

By requesting a hearing or appellate review under this Fair Hearing Plan, a Practitioner agrees to be bound by the provisions in the Medical Staff Bylaws relating to immunity from liability.

### **8.12 BOARD COMMITTEES**

In the event the Board should delegate some or all of its responsibilities described in this Article to one of its committees, the Board shall nonetheless retain ultimate authority to accept, reject, modify or return for further action or hearing, the recommendations of its committee.

### **8.13 PEER REVIEW BODIES**

The Medical Staff, the Board, and their officers, committees, and agents hereby constitute themselves as peer review bodies under the federal Health Care Quality Improvement Act of 1986 and the California Business and Professions Code, and claim all privileges and immunities afforded by the federal and state laws.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **8.14 JOINT HEARINGS AND APPEALS**

#### **8.14-1 Joint Hearings**

(a) Whenever a Practitioner is entitled to a hearing because a coordinated, cooperative, or joint corrective action has been taken or recommended, a single joint hearing may be conducted in accordance with hearing procedures that have been jointly adopted by the Medical Executive Committees (or their equivalent bodies) of the involved entities, provided such procedures are substantially comparable to those set forth in Article VIII of these Medical Staff Bylaws, and further provided that at least one (1) member of the Hearing Committee should be a Member of this Hospital's Medical Staff.

(b) In the event there is such a joint hearing, the recommendation of the Hearing Committee shall be reported to this Hospital's Board for final action.

#### **8.14-2 Joint Appeals**

The procedures may also call for joint appeal rights, provided such procedures are substantially comparable in all material respects to those set forth in Article VIII of these Medical Staff Bylaws, and further provided that at least one member of the appeal body should be a representative of this Hospital's Board.

#### **8.14-3 Effect of Joint Hearings/Appeals**

A joint hearing and/or appeal in accordance with the foregoing shall be deemed to satisfy procedural rights afforded to the Practitioner pursuant to Business and Professional Code Section 809, *et seq.*

#### **8.14-4 Provision for Separate Hearing**

Notwithstanding the foregoing, if a Practitioner can demonstrate to the Medical Executive Committee (in the case of a hearing based on a recommendation of the Medical Executive Committee), or the Board (in the case of a hearing based on a recommendation of the Board, or in the case of an appeal), prior to the initiation of a joint hearing and/or appeal, that the benefits of quasi-judicial economy and efficiency are outweighed by particular burdens or unfairness unique to the individual Practitioner's circumstances, the Medical Executive Committee or Board may, in its sole discretion, order that a separate hearing and/or appeal be conducted solely with respect to Privileges at this Hospital, in accordance with this Hospital's Fair Hearing and Appeal Plan. (Examples of such unique burdens or unfairness would include unavailability of witnesses or documents to the joint proceeding; but the mere fact that the outcome would affect privileges at more than one (1) facility would not ordinarily be deemed sufficient to preclude a joint hearing.)

## **ARTICLE IX**

### **REVIEW OF BYLAWS, RULES AND REGULATIONS, AND MEDICAL STAFF POLICIES**

#### **9.01 REQUEST FOR REVIEW**

Any Medical Staff Member, or applicant against whom an adverse action has been taken (as described in Sections 8.04-1 and 8.04-2) may request review leading to amendment or repeal of the underlying bylaw, rule or regulation, or Medical Staff policy on the basis that it is believed to be substantively irrational. Such review shall be initiated by the submission of a written request, together with the substantiating rationale for such request. A Practitioner shall have thirty (30) days following the date of receipt of Special Notice of such adverse action to file a written request for review of such bylaw, rule, regulation or policy. Such request shall be delivered to the Chief of the Medical Staff either in person or by certified or registered mail and shall include the substantiating rationale for such request.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **9.02 BYLAWS COMMITTEE OR DEPARTMENT REVIEW**

(a) The Medical Staff Bylaws Committee or the appropriate department shall consider such request within thirty (30) days. The Bylaws Committee or department shall either:

- (1) recommend amendment of the Bylaws, Rules, or Medical Staff policy;
- (2) request further information from the Practitioner and/or appropriate Medical Staff or department committees or representatives (which information should be provided within thirty (30) days), following receipt of which it shall recommend amendment or denial of the request for amendment; or
- (3) recommend denial of the request.

(b) The recommendations of the Bylaws Committee or department shall be forwarded to the Medical Executive Committee for recommendation.

### **9.03 MEDICAL EXECUTIVE COMMITTEE ACTION**

(a) If the Medical Executive Committee recommendation is to amend the Bylaws, Rules or Medical Staff policy substantially as requested, the amendment shall be processed as set forth in Article XVI of these Bylaws.

(b) If the Medical Executive Committee recommendation is to not amend the Bylaws or Rules substantially as requested, and subject to Section 9.04 below, the affected Practitioner shall be informed of such decision. Thereafter, the Practitioner may, within ten (10) days, request that the Medical Executive Committee convene an appropriate notice and comment forum for consideration of the involved provision. Such forum shall occur within forty-five (45) days of the request therefore, and shall enable all interested Medical Staff Members, adversely affected applicants, and Medical Staff or department committees or representatives, and Hospital administration an opportunity to present information relating to the involved provision.

(c) Thereafter, the Medical Executive Committee shall make its final recommendation upon the matter, considering all information presented in conjunction with the above review.

### **9.04 LIMITATION ON FREQUENCY OF REVIEW**

Notwithstanding the above, neither the Bylaws Committee, the department nor the Medical Executive Committee shall be compelled to reconsider any request for amendment as to any provision that has been reviewed (or that is then under review) pursuant to the above provisions, within the immediately preceding two-year period.

### **9.05 TIMEFRAMES**

Requests pursuant to this Article shall be processed as expeditiously as reasonably possible, and, except for good cause, each action or recommendation described above should occur, respectively, at the next regularly scheduled meeting of each involved committee.

## Sutter Medical Center, Sacramento – Medical Staff Bylaws

### ARTICLE X MEDICAL STAFF OFFICERS

#### 10.01 MEDICAL STAFF OFFICERS - GENERAL PROVISIONS

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

##### 10.01-1 Identification

- (a) There shall be the following officers of the Medical Staff:
  - (1) Chief of Staff
  - (2) Vice Chief of Staff
  - (3) Secretary – Treasurer
- (b) In addition, the Medical Staff's department and section officers, and committee chairs shall be deemed Medical Staff officers within the meaning of California law.

##### 10.01-2 Qualifications

All Medical Staff officers shall have:

- (a) An understanding of the purposes and the functions of the Medical Staff organization and a demonstrated willingness to assure that patient welfare always take precedence over other concerns.
- (b) An understanding of and willingness to work toward the attainment of the Hospital's policies and requirements that is lawful and reasonable.
- (c) Administrative ability as applicable to the respective office.
- (d) An ability to work with and motivate others to achieve the objectives of the Medical Staff organization.
- (e) Demonstrated clinical competence in his or her field of practice.
- (f) Active Staff status (and must remain in good standing as Active Staff Members while in office).
- (g) Have had no disciplinary action against them by the Medical Executive Committee in the past 12 months as listed under Section 8.04-1.

##### 10.01-3 Disclosure of Conflict of Interest

All nominees for election or appointment to Medical Staff offices (including those nominated by petition of the Medical Staff, pursuant to Section 10.01-4) shall, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. The Medical Executive Committee shall evaluate the significance of such disclosures and discuss any significant conflicts with the nominee. If a nominee with a significant conflict remains on the ballot, the nature of his or her conflict shall be disclosed, in writing, and circulated with the ballot.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### 10.01-4 Method of Selection

- (a) The Vice Chief of Staff shall accede to the position of Chief of Staff upon completion of the Chief's term.
- (b) An ad hoc nominating committee comprised of the Chief of Staff, two Medical Staff Members elected by the Medical Executive Committee and two Medical Staff Members elected biennially shall develop a slate of candidates meeting the qualifications of office, as described in Section 10.01-2 above. At least one (1) candidate shall be nominated for each of the following positions:
  - (1) Vice Chief of Staff
  - (2) Secretary-Treasurer
  - (3) Member-at-large representative on the Medical Executive Committee
- (c) The Medical Staff may nominate candidates for office by a petition signed by at least ten (10) Members of the Active Staff and a statement from the candidate signifying willingness to run.
- (d) The outcome shall be determined by a majority of the votes cast by mail ballot, which must be returned within fifteen (15) days of its mailing to the Medical Staff Services Department.
- (e) The Board of Directors will be informed of the election outcomes.
- (f) Officers shall be elected in the fall of odd-numbered years, and shall take office the following January.

### 10.01-5 Term of Office

The term of office shall be two (2) years. No officer shall serve consecutive terms in the same position.

### 10.01-6 Recall of Officers

A general Medical Staff officer may be recalled from office for any valid cause, including, but not limited to, malfeasance in office or failure to carry out the duties of his or her office. Recall of a general Medical Staff officer must be initiated by the Medical Executive Committee or by a majority vote of the Medical Staff Members eligible to vote for officers, but recall shall require a two-thirds vote of the Medical Executive Committee or two-thirds vote of the Medical Staff Members eligible to vote for general Medical Staff officers.

### 10.01-7 Filling Vacancies

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

- (a) A vacancy in the office of Chief of Staff shall be filled by the Vice Chief.
- (b) A vacancy in the office of Vice Chief shall be filled by special election held in accordance with Section 10.01-4.
- (c) A vacancy in the office of Secretary-Treasurer shall be filled by appointment by the Medical Executive Committee.

## 10.02 THE ROLE OF THE CHIEF OF STAFF

The Chief of Staff is the individual in charge of the Medical Staff organization, and, with assistance of the Medical Executive Committee, is responsible for the effective discharge of the functions of the Medical Staff as set forth in these Bylaws and the Rules. The Chief shall receive such administrative support as necessary to the effective performance of his or her responsibilities.

## Sutter Medical Center, Sacramento – Medical Staff Bylaws

### 10.02- 1 Duties

The Chief of Staff shall:

- (a) Exercise such authority as he or she deems necessary so that at all times patient welfare takes precedence over all other concerns.
- (b) In the interim between Medical Executive Committee meetings, perform those responsibilities of the Committee that, in his or her opinion, must be accomplished prior to the next regular or special meeting of the Committee.
- (c) Appoint Practitioners to such committees as he or she deems necessary to perform the functions of the Medical Staff organization.
- (d) Report regularly through the Administrator to the Board on the performance of all Medical Staff functions (as further described in Section 10.02-3), and communicate to the Medical Staff any concerns expressed by the Board with respect to the quality of medical care.
- (e) Be chair of the Medical Executive Committee, be a member of the Joint Conference Committee, and an *ex officio* member of all Medical Staff committees.
- (f) Oversee and monitor the organization and conduct of the Medical Staff.
- (g) Enforcing the Medical Staff Bylaws and Rules and Regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated.

### 10.02-2 Authority

The Chief of Staff will have the authority:

- (a) To summarily suspend Medical Staff Members.
- (b) To initiate appropriate corrective or disciplinary actions.
- (c) To require consultations whenever, in his or her discretion, he or she deems it necessary.
- (d) To appoint the chairs and members of standing and special committees of the Medical Staff with the approval of the Medical Executive Committee and in accordance with committee composition requirements as may be set out in the Rules.
- (e) To require that other Medical Staff officers, department Chiefs, Section heads and committee chairs assist him or her in performance of his or her responsibilities as Chief.
- (f) To require all Medical Staff Members to comply with the Hospital and the Medical Staff Bylaws, Rules, policies and procedures, or face disciplinary action.
- (g) To call special meetings of the Medical Executive Committee, any Staff committee, any department or section (or committee thereof), or the Medical Staff.
- (h) To contact Hospital or Medical Staff legal counsel for assistance or guidance.
- (i) To act on behalf of the Medical Executive Committee whenever he or she determines that action is called for prior to the next regular or special meeting of the Medical Executive Committee.
- (j) To take whatever action is reasonably necessary to the effective performance of his or her duties.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### 10.02-3 Accountability and Relationships

(a) The Chief of Staff shall be accountable to the Medical Staff and to the Board of Directors. Accountability shall entail at least the following:

(1) The Chief of Staff shall regularly report to the Board on the activities of the Medical Executive Committee, as described in Section 11.03-3.

(2) The Chief of Staff shall keep the Administrator informed of all violations of Medical Staff Bylaws and Rules or of Hospital bylaws or policies which put patient welfare in jeopardy and shall report on what action is being taken to prevent such incidents from recurring.

(3) The Chief of Staff shall report to the Administrator concerning the progress being made toward attaining Medical Staff and Hospital objectives with respect to the Medical Staff organization.

(4) The frequency, type, and channel of reporting shall be determined by the Chief of Staff in consultation with the Administrator.

(b) The Chief of Staff shall be the chair of the Medical Executive Committee and shall be the focal point for the Committee's:

(1) Communications with the Board.

(2) Communications with department Chiefs, section Chiefs and committee chairs.

(c) All department Chiefs and committee chairs shall be accountable to the Chief of Staff.

### 10.03 ROLE OF THE VICE CHIEF OF STAFF (VICE CHIEF)

The Vice Chief of Staff is second in charge of the Medical Staff organization, and shall accede to the position of Chief of Staff.

#### 10.03-1 Duties

The Vice Chief shall:

(a) In the absence or disability of the Chief of Staff, perform all of the duties of the Chief.

(b) Assist the Chief of Staff in the performance of his or her duties.

(c) Be a member of the Medical Executive Committee, the Joint Conference Committee, and such other committees as provided in the Rules.

#### 10.03-2 Authority

The Vice Chief shall have the authority:

(a) When acting as the Chief of Staff or at the discretion of the Chief of Staff, to exercise all the authority of the Chief of Staff.

(b) To initiate appropriate corrective or disciplinary actions.

#### 10.03-3 Accountability and Relationships

The Vice Chief shall be jointly accountable to the Chief of Staff and the Medical Executive Committee, and when acting as Chief of Staff he or she shall be accountable to the Board and relate to the Medical Staff, departments, and committees in the same manner as the Chief, as described in Section 10.02-3.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### 10.04 SECRETARY-TREASURER

#### 10.04-1 Duties

The duties of the Secretary-Treasurer are to:

- (a) Keep accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings.
- (b) Call meetings on order of the Chief of Staff.
- (c) Ensure that attendance records are maintained for Medical Staff, committee, and department meetings.
- (d) Receive and disburse money as directed by the Medical Executive Committee and keep an accurate and complete record of receipts and disbursements.
- (e) Collect dues and other assessments and notify the appropriate committee, as required in the Rules, of any Medical Staff Member's failure to pay.
- (f) Be a member of the Medical Executive Committee and the Joint Conference Committee.
- (g) Perform such additional duties as may be assigned from time to time.
- (h) In the absence or disability of the Chief of Staff or the Vice Chief, perform all the duties of the Chief or the Vice Chief.

#### 10.04-2 Authority

The Secretary-Treasurer shall have the authority to:

- (a) Receive and disburse money, as directed by the Medical Executive Committee and by these Bylaws and the Rules.
- (b) Attend to all correspondence and perform such other duties as ordinarily pertain to such office.
- (c) Delegate to Hospital administrative staff the performance of any of the duties described in Section 10.04-1(a) through (e).
- (d) When acting as the Chief of Staff or Vice Chief or at the direction of either, the Secretary-Treasurer shall have all the authority of the Chief of Staff or Vice Chief, as appropriate.

#### 10.04-3 Accountability and Relationships

The Secretary -Treasurer shall be jointly accountable to the Medical Executive Committee and to the Chief of Staff.

## Sutter Medical Center, Sacramento – Medical Staff Bylaws

### ARTICLE XI COMMITTEES AND TEAMS

#### 11.01 GENERAL

##### 11.01-1 Designation

The Medical Executive Committee and the other committees described in these Bylaws and the Rules shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee or a department to perform specified tasks. The Quality Council and any committee or team, whether Staff-wide or department or other clinical unit based, or whether standing or ad hoc, that is carrying out all or any portion of a function or activity required by these Bylaws or the Rules is deemed a duly appointed and authorized committee of the Medical Staff. These general provisions applicable to committees, committee Chairs, and committee members shall also apply to teams, team leaders, and team members.

##### 11.01-2 Appointment of Members

- (a) Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with the Medical Executive Committee. Medical Staff committees shall be responsible to the Medical Executive Committee. Medical Staff teams shall be responsible to the Quality Council and the Medical Executive Committee.
- (b) A Staff committee created pursuant to these Bylaws shall be composed as stated in the description of the committee in these Bylaws or the Rules. Except as otherwise provided in the Bylaws, committees established to perform Staff functions required by these Bylaws may include any category of Medical Staff Members; Allied Health Professionals; representatives from Hospital departments such as Administration, Nursing Services, or Health Information Services; representatives of the community; and persons with special expertise, depending upon the functions to be discharged. Each Medical Staff Member who serves on a committee participates with vote, unless the statement of committee composition designates the position as non-voting.
- (c) In general, a Medical Staff Member's eligibility to serve or vote on a Medical Staff or department committee or team shall be determined by his or her Staff category (as described in Sections 4.02 through 4.08). However, in unusual circumstances (such as the unavailability of other qualified Members or the unique background or skills of a particular Medical Staff Member), the Medical Executive Committee is authorized to allow a Medical Staff Member to participate with or without vote (as determined by the Medical Executive Committee) and, if deemed necessary and appropriate under the circumstances, to chair a committee or team, notwithstanding the Member's Medical Staff category.
- (d) The committee Chair, after consulting with the Chief of Staff and Administrator, when appropriate, may call on outside consultants or special advisors.
- (e) Each committee Chair shall appoint a Vice Chair to fulfill the duties of the Chair in his or her absence and to assist as requested by the Chair. Each committee Chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.
- (f) Each committee Chair may appoint a temporary substitute to fulfill the duties of an absent committee member. The substitute may discuss and vote on issues presented to the committee.

##### 11.01-3 Representation on Hospital Committees and Participation in Hospital Deliberations

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

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### 11.01-4 *Ex Officio* Members

The Chief of Staff and the Administrator, or their respective designees, are *ex officio* members of all standing and special committees of the Medical Staff, and shall serve without vote unless provided otherwise in the provision or resolution creating the committee.

### 11.01-5 Action Through Subcommittees

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

### 11.01-6 Terms and Removal of Committee Members

Unless otherwise specified, a committee member shall be appointed for a term of two (2) years, subject to unlimited renewal, and shall serve until the end of this period and until his or her successor is appointed, unless he or she shall sooner resign or be removed from the committee. Any committee member who is appointed by the Chief of Staff may be removed by the Chief of Staff. Any committee member who is appointed by the department Chief may be removed by the Chief or the Medical Executive Committee. The removal of any committee member who is automatically assigned to a committee because he or she is a Staff officer or other official shall be governed by the provisions pertaining to removal of such officer or official. All other committee members may be removed for failure to cooperatively and effectively perform his or her committee responsibilities.

### 11.01-7 Vacancies

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

### 11.01-8 Conduct and Records of Meetings

Committee meetings shall be conducted and documented in the manner specified in the Rules.

### 11.01-9 Attendance of Nonmembers

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

## 11.02 JOINT CONFERENCE COMMITTEE

### 11.02-1 Composition

The Joint Conference Committee is a joint committee of the Board and the Medical Staff. It shall be comprised of the Chief of Staff, Vice-Chief of Staff, Board Chair, two local Board members, area CEO, Vice-President of Clinical Integration and other invited members. The chairperson shall alternate annually between the Chief of Staff and one of the Board representatives.

### 11.02-2 Purpose, Responsibilities and Authority

This committee shall serve as a focal point for furthering an understanding of the roles, relationships, and responsibilities of the Board, administration, and the Medical Staff. It shall also serve as a forum for discussion of any Hospital matters regarding the provision of patient care. It shall meet at least three (3) times per year or as often as necessary to fulfill its responsibilities. Among the matters appropriate for Joint Conference Committee consideration would be, but not by way of limitation: selection, evaluation, and termination of key personnel in such areas as administration, nursing service, and similar positions. Any member of the Committee shall have the authority to place matters on the agenda for consideration by the Committee.

## Sutter Medical Center, Sacramento – Medical Staff Bylaws

### 11.02-3 Accountability

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

### 11.02-4 Other

All members of the Committee, including the chair, may vote.

## 11.03 MEDICAL EXECUTIVE COMMITTEE

### 11.03-1 Composition

The Medical Executive Committee shall consist of the persons (a majority of whom shall be licensed doctors of medicine or osteopathy actively practicing in the hospital) and shall be comprised of the Medical Staff officers listed in Section 10.01-1(a)-(c), the Chief of each department, the Utilization Management Team Chair, the Credentials Committee Chair, and one (1) member-at-large representative who shall serve for two (2) years and shall be subject to the same term limitation and removal provisions as apply for Medical Staff officers. All Members of the organized Medical Staff, of any discipline or specialty, are eligible for membership on the Medical Executive Committee. Nomination shall be by the ad hoc nominating committee of the Medical Staff. Vacancy will be filled by appointment by the Medical Executive Committee. The immediate past Chief of Staff will serve for two (2) years as a voting member after his or her term expires. The Administrator shall serve as an *ex officio* member without vote. The Chief of Staff shall be chair of the Medical Executive Committee. The Vice Chief or Secretary of a department may attend the Medical Executive Committee with the approval of the Chief of Staff. The Substitutes may count towards a quorum, may vote and may be in attendance during executive sessions. At the discretion of the committee Chair, any other person may attend without vote. The Chief of Staff may convene an executive session of the Medical Executive Committee as needed with voting members only to be present.

### 11.03-2 Purpose

The purpose of the Medical Executive Committee is to assist the Chief of Staff in the development and implementation of policies, procedures, programs, rules, and regulations that accomplish the purposes and functions of the Medical Staff organization. The committee shall also serve as the primary forum by which the Medical Staff formally participates in the Hospital's budget, planning, and policymaking processes.

### 11.03-3 Duties

The Medical Executive Committee shall:

- (a) Assist the Chief of Staff in supervising the performance of all Medical Staff functions, which shall include:
  - (1) Requiring regular reports and recommendations from the Quality Council, the departments, committees, teams, and officers of the Medical Staff concerning discharge of assigned functions.
  - (2) Issuing such directives as appropriate to ensure effective performance of all Medical Staff functions.
  - (3) Following up to ensure implementation of all directives.
- (b) Coordinate the activities of the committees and departments and teams.
- (c) Based upon input from committees and the departments, make recommendations to the Board regarding all applications for Medical Staff appointment, reappointment and Clinical Privileges.
- (d) In accordance with Article VII, initiate and/or pursue disciplinary or corrective actions affecting Medical Staff Members and applicants.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

- (e) Oversee the development, approval, and implementation of and assist the Chief of Staff in supervising the Medical Staff's compliance with:
  - (1) The Medical Staff Bylaws, Rules, policies, and procedures.
  - (2) Hospital bylaws, rules, regulations, policies, and procedures which are lawful and reasonable.
  - (3) State and federal laws and regulations.
  - (4) The Joint Commission accreditation requirements.
- (f) With the department Chiefs, set departmental objectives for establishing, maintaining and enforcing professional standards within the Hospital, and for the continuing improvement of the quality of care rendered in the Hospital; and assist in developing programs to achieve these objectives.
- (g) Regularly assess and report to the Board through the Chief of Staff and the Administrator, on at least the following:
  - (1) The outcomes of Medical Staff quality improvement programs with sufficient background and detail to assure the Board that quality of care is consistent with professional standards.
  - (2) Any Medical Staff disciplinary or corrective actions in progress, as well as other actions taken with respect to important problems in clinical care, clinical performance, and opportunities to improve care.
  - (3) The effectiveness of the Medical Staffs programs and actions in achieving the objectives of the Medical Staff and the Hospital.
- (h) Make recommendations to the Board regarding the structure of the Medical Staff, the mechanism used to review credentials and to delineate individual Privileges, the organization of the quality assessment and improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities, the mechanism by which membership on the Medical Staff may be terminated, and the mechanism for hearing procedures. (This responsibility may be satisfied by way of Medical Staff Bylaws and Rules addressing these issues.)
- (i) Participate in the Hospital's planning and budget review activities, including providing guidelines for the departments with respect to planning and budgets, and making recommendations to the Hospital regarding the plans and budgets of the departments.
- (j) Establish, subject to the approval of the Board such additional standing committees as necessary to carry out functions described in these Bylaws and Rules or otherwise assigned to or assumed by the Medical Staff.
- (k) Establish, as necessary, such ad hoc committees which will function for limited times for the performance of circumscribed functions and which will report directly to the Medical Executive Committee.
- (l) Develop and maintain the methods for the protection and care of patients and others in the event of internal or external disaster.
- (m) Review the quality, safety and appropriateness of clinical services provided by contract physicians or through contractual arrangements or other agreement.
- (n) Review and approve the designation of the Hospital's authorized representative for National Practitioner Data Bank purposes.
- (o) Establish a mechanism for dispute resolution between Medical Staff Members (including limited licensed practitioners) involving the care of a patient.

## Sutter Medical Center, Sacramento – Medical Staff Bylaws

- (p) Take reasonable steps to develop continuing education activities and programs for the Medical Staff.
- (q) Meet at least monthly, act for the Medical Staff in the intervals between Medical Staff meetings, and maintain a permanent record of all meetings.

### ARTICLE XII DEPARTMENTS AND CLINICAL SECTIONS

#### 12.01 ORGANIZATION OF DEPARTMENTS

Each department shall be organized as an integral unit of the Medical Staff and shall have a Chief, a Vice Chief, and a Secretary, who are selected and have the authority, duties, and responsibilities specified in the Rules. Additionally, each department may appoint standing or ad hoc committees or teams as it deems appropriate to perform its required functions. The composition and responsibilities of each standing and ad hoc department committee shall be specified in the Rules. Departments may also form sections as described below.

#### 12.02 DESIGNATION

##### 12.02-1 Current Designation

The current departments are:

Anesthesia	Medicine
Diagnostic Imaging and Radiation Oncology	Obstetrics & Gynecology
Cardiovascular Disease	Pediatrics
Emergency Medicine	Psychiatry
Family Medicine	Surgery
Laboratory Medicine	

##### 12.02-2 Future Departments

The Medical Executive Committee may periodically restudy the designation of the departments and recommend to the Board what action is desirable in creating, eliminating, or combining departments for better organizational efficiency and improved patient care.

#### 12.03 ASSIGNMENT TO DEPARTMENTS

Each Member shall be assigned membership to only one department, but may also be granted Privileges in other departments.

#### 12.04 FUNCTIONS OF DEPARTMENTS

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

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **12.05 DEPARTMENT CHIEF, VICE CHIEF AND SECRETARY**

#### **12.05-1 Qualifications**

Each Chief, Vice Chief and Secretary shall:

- (a) Be board certified or board admissible in his or her appropriate specialty.
- (b) Have demonstrated clinical competence in his or her field of practice sufficient to demand the respect of the members of his or her department.
- (c) Have an understanding of the purposes and functions of the Staff organization and a demonstrated willingness to promote patient safety over all other concerns.
- (d) Have an understanding of and willingness to work with the Hospital towards the attainment of its lawful and reasonable goals.
- (e) Have an ability to work with and motivate others to achieve the objectives of the Staff organization in the context of the Hospital's lawful and reasonable objectives.
- (f) Be (and remain during tenure in office) a Member in good standing of the Active Medical Staff.
- (g) Have had no disciplinary action (as listed under Section 8.04-1 of the Bylaws) imposed against him or her by the Medical Executive Committee in the past 12 months.

#### **12.05-2 Selection**

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

#### **12.05-3 Term of Office**

Each department Chief and Vice Chief shall serve a two-year term, the expiration of which coincides with the Medical Staff Year or until their successors are chosen, unless they shall sooner resign, be removed from office, or lose their Medical Staff membership or Privileges in that department. Department officers are eligible to succeed themselves for one additional consecutive term.

#### **12.05-4 Removal**

A department officer may be recalled from office for any valid cause, including, but not limited to, malfeasance in office or failure to carry out the duties of his or her office. Recall of a department officer must be initiated by the Medical Executive Committee or by a majority vote of the Staff Members eligible to vote for department officers, but recall shall require a two-thirds vote of the Medical Executive Committee or two-thirds vote of the Medical Staff members eligible to vote for department officers.

#### **12.05-5 Roles and Responsibilities of Department Officers**

- (a) Each department Chief shall:
  - (1) Provide for the effective performance of department functions, as described in Rule 12.02.
  - (2) In conjunction with the Chief of Staff and the department administrative committee, establish objectives for the quality medical care within the department; and assist in developing programs to achieve these objectives.
  - (3) Establish, maintain and enforce professional standards within the department and the continuing improvement of the quality of care rendered in the department, including criteria for Clinical Privileges.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

- (4) Exercise such authority as he or she deems necessary so that in his or her department patient welfare takes precedence over other concerns.
- (5) Make recommendations to the Medical Executive Committee regarding the integration of the department into the primary functions of the Hospital and the coordination and integration of interdepartmental and intradepartmental services.
- (6) Assess and recommend to Hospital Administration, off-site sources for needed patient care services not provided by the department or the organization.
- (7) In conjunction with the Medical Education Team and the department administrative committee, develop and periodically evaluate programs for the continuing education and orientation of members of his or her department.
- (8) Establish and enforce in conjunction with the Chief of Staff and the department administrative committee, written policies and Rules for the department that guide and support the provision of services which shall be reviewed at least annually. Planning and budget review, consistent with guidelines developed by the Medical Executive Committee, including, but not limited to, making recommendations for a sufficient number of qualified and competent persons to provide patient care/service, and for space and other resources needed by the department.
- (9) Supervise, or cause to be supervised, all Staff Members and Allied Health Professionals holding temporary Privileges or a probationary appointment in his or her department.
- (10) Keep the Members and Allied Health Professionals in his or her department informed as to established departmental objectives and policies and the progress being made toward fulfillment of those objectives and policies.
- (11) Implement any medical care policies and procedures approved by the Medical Executive Committee and the Board as they pertain to his or her department.
- (12) At least biennially and with the assistance of the department administrative committee and the responsible PRC, review the Privileges granted Members and Allied Health Professionals in his or her department for the purpose of making recommendations for the maintenance, increase, or reduction of such Privileges. Such recommendations shall be based upon performance improvement reports, observations of clinical performance, review of patient records, and other sources of information concerning the Practitioner's clinical performance and his or her satisfactory compliance with applicable Medical Staff, department and Hospital policies.
- (13) Chair all department meetings, receive recommendations concerning medical care policies and procedures, and report such recommendations to the Chief of Staff and the Medical Executive Committee.
- (14) Serve as an *ex officio* member of all committees of his or her department and attend such committee meetings as deemed necessary for adequate information flow.
- (15) Ensure that records of performance are maintained and updated for all members of his or her department.
- (16) Report on activities of the Medical Staff to the Board when called upon to do so by the Chief of Staff or the Administrator.
- (17) Be a member of the Medical Executive Committee.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

- (b) Each Vice Chief shall:
  - (1) Assist the department Chief in the performance of his or her duties, and, in the absence or disability of the department Chief, is responsible to perform the duties of the department Chief.
  - (2) Be a member of the Department Administrative Committee and the Peer Review Committee.
- (c) Each Secretary shall:
  - (1) Ensure that accurate and complete minutes of the Department Administrative Committee and department meetings are maintained.
  - (2) Assist the department Chief and Vice Chief in the performance of his or her duties, and in the absence or disability of the department Chief and Vice Chief, perform all duties of the department Chief.
  - (3) Be a member of the Department Administrative Committee and the appropriate Peer Review Committee.

### 12.06 CLINICAL SECTIONS

#### 12.06-1 Formal Sections

Within each department, the Practitioners of the various subspecialty groups may organize themselves as a clinical section. If a section is formally organized, the section shall develop Rules specifying the purpose, responsibilities, and method of selecting officers. These Rules shall be effective when approved as required by Section 15.03. Responsibility and accountability for performance of departmental functions shall remain at the departmental level.

#### 12.06-2 Informal Sections

Subspecialists may meet informally without necessity of rules and regulations; however, such informal structure shall not be deemed part of the formal Medical Staff organization.

## **ARTICLE XIII MEETINGS**

### 13.01 GENERAL STAFF MEETINGS

#### 13.01-1 Staff Meetings

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

#### 13.01-2 Special Meetings

Special meetings of the Medical Staff may be called at any time by the Board, the Chief of Staff, or the Medical Executive Committee. A special meeting shall also be called upon the written petition of not less than 10% of the voting members of the Staff, and shall be held within thirty (30) days of receipt of the petition. No business shall be transacted at any special meeting except that stated in the meeting notice.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### 13.01-3 Combined Medical Staffs Meeting

The Sutter Medical Center, Sacramento Medical Staff may participate in combined medical staff meetings with staff members of other hospitals, healthcare entities, and the County Medical Society.

## 13.02 COMMITTEE, TEAM, AND DEPARTMENT MEETINGS

### 13.02-1 Regular Meetings

Committees, teams, and departments may, by resolution, provide the time for holding regular meetings and no notice other than the resolution shall then be required. Each department and committee shall meet regularly, at least quarterly, to review and discuss patient care activities and to fulfill other departmental responsibilities.

### 13.02-2 Special Meetings

A special meeting of any committee, team, or department may be called by, or at the request of, the committee Chair, the team leader, the department Chief, the Board, the Chief of Staff, or by one-third of the group's current members. No business shall be transacted at any special meeting except that stated in the meeting notice.

### 13.02-3 Combined Department Meetings

Department members may participate in combined department meetings with staff members of other Sacramento-area hospitals.

## 13.03 NOTICE OF MEETINGS

Written notice of any general or special Staff meeting not held pursuant to resolution shall be posted in the Medical Staff newsletter or shall be mailed to each person entitled to be present not less than seven days before the date of such meeting. Notice of department, team, or committee meetings may be given orally. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

## 13.04 QUORUM

### 13.04-1 General Staff Meetings

The presence of 25% of the voting members of the Staff shall constitute a quorum for the transaction of business.

### 13.04-2 Department, Team, and Committee Meetings

Twenty-five percent of the voting members of a department shall constitute a quorum at any meeting of that department. Two or more physician members shall constitute a quorum at any meeting of a Medical Staff committee or team, so long as those physicians constitute a majority of voting members present at the meeting.

## 13.05 MANNER OF ACTION

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

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### 13.06 MINUTES

Minutes of all meetings shall be prepared and shall include a record of attendance and the vote taken on each matter. Copies of minutes shall be, approved by the attendees, and filed with the committee's records. Meeting minutes shall be regularly forwarded to the Medical Executive Committee.

### 13.07 MEETING ATTENDANCE

#### 13.07-1 Regular Attendance

Attendance at Medical Staff, committee, department and section meetings is encouraged. The Medical Staff is informed and updated through various methods of communication on a regular basis.

#### 13.07-2 Special Appearance

A committee, at its discretion, may require the appearance of a Practitioner during a review of the clinical course of treatment regarding a patient. If possible, the chair of the meeting should give the Practitioner at least ten days' advance written notice of the time and place of the meeting. In addition, whenever an appearance is requested because of an apparent or suspected deviation from standard clinical practice, Special Notice shall be given and shall include a statement of the issue involved and that the Practitioner's appearance is mandatory.

Failure of a Practitioner to appear at any meeting with respect to which he or she was given Special Notice shall (unless excused by the Medical Executive Committee upon a showing of good cause) result in an automatic suspension of all or such portion of the Practitioner's Clinical Privileges as the Medical Executive Committee may direct for two weeks or such longer period as the Medical Executive Committee deems appropriate. The Practitioner shall be entitled to the procedural rights described in Article VIII hereof, provided, however, that if the duration of the suspension is two weeks, the right to a hearing shall be limited to a hearing considering whether or not good cause existed for the Practitioner's failure to appear.

## **ARTICLE XIV IMMUNITY AND RELEASES**

### 14.01 CONFIDENTIALITY, IMMUNITY AND RELEASES

#### 14.01-1 General

Medical Staff, department, section or committee minutes, files and records, including information regarding any Member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the Medical Staff committee files and shall not become part of any particular patient's file or of the general Hospital records. Dissemination of such information and records shall only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff or, where no officially adopted policy exists, only with the express approval of the Medical Executive Committee or its designee and the Administrator.

#### 14.01-2 Breach of Confidentiality

Inasmuch as effective credentialing, quality improvement, peer review and consideration of the qualifications of Medical Staff Members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff departments, sections or committees, except in conjunction with peer review activities of another System Affiliate, health facility, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **14.02 IMMUNITY FROM LIABILITY**

Each representative, agent, member, and employee of the Medical Staff and Hospital and all third parties shall be exempt from liability to an applicant or Member or AHP for damages or other relief by reason of providing information to a representative of the Medical Staff, Hospital, System Affiliate, or any other health-related organization concerning such person who is, or has been, an applicant to or member of the Staff or who did, or does, exercise Clinical Privileges or provide services at this Hospital or by reason of otherwise participating in Medical Staff or Hospital credentialing, quality improvement, or peer review activities.

### **14.03 ACTIVITIES AND INFORMATION COVERED**

#### **14.03-1 Activities**

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

- (a) Applications for appointment, Clinical Privileges, or specified services.
- (b) Periodic reappraisals for reappointment, Privileges, or specified services.
- (c) Corrective action.
- (d) Hearings and appellate reviews.
- (e) Quality improvement review, including patient care audits.
- (f) Peer review.
- (g) Utilization reviews.
- (h) Morbidity and mortality conferences.
- (i) National Practitioner Data Bank queries and reports, peer review organizations, MBC and similar queries and reports.
- (j) Other Hospital, department, section or committee activities related to monitoring and improving the quality of patient care and appropriate professional conduct.

#### **14.03-2 Information**

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

### **14.04 RELEASES**

Each Practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article; however, execution of such release shall not be deemed a prerequisite to the effectiveness of this Article.

### **14.05 CUMULATIVE EFFECT**

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

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### 14.06 INDEMNIFICATION

The Hospital shall indemnify, defend and hold harmless the Medical Staff and its individual Members from and against losses and expenses (including attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon a threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review, quality management or utilization management activities including, but not limited to, (1) as a Member of or witness for a Medical Staff Department, service, committee, or hearing panel, (2) as a Member of or witness for the Hospital Board or any Hospital task force, group or committee, and (3) as a person providing information to any Medical Staff or Hospital group, officer, board member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a Medical Staff Member or applicant. The Medical Staff or Members may seek indemnification for such losses and expenses under this Bylaws provision, statutory and case law, any available liability insurance or otherwise as the Medical Staff or Member sees fit, and concurrently or in such sequence as the Medical Staff or Member may choose. Payment of any losses or expenses by the Medical Staff or Member is not a condition precedent to the Hospital's indemnification obligations hereunder.

### **ARTICLE XV GENERAL PROVISIONS**

### 15.01 MEDICAL STAFF RULES

Subject to approval by the Board, the Medical Staff may supplement these Bylaws with Medical Staff Rules ("Rules") that provide associated details, as it deems necessary, to implement more specifically the general principles established in these Bylaws.

Rules shall become effective upon approval by the Board of Directors, which shall not be withheld unreasonably. Neither the Medical Staff nor the Board of Directors may unilaterally amend the Rules. If there is a conflict between the Bylaws and the Rules or Policies, the Bylaws shall prevail. The mechanisms described herein shall be the sole method for the initiation, adoption, amendment or repeal of the Rules and Policies.

#### 15.01-1 Proposal by Medical Executive Committee

(a) The Medical Staff delegates authority to the Medical Executive Committee to initiate and adopt such Rules as it may deem necessary for the proper conduct of Medical Staff business. Recommended changes to the Rules may be submitted to the Medical Executive Committee by any member of the Medical Executive Committee or by other Medical Staff committees. If the Medical Executive Committee proposes to adopt a change(s) to the Rules, it must communicate the proposal to the Medical Staff in a reasonable manner, which may include posting in a newsletter or bulletin, distribution at a general Medical Staff meeting, or any other method regularly used by the Medical Staff Services Department to provide notices to members at least 15 days before it is adopted. The Medical Executive Committee may retain, modify or abandon the provisions, as it deems appropriate in light of the comments, if any.

(b) Following adoption by the Medical Executive Committee, such Rules shall become effective upon approval of the Board of Directors.

#### 15.01-2 Urgent Need for Legal/Regulatory Compliance

(a) The Medical Staff has delegated authority to the Medical Executive Committee to provisionally adopt, without prior notification to the Medical Staff, an amendment to the Rules when there is a documented need to promptly comply with specific rules required by law or governmental and/or accrediting agencies.

(b) The action to amend may be taken by motion and acted upon in the same manner as any other motion before the Medical Executive Committee.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

(c) Upon adoption by the Medical Executive Committee, notice will promptly be provided to the Board of Directors who will approve or reject the amendment promptly.

(d) Upon approval by the Board of Directors, the Medical Executive Committee will notify the Medical Staff promptly and provide the Medical Staff with an opportunity to retrospectively review and comment on the amendment.

(e) If there is a conflict regarding the amendment between the Medical Staff and the Medical Executive Committee, the process for resolving conflicts described in Section 15.06 will be implemented.

### **15.02 DEPARTMENTAL RULES**

Subject to the approval of the Chief of Staff, the Medical Executive Committee and the Board, each department shall formulate its own Rules for conducting its affairs and discharging its responsibilities. Such Rules shall not be inconsistent with the Medical Staff or Hospital Bylaws, Rules or other policies. Upon adoption, the department Rules shall be deemed part of these Medical Staff Bylaws, except that they may be amended as set forth in the Rules.

### **15.03 SECTION RULES**

Subject to the approval of the committee of the department that oversees the section, the Medical Executive Committee, and the Board, each section may formulate its own Rules for conducting its affairs and discharging its responsibilities. Such Rules shall not be inconsistent with the Medical Staff or Hospital Bylaws, Rules or policies. Upon adoption, the Rules shall be deemed a part of these Medical Staff Bylaws.

### **15.04 MEDICAL STAFF POLICIES**

(a) For purposes of this Section, the term “Medical Staff Policies” shall mean those Policies that are adopted by the Medical Executive Committee and pertain to the Medical Staff as a whole. It does not include Policies developed by Departments or Sections for their members or Hospital Policies, even if such Policies are approved by the Medical Executive Committee.

(b) Medical Staff Policies shall be developed as necessary to implement more specifically the general principles found within these Bylaws and the Rules. The Medical Staff delegates authority to the Medical Executive Committee to initiate and/or adopt such Medical Staff Policies as it may deem necessary for the proper conduct of the Medical Staff’s business. The Medical Executive Committee may develop such Medical Staff Policies itself or may direct a Department of designate a committee to draft a Medical Staff Policy for its review.

(c) Following adoption or amendment of a Medical Staff Policy by the Medical Executive Committee, such Medical Staff Policy shall become effective upon approval of the Board of Directors.

(d) Adoption or amendment of a Medical Staff Policy shall be communicated to the organized Medical Staff by the Medical Executive Committee.

### **15.05 DIRECT MEDICAL STAFF PROPOSAL TO BOARD OF DIRECTORS – ADOPTION AND AMENDMENTS TO RULES AND POLICIES**

Notwithstanding any other provision of these Bylaws, the Medical Staff Members who are entitled to vote may propose adoption or amendment of a Rule or Policy that pertains to the Medical Staff as a whole directly to the Board of Directors. To propose a Rule, Policy or amendment directly to the Board of Directors, an Active Member of the Medical staff in good standing must take the following steps:

(a) Obtain an initial written petition in support of the proposed Rule, Policy or amendment language signed by at least twenty-five (25%) of the Members of the Medical Staff who are entitled to vote.

(b) Communicate in writing both the proposed Rule, Policy or amendment and the reason for the proposed Rule, Policy or amendment to the Medical Executive Committee for its consideration and vote.

## Sutter Medical Center, Sacramento – Medical Staff Bylaws

- (c) *Proposed Rule.* If the Medical Executive Committee agrees with a proposed Rule or amendment, the Medical Executive Committee shall communicate the proposal to the Medical Staff in writing at least 15 days before it is adopted by the Medical Executive Committee.
- (d) *Proposed Policy.* If the Medical Executive Committee adopts the proposed Policy or amendment, it shall follow the process outlined in Section 15.04 (c) (d).
- (e) In the event of a conflict regarding the proposal, either the Medical Executive Committee or the Medical Staff petitioners may initiate the Conflict Management process described in Section 15.06 in an attempt to resolve the conflict.
- (f) If, following a failed attempt to resolve any conflict over the proposed Rule, Policy or amendment, and the Medical Executive Committee ultimately rejects the proposed Rule, Policy or amendment, the Members of the Medical Staff who are entitled to vote shall be given notice of the proposed Rule, Policy or amendment.
- (g) If the proposed Rule, Policy or amendment is adopted by the Medical Staff, it shall become effective upon approval of the Board of Directors, which approval shall not be withheld unreasonably or automatically after sixty (60) days if no action is taken by the Board of Directors. In the latter event, the Board of Directors shall be deemed to have approved the Rule, Policy or amendment.

### 15.06 CONFLICT MANAGEMENT

- (a) Under the following circumstances, the Medical Executive Committee shall initiate a conflict management process to address a disagreement between members of the Medical Staff and the Medical Executive Committee about an issue relating to the Medical Staff's documents or functions, including but not limited to a proposal to adopt or amend the Medical Staff Bylaws, Rules or Policies; or a proposal to remove some authority delegated to the Medical Executive Committee by the Medical Staff under these Bylaws (by amending the Bylaws):
  - (1) Upon written petition signed by either:
    - (a) At least 25% of the voting members of the Medical Staff, or
    - (b) At least two-thirds (2/3) of the members of any Department of the Medical; or
  - (2) Upon the Medical Executive Committee's own initiative at any time; or
  - (3) As otherwise specified in these Bylaws
- (b) A petition to initiate the conflict management process shall designate two Active Medical Staff members to serve as representatives of the petitioners, describe the nature of the conflict, and state the reasons why the conflict management process should be utilized to address it.
- (c) With respect to each particular conflict, the Medical Executive Committee shall determine and specify a process that the Medical Executive Committee deems most appropriate to the issues and circumstances. At a minimum, the conflict management process shall do all of the following:
  - (1) Provide a reasonably timely, efficient and meaningful opportunity for the parties to express their views;
  - (2) Require good-faith participation by representatives of the parties; and
  - (3) Provide for a written decision or recommendation by the MEC on the issues within a reasonable time, including an explanation of the Medical Executive Committee's rationale for its decision or recommendation.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

(d) At the Medical Executive Committee's discretion, the process for management of a conflict between the Medical Executive Committee and Medical Staff members may include the involvement of a third party to facilitate or mediate the conflict management efforts.

(e) This conflict management process shall be a necessary prerequisite to any proposal to the Board of Directors by Medical Staff members for adoption or amendment of a Bylaw, Rules provision or Policy not supported by the Medical Executive Committee, including, but not limited to, a proposed Bylaws amendment intended to remove from the Medical Executive Committee some authority that has been delegated to it by the Medical Staff.

(f) Nothing in this Section is intended to prevent Medical Staff members from communicating with the Board of Directors about Medical Staff Bylaws, Rules or Policies, according to such procedures as the Board may specify.

### **15.07 MEDICAL STAFF PARTICIPATION IN HOSPITAL DELIBERATIONS**

#### **15.05-1 General**

Medical Staff representatives as designated by the Chief of Staff shall participate in any Hospital deliberation affecting the discharge of Medical Staff responsibilities.

#### **15.05-2 Exclusive Contracting Decisions**

The Medical Executive Committee shall review and make recommendations to the Administrator regarding quality of care issues related to exclusive contract arrangements for professional medical services. In addition, the Medical Executive Committee and individual members of Medical Staff shall cooperate in providing relevant input to notice-and-comment proceedings or other mechanisms that may be implemented by Hospital administration in making exclusive contracting decisions.

### **15.08 MEDICAL STAFF DUES**

The Medical Executive Committee shall have the authority to set the amount of annual dues for Medical Staff membership, and to determine the manner of expenditure of funds received, provided, however, that such expenditures shall not jeopardize the nonprofit status of the Hospital.

### **15.09 MEDICAL STAFF LEGAL COUNSEL**

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

### **15.10 FORMS**

Application forms and any other prescribed forms required by these Bylaws or the Rules for use in connection with Medical Staff appointments, reappointments, delineation of Privileges, corrective action, notices, recommendations, reports, and other matters shall be approved by the Medical Executive Committee and the Board. Upon adoption, they shall be deemed part of the Medical Staff Rules. They may be amended by approval of the Medical Executive Committee and the Board.

### **15.11 AUTHORITY TO ACT**

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

### **15.12 DIVISION OF FEES**

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

## Sutter Medical Center, Sacramento – Medical Staff Bylaws

### 15.13 WAIVER OF BYLAWS OR RULES

Insofar as is consistent with applicable laws, the Medical Executive Committee, in consultation with the Board or its designated representative, or the Board, in consultation with the Medical Executive Committee, has the discretion to waive a provision of the Bylaws or Rules, if either determines that this waiver is necessary to serve the best interests of the patients and of the Hospital. There is no obligation to grant any such waiver and Practitioners have no right to have a request for a waiver considered and/or granted.

### 15.14 DISCLOSURE OF INTEREST

Medical Staff Members who occupy Medical Staff offices, such as Medical Staff Officers, department and committee chairships and members of the Medical Executive Committee, carry with them a requirement of loyalty and fidelity and must discharge their duties diligently and honestly, exercising their best care, skill and judgment for the sole benefit of the Medical Staff. Accordingly, it is the responsibility of each Medical Staff Member who occupies a Medical Staff office, all Medical Staff Officers, department and committee chairs, and members of the Medical Executive Committee to make full disclosure to any duality of interest that might result in a possible conflict on his or her part. The subject Medical Staff Member shall refrain from voting on any matter about which he or she has a duality or conflict of interest, and shall be excused from the room while the vote on the matter is taken.

### 15.15 MEDICAL STAFF CREDENTIALS FILES.

#### 15.15-1 Insertion of Adverse Information

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

- (a) As stated previously, in Section 6.1-2, any person may provide information to the Medical Staff about the conduct, performance or competence of its Members.
- (b) When a request is made for insertion of adverse information into the Medical Staff Member's credentials file, the respective department Chief and Chief of Staff shall review such a request.
- (c) After such a review a decision will be made by the respective department Chief and Chief of Staff to:
  - (1) Not insert the information;
  - (2) Notify the Member of the adverse information by a written summary and offer the opportunity to rebut this assertion before it is entered into the Member's file; or
  - (3) Notify the Member of the adverse information by written summary and insert the information along with a notation that a request has been made to the Medical Executive Committee for an investigation as outlined in Section 6.1 of these Bylaws.
- (d) This decision shall be reported to the Medical Executive Committee. The Medical Executive Committee, when so informed, may either ratify or initiate contrary actions to this decision by a majority vote.
- (e) A Practitioner shall be entitled to submit a rebuttal to any adverse information or letter of counseling, warning or reprimand placed in his/her credentials file by the Department or Medical Executive Committee.

## Sutter Medical Center, Sacramento – Medical Staff Bylaws

### 15.15-2 Confidentiality

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

- (a) The records of the Medical Staff and its Departments and committees responsible for the evaluation and improvement of the quality of patient care rendered at the Hospital shall be maintained as confidential.
- (b) Access to such records shall be limited to duly appointed officers and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.
- (c) Information which is disclosed to the Governing Body of the Hospital or its appointed representatives -- in order that the Governing Body may discharge its lawful obligations and responsibilities shall be maintained by that body as confidential.
- (d) Information contained in the credentials file of any Member may be disclosed with the Member's consent, or to any Medical Staff or professional licensing board, or as required by law. However, any disclosure outside of the Medical Staff shall require the authorization of the Chief of Staff and the concerned Department chair and notice to the Member.
- (e) A Medical Staff Member shall be granted access to the individual's credentials file, subject to the following provisions:
  - (1) Timely notice of such shall be made by the Member to the Chief of Staff or the Chief of Staff's designee;
  - (2) The Member may review, and receive a copy of, only those documents provided by or addressed personally to the Member. A summary of all other information, including but limited to, peer review committee findings, letters of reference, proctoring reports, complaints, shall be provided to the Member, in writing, by the designated officer of the Medical Staff, within a reasonable period of time, as determined by the Medical Staff. Such summary shall disclose the substance, but not the source, of the information summarized and shall not be removed from the review site;
  - (3) The review by the Member shall take place in the Medical Staff office, during normal work hours, with an officer or designee of the Medical Staff present.
- (f) In the event a notice of action or proposed action is filed against a Member, access to that Member's credentials file shall be governed by Section 7.2-5.

### 15.15-3 Member's Opportunity to Request Correction/Deletion of and to Make Addition to Information File

- (a) After review of the file as provided under Section 14.1-9 (e), the Member may address to the Chief of Staff a written request for correction or deletion of information in the credentials file. Such request shall include a statement of the basis for the action requested.
- (b) The Chief of Staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Committee, after such review, whether or not to make the correction or deletion requested. The Medical Executive Committee, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote.
- (c) The Member shall be notified promptly, in writing, of the decision of the Medical Executive Committee.
- (d) In any case, a Member shall have the right to add to the individual's credentials file, upon written request to the Medical Executive Committee, a statement responding to any information contained in the file.

## **Sutter Medical Center, Sacramento – Medical Staff Bylaws**

### **15.16 REQUIREMENTS FOR COMPLETING AND DOCUMENTING MEDICAL HISTORY AND PHYSICAL EXAMINATIONS**

#### **15.16-1 Responsibility for Completion of History and Physical**

Responsibility for the admission History and Physical (H&P) belongs to the attending physician unless he or she delegates this responsibility to another Practitioner or Allied Health Professional or he or she is required by the Hospital Medical Staff Bylaws or Rules to delegate or share this responsibility with another Practitioner. When anesthesia is required for non-invasive diagnostic radiology procedures, the Anesthesia Department Evaluation, as currently performed, will serve as the H&P. Advanced Practice RNS (Nurse Practitioner and CRNAs) and Physician Assistants are permitted to perform H&Ps as long as they are credentialed and have been approved for H&P privileges. The findings, conclusions and assessment of risk must be confirmed or endorsed by a qualified physician. In addition, the H&P must be countersigned and dated by the supervising physician within 30 days of care.

#### **15.16-2 Timeliness**

The H&P shall be completed and placed on the record up to 24 hours prior to the admission and no later than 24 hours after the patient's admission, unless the patient will be taken to surgery before that time, in which case the H&P report must be placed in the patient's chart before the patient is taken to surgery. If it is impossible to have a dictated H&P report prepared and placed in the chart prior to surgery, the physician shall include a handwritten H&P (to include all the elements as stated in #6 of Policy for Completion of Medical Record) in the record.

## **ARTICLE XVI ADOPTION AND AMENDMENT OF BYLAWS**

### **16.01 MEDICAL STAFF RESPONSIBILITY AND AUTHORITY**

(a) The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend Medical Staff Bylaws and amendments, which shall be effective when approved by the Board which approval shall not be unreasonably withheld. The Board shall take action within sixty (60) days of receipt for such change from the Medical Staff. If no action is taken within sixty (60) days, the Bylaws shall be deemed automatically approved. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Board. Neither the Medical Staff nor the Board may unilaterally amend medical staff bylaws. The medical staff bylaws, rules and policies and the governing body bylaws do not conflict.

(b) Upon the request of (1) the Medical Executive Committee, the Chief of Staff or the Bylaws Committee, and after approval by the Medical Executive Committee, or (2) upon timely written petition signed by at least twenty-five percent (25%) of the Members, consideration shall be given to the adoption, amendment, or repeal of these Bylaws by the Medical Staff Members entitled to vote in the manner described in Section 16.02 (a). Upon adoption by the Medical Staff, the procedure in Section 16.02 (b) shall be followed to obtain approval by the Board of Directors.

### **16.02 METHODOLOGY**

Medical Staff Bylaws may be adopted, amended, or repealed by the following combined actions:

(a) The affirmative vote of a majority of the Medical Staff Members voting on the matter by mailed secret ballot; provided at least twenty-one (21) days advance written notice, accompanied by the proposed bylaws and/or alterations, has been given; and

(b) The approval of the Board, whose approval shall not be unreasonably withheld. The Board shall not repeal, amend, or adopt Medical Staff Bylaws without the Medical Staff's adoption and approval, unless failure to do so would result in a violation of law.

**Sutter Medical Center, Sacramento – Medical Staff Bylaws**

16.03 TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Executive Committee shall have the authority to approve technical corrections such as reorganization or renumbering of the Bylaws, to correct punctuation, spelling or other errors of grammar or expression, or inaccurate cross-references. No substantive amendments are permitted pursuant to this Section. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board within ninety (90) days after adoption by the Medical Executive Committee. The action to amend may be taken by motion acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such amendments shall be communicated in writing to the Medical Staff and to the Board.

16.04 PRESERVATION OF BYLAWS

In the event the Board elects to sell or lease one or both of the Hospitals, these Bylaws shall remain in effect until or unless these Bylaws are amended or new bylaws are adopted in accordance with Sections 16.01 and 16.02 of these Bylaws. (The requirements of this Section 16.04 shall be included in any contract to sell or lease the Hospitals.)

**ADOPTED by the MEDICAL STAFF and APPROVED by the BOARD September 12, 2011**