

***MEDICAL STAFF BYLAWS  
AND  
RULES AND REGULATIONS  
  
OF  
  
STANFORD HEALTH CARE***

*300 Pasteur Drive  
Stanford, California 94305*

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**STANFORD HEALTH CARE**  
**MEDICAL STAFF BYLAWS AND**  
**RULES & REGULATIONS**

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## BYLAWS OF THE MEDICAL STAFF

### STANFORD HEALTH CARE

#### PREAMBLE

**WHEREAS, STANFORD HEALTH CARE (SHC)** is a non-profit corporation organized under the laws of the State of California; and

**WHEREAS**, its purpose is to provide patient care, education, and research in both the hospital and clinic settings; and

**WHEREAS**, it is recognized that the Medical Staff is responsible to its patients, trainees, the Medical Executive Committee, and the Stanford Health Care Board of Directors for the quality of professional care performed in SHC;

**THEREFORE**, the physicians, dentists, podiatrists, and clinical psychologists who practice in SHC hereby organize themselves into a Medical Staff in conformity with these Bylaws.

**ARTICLE ONE:  
NAME AND PURPOSES**

**1.1 NAME**

The name of the organization is the Medical Staff of Stanford Health Care. The organized Medical Staff is accountable to the Board of Directors of the Hospital.

**1.2 PURPOSES**

The purposes of the Medical Staff of SHC are:

- A. To strive to ensure that all patients admitted to, or treated in, SHC receive quality care without regard to race, religion, color, ancestry, economic status, educational background, marital status, disability, sex, age, sexual orientation, national origin, or payment, or other potential discriminants;
- B. To conduct education and research that will maintain ethical and scientific standards of medical care and will lead to advancement in professional knowledge and skill, while maintaining the quality of care and dignity for all patients;
- C. To develop and maintain rules of self-governance and conduct of the Medical Staff that assure the quality of professional care performed within SHC, including recommendations for appointment and reappointment to the Medical Staff;
- D. To provide a forum whereby issues concerning the Medical Staff may be discussed by the Medical Staff with the SHC Board of Directors and the President and CEO of SHC, or their designees;
- E. To approve and amend the Medical Staff Bylaws, to supervise and ensure compliance with these Bylaws, Policies, Rules and Regulations of the Medical Staff, and SHC policies approved by the SHC Board of Directors;
- F. To provide oversight of care, treatment, and services provided by practitioners at SHC; provide for a uniform quality of safe patient care, treatment and services; report to, and be accountable to, the Board of Directors;
- G. To provide a means for effective communication among patients, the Medical Staff, Hospital Board, and Administration on issues of mutual concern; and
- H. To maintain professional, collegial relationships within the Medical Staff.

**1.3 SELF GOVERNANCE**

The Medical Staff's right of self-governance includes, but is not limited to, all of the following:

- A. Establishing in the 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 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 may not be unreasonably withheld.

## **ARTICLE TWO: DEFINITIONS**

### **2.1 ACCESS**

Term used to refer to the granting of permission under the limited or controlled access policy of the SHC Board of Directors for community physicians to utilize certain specific Hospital-based services or laboratories. A physician must have Hospital admitting privileges as a member of the Medical Staff and be credentialed as having the necessary professional qualifications to perform specialized procedures in the service or laboratory where access is sought.

### **2.2 ADJUNCT CLINICAL FACULTY (ACF)**

The ACF consists of physicians and certain other health professionals appointed in Clinical Departments of Stanford University School of Medicine for the purpose of participation on a voluntary, part-time basis in the academic programs of the Departments.

### **2.3 ADMITTING PRIVILEGES**

The right of members of the Medical Staff to admit their patients to the Hospital

### **2.4 ADVANCED PRACTICE PROFESSIONALS (APP)**

Individuals (excluding medical students and housestaff) who hold a valid license, certificate, or other legal credential as required by California law that authorizes the provision of clinical services to patients, while working collaboratively with a member of the Medical Staff. APPs must provide safe patient care, treatment, and services under the terms and conditions recognized by these Medical Staff Bylaws, Rules and Regulations, Clinical Service Rules and Regulations, and the Advanced Practice Professional Guidelines. APPs may not be members of the SHC Medical Staff, but are eligible for practice prerogatives.

### **2.5 ASSOCIATE CHIEF OF STAFF**

An Active Medical Staff member appointed by the Chief of Staff, with the approval of the Medical Executive Committee, to assist in the work of the organized Medical Staff.

### **2.6 ATTENDING PHYSICIAN**

The Medical Staff member who is the physician of record for a given patient.

### **2.7 CHIEF OF SERVICE**

The Chief or Acting Chief of each Clinical Service of the Medical Staff is a physician and will ordinarily be the Chair or Acting Chair of the corresponding Department of the Stanford University School of Medicine, and is responsible for the clinical work of the Department.

### **2.8 CHIEF OF STAFF (COS)**

The physician elected to serve as the liaison between SHC Board of Directors and the Medical Staff, responsible for administration of Medical Staff Bylaws, and the performance of other duties as are outlined in these Bylaws or as may be assigned by the Medical Executive Committee. The Chief of Staff is accountable to the Medical Executive Committee as appropriate, for the discharge of duties in accordance with Section 9.1.B.

**2.9 CLINICS**

The clinics owned by SHC and operated by it in cooperation with, and/or in support of, the Stanford University School of Medicine primarily for the purpose of medical education.

**2.10 CLINICAL PRIVILEGES (PRIVILEGES)**

The permission granted to a Medical Staff member to render specific diagnostic, therapeutic, medical, dental, surgical, podiatric, psychological services.

**2.11 COMMUNITY PHYSICIAN**

A physician member of the Medical Staff who receives less than a majority of his or her clinical compensation from Stanford University.

**2.12 CONSTRUCTION OF TERMS AND HEADINGS**

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

**2.13 DEPUTY CHIEFS OF SERVICE**

A community physician on the Active Medical Staff may be elected as Deputy Chief. The Deputy Chief is elected biennially by the current Active Medical Staff Community Physician members of the Service, to serve with and assist the Chief of Service in the oversight of the professional and administrative activities within the Service.

**2.14 DESIGNEE**

Any reference to an individual holding a duly-authorized office (including Chiefs of Clinical Service) under these Bylaws includes, unless otherwise indicated, the designee of that individual.

**2.15 EMERGENCY**

A condition in which serious harm could result to a patient, or in which the life of a patient is in immediate danger, and any delay in administering treatment would add to that harm or danger.

**2.16 EX OFFICIO**

A member of a committee or body by virtue of an office or position held, with voting rights unless otherwise expressly provided.

**2.17 FELLOW**

A physician registered as a post graduate fellow in the Stanford University School of Medicine

**2.18 HIPAA PRIVACY REGULATIONS**

The federal privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996.

**2.19 HOSPITAL**

The general acute care hospital of SHC, including the associated ambulatory treatment areas and the Emergency Department, which are included in the general acute care hospital license.

**2.20 HOUSESTAFF**

A physician who is in an SHC approved residency or fellowship program.

**2.21 IN GOOD STANDING**

In good standing means a member is currently not under suspension or serving with any limitation of voting or other prerogatives imposed by operation of the bylaws, rules and regulations, or policies of the Medical Staff.

**2.22 INVESTIGATION**

Investigation means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, of a concern or complaint raised against a member of the Medical Staff, and does not include activity of the Well Being of Physicians and Physicians-in-Training-Committee, or the processes of Ongoing Professional Practice Evaluation, Focused Professional Practice Evaluation, or ongoing quality review.

**2.23 LICENSED INDEPENDENT PRACTITIONERS**

Licensed independent practitioners include physicians, dentists, clinical psychologists, and podiatrists who provide medical care to patients, in accordance with state licensure laws, without supervision by a physician.

**2.24 MEDICAL EXECUTIVE COMMITTEE**

The Executive Committee of the Medical Staff with the responsibilities set forth in these Bylaws.

**2.25 MEDICAL DIRECTOR**

A Medical Staff physician member employed or otherwise serving SHC to provide medical direction in a specific clinical unit or function of SHC. Responsibilities may include both administrative and clinical duties.

**2.26 MEDICAL STAFF**

The formal organization of all licensed physicians, dentists, clinical psychologists, and podiatrists who may practice independently are granted recognition as members under the terms of these Bylaws.

**2.27 MEDICAL STAFF YEAR**

The period from September 1 through August 31.

**2.28 MEDICAL STUDENT**

A student currently enrolled in Stanford University School of Medicine in pursuit of a medical degree, or enrolled as a student in another accredited School of Medicine and doing an elective at SHC.

**2.29 ORGANIZED HEALTH CARE ARRANGEMENT (OHCA)**

A clinically integrated care setting in which individuals typically receive health care from more than one health care provider.

**2.30 PHYSICIAN**

An individual with an M.D. or D.O. degree who is licensed to practice in the State of California.

**2.31 PRACTITIONER**

Unless otherwise expressly limited, any physician, dentist, podiatrist, or clinical psychologist who is applying for Medical Staff membership and/or clinical privileges or who is a Medical Staff member and/or who exercises clinical privileges at SHC.

**2.32 PREROGATIVE**

The participatory rights granted, by virtue of Staff category or otherwise, to a Medical Staff member, which is exercisable subject to, and in accordance with, the conditions imposed by these Bylaws

**2.33 PROCTOR**

An Active member, in good standing, of the Medical Staff of SHC with privileges in the specialty area being proctored.

**2.34 PROTECTED HEALTH INFORMATION**

Any information, whether oral or recorded in any form or medium: a) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and b) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

**2.35 SHC POLICIES**

Policies concerning the operation of SHC adopted by the President and CEO, or Medical Executive Committee, and approved by the Stanford Board of Directors.

**2.36 STANFORD HEALTH CARE (SHC)**

The Hospital and Clinics.

**2.37 STANDING COMMITTEE OF THE MEDICAL EXECUTIVE COMMITTEE**

A duly authorized Committee of the Medical Staff reporting to the Medical Executive Committee.

**2.38 STANFORD HEALTH CARE BOARD**

The Board of Directors of Stanford Health Care, which serves as its governing body.

**2.39 VICE-CHIEF OF STAFF**

An elected physician officer of the Medical Staff who, upon completion of the two (2) year term of office, will succeed to the office of Chief of Staff.

**ARTICLE THREE:  
MEDICAL STAFF MEMBERSHIP AND CLASSIFICATION**

**3.1 MEMBERSHIP**

Membership on the Medical Staff will be extended to physicians, dentists, podiatrists, and clinical psychologists who continuously meet the requirements, qualifications, and responsibilities set forth in these Bylaws and who are appointed by the SHC Board of Directors. Membership on the Medical Staff or clinical privileges will not be granted or denied on the basis of race, religion, color, age, sex, national origin, ancestry, economic status, marital status, disability, or sexual orientation.

No physician, dentist, clinical psychologist, or podiatrist may admit or provide services to patients in the Hospital unless he/she is a member of the Medical Staff or has been granted temporary, disaster, or emergency privileges in accordance with the procedures set forth in these Bylaws.

Members of the Housestaff of SHC, or of any other hospital, and Fellows of the Stanford University School of Medicine, are not eligible for membership on the Medical Staff or for privileges in the area in which they are in clinical training, and must be under the supervision of the Chief of Service and the attending physician. A Chief of Service may request privileges for trainees of the Stanford University School of Medicine to perform clinical work in the medical discipline for which they have had previous training if the privilege requested is unrelated to the area of their current training. Such applicants must meet all requirements, qualifications, and responsibilities of the Medical Staff, and are subject to such policies as may be established by the Chief of Staff. Members of the Housestaff are expected to participate in the continuous quality improvement program of their department, and the Hospital, as outlined in the Housestaff Manual and the Supervision of Housestaff Policy. Housestaff appointments and job qualifications, including job descriptions, are maintained by the Office of Graduate Medical Education and their respective academic departments.

**3.2 EFFECT OF OTHER AFFILIATIONS**

No physician, dentist, clinical psychologist, or podiatrist will be automatically entitled to Medical Staff membership or to exercise any particular clinical privilege merely because he/she holds a certain degree; is licensed to practice in California or any other state; is a member of any professional organization; is certified by any clinical board; previously had membership or privileges at SHC; or had, or presently has, Staff membership or privileges at another health care facility. Medical Staff membership or clinical privileges will not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, IPA, PPO, PHO, hospital-sponsored foundation, or on a practitioner's opting in or out of Medicare and MediCal participation.

**3.3 CLASSIFICATION**

The categories of the Medical Staff include the following: Active, Courtesy Admitting, Courtesy Teaching, Affiliate, Administrative, Honorary, and Retired categories. Each time Medical Staff membership is granted or renewed, or at other times as deemed appropriate, the member's staff category will be determined by the Medical Executive Committee. For the purposes of the below qualifications, patient contact includes admissions, treatments, consults, teaching and supervision of physicians in training, outpatient clinic visits, and outpatient surgery and procedures.

## A. ACTIVE MEDICAL STAFF

### 1. Qualifications

The Active Staff consists of physicians, dentists, podiatrists, and clinical psychologists who:

- a. Meet the Membership Criteria set forth in Section 3.5;
- b. Are able to provide continuous care, treatment, and services to their patients in the Hospital and Clinics, as defined in the relevant Department's Policies and Rules and Regulations; and
- c. Regularly admit, or are otherwise regularly involved in the care of patients in this facility (a minimum of eleven [11] patient contacts per year) or are regularly involved in Medical Staff functions, as determined by the Medical Staff.

### 2. Prerogatives

The prerogatives of Active Staff members are to:

- a. Admit, treat, or perform services on Hospital and Clinic patients
- b. Exercise such clinical privileges as are granted to them pursuant to Article Five. Medical Staff members may admit patients to the Hospital. Non-physician members must exercise their privileges subject to a physician member having the responsibility for the basic medical appraisal of the limited license practitioner's patients, and for the care of any medical problem beyond the scope of the non-physician's license that may be present or may arise during hospitalization. Non-physician members may write orders to the extent allowed in the Rules and Regulations of the Medical Staff and their Service's requirements, but not beyond the scope of their license.
- c. Vote on all matters presented at general and special meetings of the Medical Staff or Clinical Service and matters of Medical Staff or Clinical Service committees of which they are a member, and in elections of Medical Staff officers (based on eligibility).
- d. Hold office in the Medical Staff organization and in the Service and committees of which they are a member.

### 3. Responsibilities

The responsibilities of the Active Staff members are to:

- a. Meet the basic responsibilities of Staff membership defined in Section 3.5.
- b. Satisfy the requirements of the Service of which he/she is a member.
- c. Actively participate in Staff committees, performance improvement functions, quality assurance and quality improvement activities, in supervising provisional appointees, in evaluating and monitoring Medical Staff members, and in discharging such other Staff functions as may from time to time be required. This participation is a duty derived from the privilege of Active Staff membership.

- d. Satisfy the requirements set forth in Article Twelve for attendance at meetings of the service and committees of which he/she is a member.
- e. Pay dues and fees as determined in accordance with Section 13.5.

4. Transfer of Active Staff member

After two (2) consecutive years in which a member of the Active Medical Staff fails to regularly care for patients in this hospital, or be regularly involved in Medical Staff functions as determined by the Medical Staff, that member will be automatically transferred to the appropriate category, if any, for which the member is qualified.

B. COURTESY STAFF

1. Qualifications

The Courtesy Admitting Staff consists of physicians, dentists, podiatrists, and clinical psychologists who:

- a. Meet the Membership Criteria set forth in Section 3.5 and in the Credentialing policies in regards to activity requirements;
- b. Are members in good standing and who are actively practicing at another facility in California
- c. Have a minimum of three (3) and maximum of ten (10) patient contacts per year at this facility.

2. Medical staff members who hold privileges for invasive procedures which may be performed under urgent or otherwise high-risk conditions (as determined by the Credentialing and Privileging Committee, with advice from the relevant service/division chief), DO NOT qualify for this category, unless they actively practice at Lucille Packard Children's Hospital (LPCH). Prerogatives

The Prerogatives of a Courtesy Admitting Staff member are to:

- a. Admit, treat, or perform services on Hospital patients.
- b. Exercise such clinical privileges as are granted to him/her pursuant to Article Five. Medical Staff members may admit patients to the Hospital. Limited license practitioner members must exercise their privileges subject to a physician member's having the responsibility for the basic medical appraisal of the non-physician's patients and for the care of any medical problem beyond the scope of the non-physician's license that may be present or may arise during hospitalization. Non-physician members may write orders to the extent allowed in the Rules and Regulations of the Medical Staff and their Service's requirements, but not beyond the scope of their license.
- c. Serve on Medical Staff Committees and may be given a vote on those committees. However, he/she may not be a candidate for any Medical Staff or Service elective positions (e.g. deputy chief, chief of staff, MEC member at large), nor may vote in elections for those positions.



3. Responsibilities

A member of the Courtesy Admitting Staff must:

- a. Meet the responsibilities of Medical Staff Membership contained in Section 3.5.
- b. Provide patient activity and quality review information from primary facility as requested at time of reappointment.
- c. Satisfy the requirements of the Service of which he/she is a member.
- d. Satisfy the requirements set forth in Article Twelve for attendance at meetings of the Service and committees of which he/she is a member.
- e. Participate as appropriate in Medical Staff committees, performance improvement functions, quality assurance and quality improvement activities, in supervising provisional appointees, in evaluating and monitoring Medical Staff members, and in discharging such other Staff functions as may from time to time be required. This participation is a duty derived from the privilege of Courtesy Staff (Admitting) membership.
- f. Pay dues and fees as determined in accordance with Section 13.5.

4. Limitation

Courtesy Admitting staff members who regularly admit or care for more than ten (10) patients per year at this facility will, upon review by the Medical Executive Committee, be obligated to seek appointment to the appropriate staff category

C. COURTESY TEACHING STAFF

1. Qualifications

The Courtesy Teaching Staff consists of physicians, dentists, podiatrists, clinical PhD pathologists, and clinical psychologists who:

- a. Meet the Membership Criteria set forth in Section 3.5.
- b. May hold a current teaching appointment (Faculty, Clinician Educator, or Adjunct Clinical Faculty) within the Stanford School of Medicine.  
Treat SHC patients only when incident to performing clinical teaching responsibilities
- c. Have at least eleven (11) patient contacts per year at SHC, or
- d. If less than eleven (11) contacts, are members in good standing and actively practicing at another facility in California, or
- e. If not meeting these activity requirements, provide a letter from their Service Chief attesting that he/she is confident in their clinical abilities and will provide whatever level of concurrent monitoring that he/she deems warranted to ensure high quality of care.

2. Prerogatives

The prerogatives of a Courtesy Teaching Staff member are:

- a. To treat patients at SHC only when acting as the teaching attending.
- b. To exercise such clinical privileges as are granted to them pursuant to Article Five.
- c. Courtesy Teaching Staff may not serve as a voting member of Medical Staff or Service committees and may not vote in elections or hold office in the Medical Staff or Clinical Service of which he/she is a member.

3. Responsibilities

The responsibilities of Courtesy Teaching Staff are to:

- a. Meet the basic responsibilities of Medical Staff membership defined in Section 3.5.
- b. Satisfy the requirements of the Service of which he/she is a member.
- c. Participate in Medical Staff or Clinical Service committees of which he/she is a member.
- d. Attend meetings of the Medical Staff or Clinical Service of which he/she is a member.
- e. Courtesy Teaching Staff will be exempt from paying Medical Staff dues but will pay credentialing fees in accordance with Section 13.5.B.

D. REFERRAL

1. Qualifications

The Referral Medical Staff consists of physicians, dentists, podiatrists, and clinical psychologists who:

- a. Meet the Membership Criteria set forth in Section 3.5
- b. Do not meet criteria for membership in other categories

2. Prerogatives

The prerogatives of the Referral Medical Staff are:

- a. To write orders and exercise related privileges for patients to receive therapeutic infusions at the Ambulatory Treatment Infusion Center.
- b. May not serve as a voting member of the Medical Staff or Service Committees and may not vote in elections or hold office in the Medical Staff

3. Responsibilities

- a. Meet the basic responsibilities of Medical Staff membership defined in Section 3.5
- b. Satisfy the requirements of the Service of which he/she is a member.
- c. May attend meetings of the Medical Staff
- d. Will be exempt from paying Medical Staff dues but will pay credentialing fees in accordance with section 13.5.B.

## E. LPCH STAFF

### 1. Qualifications

The LPCH Staff consists of those physicians who:

- a. Meet the membership criteria set forth in Section 3.5.
- b. Are members of the Active Medical Staff at LPCH
- c. Are called to SHC periodically to render care to patients treated at or admitted to this facility.

### 2. Prerogatives

- a. Treat and otherwise care for patients at this facility on request of the patient's attending physician.
- b. Exercise all clinical privileges held at LPCH, which privileges are automatically granted by a favorable determination regarding Staff membership in this category. Provisional Staff membership and proctoring may be waived for members in this category with respect to membership determination and all clinical privileges held at LPCH.
- c. Exercise such additional clinical privileges beyond the privileges held at LPCH as are granted through the standard clinical privilege approval process of this Medical Staff.

### 3. Responsibilities

- a. Satisfy the requirements of the Service of which he/she is a member.
- b. Are not required to meet the various attendance or activity requirements of these Bylaws, pay dues or pay application fees.
- c. May be appointed as voting members of Medical Staff committees, but may not otherwise vote on Medical Staff matters or hold office.

## F. AFFILIATE

The Affiliate Medical Staff consists of Medical Staff who do not have patient activity at Stanford Hospital, but who are providers under the Stanford managed care contracts or providers who work at University Health Care Alliance (UHA) and need to be credentialed and re-credentialed through SHC. This category also applies to faculty members who practice outside SHC (and so do not require privileges here) but who require credentialing to enable coverage by SUMIT malpractice insurance.

### 1. Qualifications

The qualifications of Affiliate Medical Staff member are to:

- a. Meet the Membership Criteria set forth in Section 3.5.
- b. Do not admit or treat patients in SHC, nor have ongoing admitting privileges.

- c. May hold a faculty appointment within the Stanford School of Medicine and/or be a member of the provider group under the Stanford managed care contracts or provide care at University HealthCare Alliance (UHA).

2. Prerogatives

The Prerogatives of an Affiliate member are:

- a. May not serve as a voting member of Medical Staff or Service committees.
- b. May attend meetings of the Medical Staff and his/her Service without vote.
- c. May not hold office within the Medical Staff or Service.

3. Responsibilities

- a. Meet the basic responsibilities of Medical Staff membership defined in Section 3.5.
- b. Satisfy the requirements of the Service of which he/she is a member.
- c. Are not required to meet the attendance requirements of Article Twelve.
- d. Are exempt from paying Medical Staff dues but are required to pay applicant fees.
- e. Must meet all requirements of Medical Staff contracts, if applicable.

G. ADMINISTRATIVE STAFF

Administrative staff category membership may be held by any physician who is not otherwise eligible for another staff category and who is retained by the hospital or medical staff solely to perform ongoing medical administrative activities.

The administrative staff consists of members who:

1. QUALIFICATIONS

- a. are charged with assisting the medical staff in carrying out medical-administrative functions, including but not limited to quality assessment and improvement and utilization review;
- b. document their (1) good judgment, and (2) current physical and mental health status, so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent to exercise their duties;
- c. are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect their judgment in carrying out the quality assessment and improvement functions, and (3) to be willing to participate in and properly discharge those responsibilities determined by the medical staff.
- d. hold a current valid CA medical License

## 2. PREROGATIVES

- a. The administrative staff are entitled to: Attend meetings of the medical staff and various departments, including open committee meetings and educational programs, but have no right to vote at such meetings, except to the extent the right to vote is specified at the time of appointment. Administrative staff members are not eligible to hold office in the medical staff organization, admit patients or exercise clinical privileges.

## H. HOUSESTAFF

A member of the Housestaff does not have independent privileges to admit or treat patients at SHC. The Housestaff are employees of SHC and their scope of practice is defined by the Graduate Medical Education Program. Specific policies and procedures governing the oversight of Housestaff within SHC are set forth in the Housestaff Policies and Procedures manual. Housestaff will act under the supervision and credentials of a Medical Staff member in accordance with all relevant Medical Staff and SHC policies. They are not subject to fees or dues. An official list of current Housestaff Members will be kept in the Office of Graduate Medical Education.

## I. FELLOW

A Fellow in an ACGME approved training program does not have independent privileges to admit or treat patients at SHC and is not eligible for Medical Staff membership and clinical privileges in the area of his/her Fellowship. The Fellows are employees of SHC or the Stanford School of Medicine and their scope of practice is defined by the Graduate Medical Education Program. Specific policies and procedures governing the oversight of Fellows within SHC are set forth in the Departmental Policies and Procedures. Fellows will act under the supervision and credentials of a Medical Staff member in accordance with all relevant Medical Staff and SHC policies. They are not subject to fees or dues. An official list of current Fellows will be kept in the Graduate Medical Education Office.

## J. HONORARY MEDICAL STAFF

The Honorary Medical Staff consists of those individuals who, in the judgment of the Chief of Staff and the Medical Executive Committee, are distinguished practitioners whose contributions to SHC or whose recognized professional eminence merit special recognition. A change of practitioner status to Honorary Medical Staff will be initiated by the Chief of Staff or the Medical Executive Committee.

Members of the Honorary Medical Staff are eligible to receive Medical Staff meeting notices and to attend Medical Staff and Service meetings. They do not have privileges to admit or treat patients in SHC, nor are they eligible to vote or hold office in this Medical Staff organization.

They are not required to pay Staff dues/fees or to attend meetings of the Medical Staff or their Service.

## K. RETIRED MEDICAL STAFF

Members of the Medical Staff of SHC who are in good standing in the category to which they are assigned, and who subsequently retire from practice may request a Retired Medical Staff category. Retired Staff category members are eligible to receive Medical Staff meeting notices and to attend Medical Staff and Service meetings. They do not have privileges to admit or treat patients in SHC, nor are they eligible to vote or hold office in this Medical Staff organization. They are not required to pay Staff dues/fees or to attend meetings of the Medical Staff or their Service.

## 3.4 PROVISIONAL STATUS

All initial Medical Staff appointees to the Active, Courtesy-Admitting or Courtesy-Teaching Staff, or appointees to the Active, Courtesy-Admitting or Courtesy-Teaching Staff after termination of a prior appointment, will be in provisional status until proctoring is complete. Active, Courtesy-Admitting or Courtesy-Teaching members in provisional status will be assigned to a Clinical Service in which their performance will be evaluated through proctoring to determine their eligibility for advancement to non-provisional status in the Active, Courtesy-Admitting or Courtesy-Teaching Staff. The requirements of this Section 3.4 will not apply to re-appointees when there has been no prior termination of appointment or to Affiliate-Managed Care, Honorary and Retired appointees.

### A. QUALIFICATIONS

Active, Courtesy-Admitting and Courtesy-Teaching Staff members in provisional status will consist of those physicians, dentists, clinical psychologists, and podiatrists who meet the Membership Criteria set forth in Section 3.5, but who have not completed the proctoring requirements set forth in Section D below, if applicable, and/or or have been in provisional status for less than twelve (12) months.

### B. TERM

Members will remain in provisional status until proctoring has been completed. The Medical Executive Committee will initiate action to terminate the membership and privileges of an Active, Courtesy-Admitting or Courtesy-Teaching member in provisional status who does not qualify for advancement to non-provisional status within twelve months. A member may immediately re-apply for privileges with a plan to meet the proctoring requirement. The Member will not be entitled to the procedures set forth in Article Seven if advancement was denied because of a failure to have a sufficient number of cases proctored, or because of a failure to maintain a satisfactory level of clinical activity. The Member will be entitled to the procedures set forth in Article Seven, if advancement was denied for a medical disciplinary cause or reason.

A service chief or credentials committee may adjust proctoring (FPPE) of an applicant, if the applicant is a recent (within two years) trainee of a Stanford University School of Medicine residency or fellowship, or has been a member of the Medical Staff within the

last two years. Any adjustments outside of that situation must be reviewed and approved by the MEC.

#### C. PREROGATIVES AND RESPONSIBILITIES

A Medical Staff member in provisional status will have all the prerogatives and responsibilities of the Active, Courtesy-Admitting or Courtesy-Teaching members, as appropriate, in non-provisional status.

#### D. PROCTORING (FPPE)

1. Each member in provisional status will complete such proctoring (Focused Professional Practice Evaluation – FPPE) as may be required by the Clinical Service. Proctoring will be completed in accordance with criteria set forth in the appropriate Clinical Service Rules and Regulations, and/or the Proctoring Guidelines, and may include direct observation of performance and/or chart review. Proctoring may be altered only if the applicant is a recent (within two years) trainee of a Stanford University School of Medicine residency or fellowship, or had been a member of the Medical Staff within the last two years. A Member in provisional status will remain subject to completion of proctoring. Documentation attesting to completion of proctoring will be signed by the proctor or Service Chief, along with an evaluation of performance, and a statement as to whether the Member meets all of the qualifications.

2. Medical Staff members who change Medical Staff classification to one of greater clinical responsibility, or who are granted additional privileges, must also complete a period of proctoring as assigned by the Service Chief and approved by the Credentials and Privileging Committee. Proctoring will be performed by a member in good standing of the Medical Staff of SHC, with privileges in the specialty area being proctored. Each Clinical Service will establish proctoring guidelines, a term of, and process for, proctoring. Proctoring Policy and guidelines are subject to approval by the Credentials and Privileging Committee.

If a sufficient amount of clinical activity has not occurred during the provisional period, proctoring may be extended beyond the provisional period upon formal request to, and approval by, the Service Chief and approval by the Credentials Committee.

If a sufficient amount of clinical activity has not occurred to evaluate a practitioner's ongoing professional competence, the Service Chief may impose proctoring with the concurrence of the Credentials Committee. Such proctoring will not entitle the practitioner to the procedures set forth in Article Seven.

If an initial appointee fails to provide the documentation required in Subsection D.1 above within the proctoring term, his/her Medical Staff membership or particular clinical privileges, as applicable, may be automatically suspended and/or terminated. If a Medical Staff member requesting additional privileges fails, within the proctoring term, to provide the documentation required in Subsection D.1 above, the additional privileges may be automatically suspended and/or terminated. In both cases noted above, the Credentials and Privileging

Committee could grant up to a 3 month extension. If privileges are terminated or suspended based on non-completion of proctoring requirements, it does not constitute an indication for a fair hearing addressed in Article Seven of the Fair Hearing Section of these Bylaws.

### 3.5 REQUIREMENTS FOR MEDICAL STAFF MEMBERSHIP

#### A. BASIC REQUIREMENTS

In order to obtain or maintain membership on the Medical Staff, or be granted clinical privileges, applicants must have and document:

1. Current, unrestricted certificate or license to practice medicine and surgery, dentistry, podiatry, or clinical psychology in the State of California (or a licensure exception allowed by a State of California Licensing Board).
2. Eligibility to participate in the Medicare, Medicaid and other federally sponsored health programs.
3. Applicants for clinical privileges at SHC must have in force professional liability insurance which covers all privileges requested. Medical Staff members must maintain medical liability insurance covering all privileges which they continue to hold. The Medical Executive Committee and the Board of Directors will jointly determine the minimum coverage amounts, if any, and also reserve the right to reject any particular insurance carrier solely at their joint discretion.
4. Maintenance of DEA certification. Psychologists are exempt; pathologists and non-interventional radiologists may also be exempted from this requirement if they provide an attestation confirming that they do not and will not prescribe any controlled substances.
5. Board Certification:
  - a. Applicants must be board certified (except as specified below) to hold privileges in a specialty or sub-specialty recognized by the American Board of Medical Specialties. (this does not include clinical psychologists) Osteopathic board certification meets this requirement, as do foreign certifications deemed acceptable by the Credentials and Privileging committee.
  - b. Board certification must be maintained in order to maintain corresponding privileges. . If an applicant loses board certification for any reason, that applicant may appeal to the Credentials and Privileging committee for an extension of privileges for a limited period of time while actively pursuing renewal of certification.
  - c. Applicants who are “actively participating” toward board certification (as defined by the relevant Board) may hold privileges for up to 5 years during that process.
  - d. Applicants who completed their relevant training before 2010, and hold privileges as of March 1, 2014, but are not board certified (or actively participating in the board certification process) are considered “grandfathered”. They will not have to become board certified to maintain their current privileges (unless specifically required for those privileges).



- i. Applicants who have allowed board certification in their area of privileges to lapse must re-gain board certification prior to re-credentialing, starting March 1, 2017.
- e. Applicants in divisions where there is a corresponding ABMS subspecialty Board will require a subspecialty certificate in that area for privileging. Any exceptions to this policy must be approved by the Credentialing and Privileging Committee.
- f. Applicants who hold multiple boards certifications must maintain certification in areas where they are privileged. For example, if they practice in a subspecialty only (e.g., cardiology but not general medicine), they need not maintain privileges in the primary specialty. However, if they practice in multiple specialties or subspecialties (e.g., a cardiologist who also has a general medicine clinic), they must maintain board certification in each of those areas.
- g. These minimum requirements do not preclude stricter requirements (e.g., no grandfathering allowed) for specified privileges at the discretion of the service/division chief and the Credentialing and Privileging Committee.
- h. Board certification is a complex process with multiple different boards and requirements. It is recognized that unanticipated situations may arise where specified requirements and deadlines are not fully appropriate. Any such cases will be adjudicated by the Credentials and Privileging Committee, with final approval from MEC for any suggested exceptions to these requirements.

A practitioner who does not meet these basic qualifications is ineligible to apply for Medical Staff membership, and the application will not be accepted for review, except that members of the Administrative, Honorary, and Retired Staff do not need to comply with the basic qualifications. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application will be discontinued. An applicant who does not meet the basic qualifications is not entitled to the procedural rights set forth in Article Seven, but may submit comments and a request for reconsideration of the specific qualifications that adversely affect such practitioner. The comments and request will be reviewed by the Medical Executive Committee and the Board of Directors, which will have the sole discretion whether to consider any changes in the basic qualifications or to grant a waiver pursuant to Section 3.9.

## B. GENERAL REQUIREMENTS

In order to obtain or maintain membership on the Medical Staff or be granted clinical privileges, applicants must have and document:

- 1. Current competence in their respective fields, ability to perform the clinical privileges requested, and adherence to standards of character and ethics established in their respective professions; including:
  - a. Areas of general competence:
    - Patient Care
    - Medical/Clinical Knowledge
    - Practice-Based Learning and Improvement
    - Interpersonal and Communication Skills

- Professionalism
  - Systems-Based Practice
- b. The ability to work cooperatively with others so as to not adversely affect the provision of care, treatment, and services.
  - c. Relevant training and/or experience.
  - d. Adequate physical and mental health, so as to demonstrate to the satisfaction of the Medical Executive Committee that they are competent to render to any patient, care of the generally recognized professional level of quality established by the Medical Executive Committee and the SHC Board of Directors.
2. Their ability to provide patients with continuous care that meets the professional standards established by the Medical Staff.
  3. Their promise to make appropriate arrangements for coverage of that member's patients as determined by the Medical Staff.
  4. Their promise to abide by all federal and State regulations with respect to professional billing practices; including not cooperating or participating in the division of any fee for professional services.
  5. Their promise to abide by the decisions of all duly-appointed Medical Staff committees and cooperate in safe patient care, treatment, and services and Medical Staff activities, including proctoring, performance improvement, utilization review, peer review, and attendance at Medical Staff and Clinical Service meetings
  6. Their promise to prepare and complete, in a timely, accurate and legible manner, the medical record and other required records for all patients the member in any way provides care to while at SHC. This includes assuring the completion and documentation of a physical examination and medical history on all patients within 24 hours of admission by a physician (as defined in Section 1861(r) of the Social Security Act (42 U.S.C. § 1395x(r)), an oromaxillofacial surgeon or other qualified individual in accordance with state law and hospital policy. . This requirement may be satisfied by a complete history and physical that has been performed within the 30 days prior to admission (the results of which are recorded in the hospital's medical record) so long as an examination for any changes in the patient's condition is completed and documented in the patient's medical record within 24 hours after admission. Additionally, the history and physical must be updated within 24 hours prior to any surgical procedure or other procedure requiring general anesthesia or moderate or deep sedation.
  7. Their promise to notify the Chief of Staff in writing immediately of any California Medical Board accusation, reprimand, change in primary or secondary medical license status, or other adverse action by any health care entity or law enforcement agency including any reprimands, change in primary or secondary medical license status, conviction of a misdemeanor or felony; the settlement or adverse judgment or verdict of any professional liability suit against the member; a voluntary or involuntary termination of Medical Staff membership or voluntary

or involuntary limitation or imposition of a monitoring requirement; reduction, loss or change of clinical privileges at another health care entity; contact by an investigator from a regulatory agency such as FDA, DEA, MBC, etc. regarding an investigation of the practitioner. Health care entity includes, but is not limited to, a State or federal licensing or certification agency, another hospital, health care organization, professional society, health maintenance organization, independent practice association, or medical group (see also Section 16.3.B.).

8. Their promise to notify the Chief of Staff in writing immediately of any change or termination of malpractice insurance coverage.
9. Their promise to provide to the Chief of Staff in writing immediately information as to details of any prior or pending government agency or third-party payor proceeding or litigation challenging or sanctioning applicant's patient admission, treatment, discharge, charging, collection, or utilization practices, including, but not limited to, Medicare and MediCal fraud and abuse proceedings and convictions.
10. Their promise to abide by the Medical Staff Bylaws, Rules and Regulations; the policies and requirements of the Clinical Service of which they are a member, the Bylaws of the Hospital, and other policies of the Medical Staff and SHC, including: policies regarding discrimination and harassment; the SHC Code of Conduct, the SHC Statement of Principles, and policies regarding the privacy, confidentiality and security of Protected Health Information.
11. Their promise to meet all educational requirements for membership such as Quality Assurance/Quality Improvement Training, training on computer systems, training on compliance standards such as HIPAA, and other training as required by the credentialing process or the Medical Executive Committee.
12. Their promise to fulfill necessary continuing education requirements for licensure.
13. Their promise to assist in any Medical Staff-approved teaching activities for medical students, interns, residents, fellows, nurses, Medical Staff members, and others as required by the Clinical Service of which they are a member.
14. Their promise to participate in emergency or other Clinical Service coverage as specified in the requirements of the Clinical Service of which they are a member, or any consultation panel responsibilities as may be determined by the Medical Executive Committee, Chief of Staff, or Service Chief.
15. Their promise to participate in quality assurance and quality improvement activities of the Medical Staff and the Clinical Service as assigned by the Service Chief and to hold knowledge of the content of these activities as strictly confidential. Appeals to the process can be made to the Credentials and Privileges Committee.
16. Their promise to notify the Chief of Staff in writing of any geographical relocation of practice or any limitation or cessation of professional practice of thirty (30) days or more in duration.

17. Their promise to notify the Chief of Staff in writing within thirty (30) days of any change in clinical privileges at other hospitals, whether voluntary or involuntary.
18. Maintenance of current licensure, DEA and Professional liability insurance (Pathologists and Psychologists are exempt).
19. Their promise to provide a valid business address and email address to the Medical Staff Office to be used for communication of Medical Staff business, and to notify the Medical Staff Office of any changes to the business or email address.

### **3.6 DURATION OF APPOINTMENT TO THE MEDICAL STAFF**

Appointments and reappointments to the Medical Staff will be for a period of not more than two (2) years. This provision does not apply to Honorary or Retired Staff members who have no patient care responsibilities or prerogatives, whose appointments will not expire.. This provision also does not apply to Administrative Staff members, however, Administrative Staff appointments will expire when his/her administrative role, for which he/she was retained, expires.

### **3.7 MODIFICATION OF MEMBERSHIP**

Upon recommendation of the Credentials Committee or Service Chief, pursuant to a request by the member, or upon the direction of the Board of Directors, the Medical Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of the Bylaws.

### **3.8 MEDICO-ADMINISTRATIVE APPOINTMENTS**

A practitioner who is appointed, employed, or under contract to perform administrative duties and who also renders clinical care (e.g., Chief of Service, Director of Laboratory, Medical Director), must meet the qualifications for Medical Staff membership and all necessary clinical privileges.

### **3.9 TERMINATION, SUSPENSION OR ADMINISTRATIVE LEAVE OF FACULTY APPOINTMENT**

Any Medical Staff member who has held Medical Staff membership while having a regular or full-time faculty appointment given by the Board of Trustees of Stanford University, or held Medical Staff membership solely on the basis of appointment to a Clinician Educator category by the Stanford University School of Medicine, will be deemed to have resigned from the Medical Staff upon relinquishment or termination of his/her faculty or Clinician Educator appointment, effective the last date of said appointment. If such individual wishes to retain his/her Medical Staff membership, he/she must so indicate in writing to Medical Staff Services prior to the termination date of the faculty or Clinician Educator appointment. The individual's current appointment will be maintained upon receipt of a letter from the Service Chief to the effect that the member was in good standing at the time of his/her faculty resignation or termination and there is no information that would indicate the former faculty member is not eligible for Medical Staff membership.

Similarly, during any period of suspension or administrative leave of a faculty/clinician educator's School of Medicine appointment, the member's medical staff membership will be deemed suspended as well, with the exception that medical staff membership and clinical privileges may be continued upon receipt of a letter from the Service Chief to the effect that the member remains

in good standing and there is no information that would indicate the suspended faculty member is not eligible for Medical Staff membership.

### **3.10 WAIVER OF QUALIFICATIONS**

Any qualification requirements in this Article or any other Article of these Bylaws not required by law or governmental regulation may be waived at the discretion of the SHC Board of Directors upon recommendation of the Medical Executive Committee, upon determination that such waiver will serve the best interests of the patients of SHC.

### **3.11 HARASSMENT PROHIBITED**

Harassment by a Medical Staff member against any individual (i.e., against another Medical Staff member, Housestaff, medical and/or graduate student, Hospital employee, patient, vendor or visitor) on the basis of race, religion, color, national origin, ancestry, age, disability, medical disability, marital status, sex or gender, or sexual orientation will not be tolerated.

“Harassment” is verbal or physical conduct that denigrates or shows hostility or aversion toward an individual because of his/her race, religion, color, national origin, ancestry, age, disability, medical disability, marital status, sex or gender, or sexual orientation or that of his/her relatives, friends, or associates, and that has the purpose or effect of (1) creating an intimidating, hostile, or offensive working environment, (2) unreasonably interfering with an individual's work performance, or that otherwise adversely affects an individual's employment opportunities. Harassing conduct includes (1) epithets, slurs, negative stereotyping, or threatening, intimidating or hostile acts that relate to race, religion, color, national origin, ancestry, age, disability, medical disability, marital status, sex or gender, or sexual orientation and (2) written or graphic material that denigrates or shows hostility or aversion toward an individual or group because of race, religion, color, national origin, ancestry, age, disability, medical disability, marital status, sex or gender, or sexual orientation and that is placed on walls, bulletin boards, or elsewhere on the employer's premises, or circulated in the workplace.

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

Sexual harassment includes unwelcome advances, requests for sexual favors or any other verbal, visual or physical conduct of a sexual nature when submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, benefits or other aspects of employment; training and education or training and educational opportunities; medical treatment; referrals; purchases; etc. It also includes such conduct when the conduct interferes with the individual's employment or education/training, or creates an intimidating, hostile or offensive work, education or treatment or education environment.

All allegations of harassment will be investigated by the Medical Staff and, if confirmed, will result in appropriate corrective action, including, but not limited to, reprimands, suspension, restriction or revocation of all or any part of Medical Staff membership and/or clinical privileges as outlined in Article Six.

**ARTICLE FOUR:  
APPOINTMENT, REAPPOINTMENT CREDENTIALING AND RECREDENTIALING TO THE MEDICAL  
STAFF**

The basic steps of the appointment, reappointment, credentialing and recredentialing processes are set forth in Sections 4.1 through 4.6 below.

**4.1 PROCEDURE FOR APPLICATION**

Every applicant for appointment or reappointment to the Medical Staff will:

- A. Be subject to the application and reappointment process set forth in the Credentialing Policy and Procedure Manual. Such policies and procedure will be reviewed and approved at the direction of the Medical Executive Committee.
- B. Submit a properly completed application, signed by the applicant, to the Chief of Staff, on the forms prescribed for the purpose by the Executive Committee; properly completed means that all provisions have been completed or an explanation provided of any that are not, and all required supporting documentation has been submitted.
- C. Acknowledge that he/she will notify the Chief of Staff of any changes in the information provided in the application during the application period or at any subsequent time.
- D. Submit with the application for initial appointment such written recommendations as are required by the Medical Executive Committee and stated on the application.
- E. Authorize the Hospital to carry out a background check.
- F. Authorize the Hospital to consult with members of the Medical Staffs of other hospitals with which the applicant has been associated and with others who may have information about the applicant's qualifications.
- G. Authorize the release of all records and documents that, in the judgment of the Chief of Staff, the Department Head, the Service Chief, the Credentials Committee, the Medical Executive Committee, or the Board of Directors, may be material to an evaluation of the applicant's qualifications.
- H. Submit information as to any action, including any past or pending investigation, which has been undertaken regarding the applicant's professional status or qualifications, including but not limited to, licensure, Staff membership and/or clinical privileges, professional organizations, and related matters.
- I. Submit information satisfactory to the Medical Executive Committee pertaining to the applicant's professional liability insurance coverage, including appropriate amounts and coverage for all privileges requested, and any claims, professional liability suits, judgments, settlements, or arbitration proceedings against him and the status of such matters.
- J. Submit any information regarding any past, present, or current exclusion from a federal healthcare program.

- K. Submit relevant information pertaining to the applicant's physical and mental health.
- L. Submit information pertaining to his/her voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges. A voluntary termination is considered a disciplinary action when the relinquishment is done to avoid an adverse action, preclude an investigation, or is done while the licensee is under investigation related to professional conduct.
- M. Acknowledge that he/she has received a copy (or has been given access to), and read the Medical Staff Bylaws and Rules and Regulations, and Clinical Service requirements, and that he/she agrees to be bound by the terms thereof, as they may be amended from time to time, if he/she is granted membership or clinical privileges, and to be bound by the terms thereof without regard to whether or not he/she is granted membership and/or clinical privileges in all matters relating to consideration of this application.
- N. Agree to appear for such interviews and provide such additional information as may be requested by the Chief of Staff, Service Chief, Division Head, Credentials Committee, Medical Executive Committee, or Board of Directors.
- O. Release from liability all representatives of the Hospital and the Medical Staff for their acts performed in good faith in evaluating the applicant's qualifications.
- P. Release from liability all individuals and organizations who in good faith provide information to the Hospital and its Medical Staff concerning the applicant, including otherwise privileged or confidential information.
- Q. Failure to pay credentialing fees for initial application or for reappointment application, as required under Section 13.5, will deem the application to be incomplete.
  - 1. For new applicants, application will be considered withdrawn and not processed.
  - 2. For reappointments, Medical Staff member will be processed as a voluntary resignation.

#### **4.2 APPLICANT'S BURDEN**

The applicant for appointment, reappointment, advancement or transfer, will have the burden of producing complete, accurate, and adequate information for a proper evaluation of his/her qualifications including all requirements specified in the Medical Staff Bylaws and Rules and Regulations, and the Rules and Regulations of the Department in which he/she is requesting membership, for resolving any doubts about these matters, and of providing any additional information requested by the Chief of Staff or Medical Staff Services. This burden may include submission to a medical, psychiatric, or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Executive Committee which may select the examining physician. The applicant's failure to sustain this burden and/or the provision of information containing any misrepresentations or omissions will be grounds for denial of the application or subsequent termination, suspension or limitation of membership or privileges under Article Six of these Bylaws. The Chief of Staff or Medical Staff Services will notify the applicant of any areas of incompleteness and/or failure of others to respond to such information collection or verification efforts within forty-five (45) days of receipt of the initial application, and it will then be the applicant's obligation to obtain all required information. Failure to complete the application and/or to submit any additional requested information within thirty (30) days of a request by the Chief of Staff or Medical Staff Services may, in the sole discretion of the Chief of Staff, be deemed a

voluntary withdrawal of the application and not subject to challenge under Article Seven of these Bylaws. If interim membership and clinical privileges were granted pending the completion of the application, they will be deemed expired at this time.

#### **4.3 CONSIDERATION OF APPLICATION**

- A. The procedure for consideration for appointment to the Medical Staff will be outlined in the Credentialing Policy and Procedure Manual.
- B. After an examination of the completed application, the report of the Chief of Service, and all supporting material, the Credentials Committee will transmit a written report to the Medical Executive Committee, along with supporting materials, which will indicate, on the basis of its evaluation of the applicant's competence, ability to perform the clinical privileges requested, character, health, and ethics, its recommendations and the reasons therefore, as to:
  - 1. Whether the applicant should be appointed to the Medical Staff.
  - 2. What specifically delineated clinical privileges should be granted to the applicant, and in which Clinical Service or Services.
- C. Upon receipt of the recommendations of the Credentials Committee, the Medical Executive Committee will review this information, conduct any further investigation regarding the applicant's character, competence, health, and ethics it deems appropriate, and:
  - 1. Provide the SHC Board of Directors with a recommendation that the applicant be appointed to the Medical Staff with the specific clinical privileges requested; or
  - 2. Provide the SHC Board of Directors with a recommendation that the applicant be appointed to the Medical Staff, but not with all of the specific clinical privileges requested; or
  - 3. Provide the SHC Board of Directors with a recommendation that the applicant will not be appointed to the Medical Staff.
- D. In the event that the Medical Executive Committee takes action C.2 or C.3 above, the applicant will be notified of the adverse recommendation and of his/her right to request a hearing under Article Seven. No final action will be taken by the SHC Board of Directors until the applicant has waived or exhausted his/her hearing rights.
- E. Upon receipt of the application, supporting information, and recommendation from the Medical Executive Committee, the SHC Board of Directors will act upon the application and will notify the applicant of its decision. The Board of Directors may either adopt the Medical Executive Committee's decision or refer the matter back to the Medical Executive Committee for further proceedings. If the decision of the Board of Directors is to appoint the applicant to the Medical Staff, the Board of Directors will approve the specific privileges to be granted the Medical Staff member. The Board of Directors must give great weight to the actions and recommendations of the Medical Executive Committee and may not act in an arbitrary and capricious manner. When the SHC Board of Directors has adopted the decision, it will be considered the final decision of the Hospital.



- F. All decisions by the SHC Board of Directors approving or disapproving the appointment or reappointment of an applicant will be forwarded in writing to the applicant with a copy to the Chief of Staff.
  
- G. The SHC Board of Directors may establish a committee, with a quorum of two, consisting of at least two physician members of the SHC Board of Directors, for the purpose of acting on its behalf on the credentials and privileges of practitioners as well as their reappointments to the Medical Staff of SHC between meetings of the SHC Board of Directors. This Committee will review all applications for appointment and reappointment to the Medical Staff including recommendations from Service Chiefs, Credentials Committee, and Medical Executive Committee, along with any relevant peer reference or quality review information. Any actions taken by this committee will be reported to, and confirmed by, the SHC Board of Directors at its next regular meeting.
  
- H. Should the SHC Board of Directors' preliminary decision be adverse to the applicant after either: (1) a favorable Medical Executive Committee recommendation; or (2) without benefit of a Medical Executive Committee recommendation in accordance with 4.3.G above, the applicant will be notified of the preliminary adverse decision and of his/her right to request a hearing under Article Seven. No final action will be taken by the SHC Board of Directors until after the applicant has waived or exhausted his/her hearing rights.
  
- I. Any time periods specified in this Section 4.3 are to assist those named in accomplishing their tasks and will not be deemed to create any right of the applicant to have his/her application processed within those periods.
  
- J. A Medical Staff member who has been the subject of an adverse decision denying an application, an adverse corrective action decision, or a resignation in lieu of a medical disciplinary action, will not be eligible to reapply for Medical Staff membership and/or clinical privileges affected by such action for a period of at least two (2) years from the date the adverse decision became final, the date the application or request was withdrawn, or the date the former Medical Staff member's resignation became effective, whichever is applicable.

#### **4.4 LEAVE OF ABSENCE**

- A. A Medical Staff member who wishes a leave of absence must, unless excused by the Chief of Staff for good cause, submit a written request for the leave to the Chief of Staff at least thirty (30) days prior to the commencement of leave. The Chief of Staff will determine, subject to the approval of the Medical Executive Committee, whether or not to grant the leave. A leave of absence may not be less than three (3) or more than twelve (12) consecutive months.

An approved leave is renewable once for a period not to exceed twenty-four (24) consecutive months from the initial date of the leave. Renewals will be processed following the same procedures as for an initial leave, except that the Member must request a renewal of the leave thirty (30) days prior to the end of the initial leave.

Failure, without good cause, to submit a timely request for a leave or renewal of leave to

the Chief of Staff will be deemed a voluntary resignation from the Medical Staff and the member will not, as a result, be entitled to the procedural rights of Article Seven.

If a leave of absence is granted or renewed, a written report stating the reasons for the leave or renewal will be forwarded to the Credentials Committee.

- B. While on an approved leave, a Medical Staff member will not have privileges to admit or treat patients, nor have any other of the prerogatives or responsibilities of Medical Staff membership, and will not be required to pay dues or fees.
- C. At least thirty (30) days prior to termination of leave, the member must submit a written request for the reinstatement of membership and clinical privileges to the Chief of Staff. At the request of the Chief of Staff, the member must submit a summary of relevant activities while on leave including, if requested, information relevant to current competency and health. Thereafter, the Chief of Staff, subject to the approval of the Medical Executive Committee and the Board of Directors, will make a recommendation regarding reinstatement of the member's privileges. A determination that a member be denied reinstatement will be considered a denial of privileges and may be appealed as such pursuant to Article Seven of these Bylaws.
- D. Failure to request reinstatement or submit a requested summary of activities will be deemed a voluntary resignation from the Medical Staff. In such a case, the procedural rights of Article Seven will apply solely for determining whether there was good cause to excuse the failure to request reinstatement or submit the requested summary of activities.
- E. Medical Leave of Absence  
The Medical Executive Committee will determine the circumstances under which a particular Medical Staff member will be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. In the discretion of the Medical Executive Committee, unless accompanied by a reportable restriction of privileges, the leave will be deemed a "medical leave" which is not granted for a medical disciplinary cause or reason.
- F. Military Leave of Absence  
Requests for leave of absence to fulfill military service obligations will be granted, upon notice and review by the Medical Executive Committee. Reactivation of membership and clinical privileges previously held will be granted, notwithstanding the provisions of Section 4.4, but may be granted subject to proctoring as determined by the Medical Executive Committee.

#### **4.5 REAPPOINTMENT TO THE MEDICAL STAFF**

- A. Reappointment to the Medical Staff must occur biennially. Staff members whose appointments are scheduled to expire will receive notification and will submit a completed and signed reapplication form, as well as all materials necessary to processing of the form as set forth in the Credentialing Policy and Procedure Manual.
- B. The reapplication will be processed in all respects in the same manner as applies under Sections 4.1 through 4.3 for applications for appointment to the Medical Staff, and the applicant will, in all respects, have the same rights and be subject to the same

requirements as apply under Sections 4.1 through 4.3 for applications for appointment to the Medical Staff. The Credentials Committee or Medical Executive Committee may require additional proctoring for any clinical privileges that are used so infrequently as to make it difficult or unreliable to assess current competency without additional proctoring, and such proctoring requirements imposed for lack of activity will not result in any hearing rights.

- C. The properly completed reapplication form and all necessary documentation will be forwarded to the Clinical Service for evaluation and recommendation as to whether or not the member should be reappointed to the Medical Staff and a recommendation on the specific clinical privileges requested. In making such recommendations, the Clinical Service will consider the member's clinical performance while a member of the Medical Staff including the results of quality assessment and peer review activities, and recommendations from the member's peers. The recommendations of the Clinical Service are forwarded to the Medical Executive Committee for review and recommendation to the Board of Directors.
- D. If a completed reappointment packet is not returned within the time period specified, the member will be processed as having voluntarily resigned effective on the date his/her appointment expires, except in the event of an ongoing formal review of the Medical Staff member's conduct, or unless otherwise extended by the Medical Executive Committee, subject to Board of Directors approval, and such other penalties as may be imposed by the Medical Executive Committee, subject to Board of Directors approval.
- E. A subsequent request for Medical Staff membership received from a member who has voluntarily resigned in this manner will be submitted and processed in accordance with the procedure specified for applications for initial appointments. The procedural rights set forth in Article Seven of the Medical Staff Bylaws do not apply to a voluntary resignation under this section.

#### **4.6 AUTHORITY FOR DOCUMENTATION AND VERIFICATION SERVICES**

The Credentials Committee and/or Medical Executive Committee and the SHC Board of Directors may designate a verification service to serve as a designee of the Medical Staff, the Chief of Staff, Medical Staff Services, the President and CEO and the SHC Board of Directors under this Article, to provide documentation and verification services with respect to applicants for appointment and reappointment. The documentation and verification services will be limited to collecting verified, objective data, and the Medical Staff and SHC Board of Directors remain responsible for evaluating and making recommendations with respect to applications for appointment and reappointment for membership and/or clinical privileges. By applying for membership and/or clinical privileges, each applicant for appointment or reappointment authorizes the Medical Staff, the Chief of Staff, Medical Staff Services, the President and CEO and/or SHC Board of Directors to use the services of a documentation and verification service for the limited purposed described in this Section.

## **ARTICLE FIVE: CLINICAL PRIVILEGES**

The basic steps for processing requests for privileges are described in Sections 5.1 through 5.12 below.

### **5.1 PRIVILEGES EXTENDED TO THE MEDICAL STAFF**

- A. Members of the Medical Staff are entitled to exercise only those delineated clinical privileges specifically granted to them by the Medical Executive Committee and the SHC Board of Directors in accordance with these Bylaws. All clinical privileges must be requested and processed pursuant to the procedures outlined in Article Five. A mechanism is in place that allows assessment of whether an individual with clinical privileges provides services within the scope of those privileges granted.
- B. Each Clinical Service must define the privileges delineation and criteria the Service will use for recommending privileges in the initial appointment, reappointment, and evaluation of Staff members. If privilege delineation is based primarily on experience, the individual's credentials record reflects the specific experience and successful results that form the basis for the granting of privileges.

### **5.2 PROVISIONAL CLINICAL PRIVILEGES**

- A. All clinical privileges initially granted to a member by the SHC Board of Directors are provisional and subject to the terms of Section 3.4 above.
- B. Each Department must define in the Rules and Regulations (or other appropriate document) of that Department the criteria used for recommending privileges in the initial appointment, reappointment, and evaluation of Staff members.

### **5.3 ADDITIONAL CLINICAL PRIVILEGES**

A member of the Medical Staff may apply for additional clinical privileges on a form prescribed for that purpose by the Medical Executive Committee. The application will, in all respects, be processed in the same manner as applies under Article Four to an application for appointment or reappointment to the Medical Staff, and the applicant will, in all respects, have the same rights and be subject to the same requirements as apply under Article Four to an application for appointment or reappointment to the Medical Staff.

### **5.4 BASES FOR PRIVILEGES DETERMINATION**

The Medical Staff will make an objective and evidence-based decision with regard to each request for clinical privileges. Requests for clinical privileges will be evaluated on the basis of the member's education, training, experience, current demonstrated professional competence and judgment, evidence of current proficiency in the Hospital's general competencies; applicant specific information regarding applicant's clinical performance at this Hospital and in other settings, comparisons made to aggregate information (when available) about performance, judgment and clinical or technical skills; morbidity and mortality data (when available); current

health status; the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate; performance of a sufficient number of procedures to develop and maintain the practitioner's skills and knowledge; and compliance with any specific criteria applicable to the privileges, included in-house training which may be required.

Requested privileges should be assessed individually to determine the Hospital's needs and ability to support the applicant with respect to the requested privileges, and the applicant's current proficiency with respect to the hospital's general competencies. Privilege determination may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges. The decision to grant or deny a privilege and/or to renew an existing privilege will also be based on peer recommendations which address the applicant's:

- Medical/clinical knowledge
- Technical and clinical skills
- Clinical judgment
- Interpersonal skills
- Communication skills
- Professionalism
- Health status

When available, relevant practitioner-specific data as compared to aggregate data and mortality and morbidity data will be considered.

## **5.5 "CROSS-SPECIALTY" PRIVILEGES WITHIN THE HOSPITAL**

Any request for clinical privileges that are either new to the Hospital, or that overlap more than one department, will initially be reviewed by the appropriate departments, in order to establish the need for, and appropriateness of, the new procedure or services. All such privileges will be processed in accordance with the Medical Staff policy on New Privileges.

## **5.6 TEMPORARY CLINICAL PRIVILEGES**

When appropriate, if the Medical Staff is in receipt of a complete application and after evaluation by the Credentials Committee or Credentials Sub-Committee, the Chief of Staff, as the designee of the President and CEO, may, with the evaluation and written approval of the appropriate Service Chief, and on the authority of the SHC Board of Directors, grant temporary privileges to a qualified practitioner under the circumstances stated below. Temporary Privileges for new applicants are granted for no more than 120 days. There is no right to temporary privileges. The Department Head/Service will assign proctors as appropriate.

### **A. WHILE AWAITING APPROVAL BY THE BOARD OF DIRECTORS**

Temporary privileges for new applicants may be granted while awaiting review and approval by the Medical Executive Committee and Board of Directors staff upon verification of the following:

- Current licensure.

- Relevant training or experience.
- Current competence.
- Ability to perform the privileges requested.
- Other criteria required by the organized medical staff bylaws.
- A query and evaluation of the National Practitioner Data Bank (NPDB) and the Medical Board of California information as well as information for other state medical boards.
- A complete application.
- No current or previously successful challenge to licensure or registration.
- No subjection to involuntary termination of medical staff membership at another organization.
- No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges.
- Any other hospital requirements set forth in these bylaws or credentialing policies.

B. IMPORTANT PATIENT CARE NEED as defined by the Chief of Staff or designee.

C. VISITING TEMPORARY PRIVILEGES

Upon receipt of a written application for specific temporary privileges, an individual otherwise eligible for Medical Staff privileges, but who is not an applicant for membership, may be granted temporary privileges for the care of one or more specific patients. Such privileges will be restricted to the treatment of not more than three (3) patients in any one year by any such individual, except that individuals from out of state granted temporary consulting privileges within the limitations of California Business and Professions Code Section 2060 are not subject to this limitation. Such privileges are subject to the requirements set forth in the Credentialing Policy and Procedure Manual.

D. LOCUM TENENS

Upon receipt of a written application for specific temporary privileges, a practitioner of documented competence who is serving as a locum tenens for a Medical Staff member, and who is a member of the Medical Staff in good standing of another Joint Commission accredited California licensed health care entity, may, without applying for membership on the Staff, be granted temporary privileges for an initial period of up to ninety (90) days, not to exceed two (2) such occurrences per calendar year. Such privileges may be renewed for one successive period of up to ninety (90) days in one calendar year but not to exceed his/her services as locum tenens, and will be limited to treatment of the patients of the practitioner or practitioner group for whom he/she is serving as locum tenens. Practitioners requesting such privileges are responsible for the payment of processing fees as outlined in Section 13.5.B. He/she will not be entitled to admit his/her own patients to the Hospital.

E. CONDITIONS

Temporary privileges may be granted only when the practitioner has submitted a written request for temporary privileges and the information available reasonably supports a favorable determination regarding the requesting practitioner's licensure, qualifications, ability, and judgment to exercise the privileges requested, and only after the practitioner has satisfied the requirement of Section 3.5.A. regarding professional liability insurance.

The Chief of the Service to which the practitioner is assigned will be responsible for monitoring the performance of the practitioner granted temporary privileges, or for designating a Service member who will assume this responsibility. Special requirements of consultation and reporting may be imposed by that Chief. Before temporary privileges are granted, the practitioner must acknowledge in writing that he/she has received, or has been given access to, and read the Medical Staff Bylaws and Rules and Regulations and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary privileges. Under circumstances necessitating important patient care, the requirement for written request of temporary privileges may be waived by the Chief of Staff.

## **5.8 DENIAL OR TERMINATION OF INTERIM/TEMPORARY PRIVILEGES**

On the discovery of any information or the occurrence of any event of a nature which raises a question about a practitioner's professional qualifications, ability to exercise any interim or temporary privileges granted, or compliance with these Bylaws, Rules and Regulations, requirements of the Clinical Services, or other requirements, the Chief of Staff may, after consultation with the Chief of Service, deny or terminate any or all of such individual's interim or temporary privileges and or membership. The denial or termination of interim or temporary privileges will not be reviewable according to the procedures set forth in Article Seven of the Medical Staff Bylaws unless required to be reported pursuant to California Business and Professions Code section 805. In the event of any such denial or termination, the practitioner's patients in the Hospital will be assigned to another practitioner by the Chief of Service. The wishes of the patient will be considered, when feasible, in choosing a substitute practitioner. An applicant whose interim appointment and interim clinical privileges were terminated for administrative purposes, e.g., failure to pay fees, will remain eligible to apply for Medical Staff membership and clinical privileges.

## **5.9 EMERGENCY CLINICAL PRIVILEGES**

### **A. PATIENT EMERGENCY**

For the purposes of this Section, an "emergency" is defined as a condition in which a patient is in imminent danger of serious or permanent harm or death and any delay in administering treatment would add to that danger. In the case of an emergency, any practitioner, to the degree permitted by his/her license and regardless of Clinical Service, Medical Staff status, or clinical privileges, will be permitted to do, and will be assisted by SHC personnel in doing everything possible to save a patient from such danger. When the emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient.

### **B. EMERGENCY MANAGEMENT PLAN**

Emergency privileges of licensed independent practitioners may be granted when the Hospital's Emergency Management Plan is activated and the organization is unable to handle immediate patient needs. The Chief Executive Officer or designee may grant emergency temporary privileges to a physician based upon presentation of appropriate identification and licensure as outlined in hospital policy. Formal verification of credentials and privileges will begin as soon as the immediate emergency situation is under control.

## **5.10 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS**

### **A. ADMISSIONS**

1. Limited License Practitioners [Dentist (DDS), non-MD oral surgeon (DMD), clinical psychologists (PhD), and podiatrist (DPM)] members of the Medical Staff may only admit patients if a physician member assumes 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 limited license practitioner's lawful scope of practice.
2. When evidence of appropriate training and experience is documented, a limited license practitioner may perform the history or physical on his/her own patient. Otherwise a physician member must conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry or podiatry).

### **B. SURGERY**

Surgical procedures performed by dentists, non-MD oral surgeons and podiatrists will be under the overall supervision of the Chief of the designated Service or his/her designee.

### **C. MEDICAL APPRAISAL**

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

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

On its own, upon recommendation of the Credentials Committee, or pursuant to a request from the practitioner, the Medical Executive Committee may recommend a change in the clinical privileges or department assignment(s) of a member. The Medical Executive Committee may also recommend that the granting of additional privileges to a current Medical Staff member be made subject to proctoring in accordance with procedures outlined in Section 3.4.D.

## **5.12 LAPSE OF APPLICATION**

If a Medical Staff member requesting a modification of clinical privileges or department assignment fails to timely furnish the information necessary to evaluate the request, the



application will automatically lapse, and the applicant will not be entitled to a hearing as set forth in Article Seven.

**5.13 DISSEMINATION OF PRIVILEGES LIST**

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

**ARTICLE SIX:  
REVIEW OF MEDICAL STAFF MEMBER CONDUCT**

**6.1 BASIS FOR REVIEW**

The procedures provided in this Article will be invoked whenever it appears that the activities or professional conduct of any member of the Medical Staff:

- A. Jeopardizes or may jeopardize the safety, best interests, quality of care, treatment, or services of a patient, or the safety or best interests of a visitor, or employee;
- B. Presents a question regarding the competence, character, judgment, ethics, stability of personality, including the ability to work cooperatively with others in the provision of safe patient care, treatment, and services, adequate physical and mental health, moral character, or qualification of the member; or
- C. Violates these Medical Staff Bylaws, Rules and Regulations, the requirements of the Clinical Services, or SHC policies, including Code of Conduct, or constitutes conduct that is, or is reasonably probable of being, disruptive to SHC operations

**6.2 INITIATION**

A request for an investigation of the conduct of a member of the Medical Staff raising a question under Section 6.1 above must be in writing, submitted to the Chief of Staff, and supported by reference to specific activities or conduct alleged. The Chief of Staff will apprise the Medical Executive Committee of the request for investigation. After discussion of the request for an investigation, the Medical Executive Committee will determine whether an investigation is warranted and will notify the affected member of the Medical Staff of their decision in writing. If the Medical Executive Committee was the source of the request for an investigation, it will make an appropriate record of the reasons.

**6.3 INVESTIGATION**

On recommendation of the Chief of Staff, the Medical Executive Committee may conduct any investigation it deems necessary or may assign this task to an appropriately charged officer or to an ad hoc committee of at least three (3) members of the Medical staff appointed by the Chief of Staff and approved by the Medical Executive Committee. Should the member believe anyone on the investigating body is biased and should not participate in the investigation, he/she may notify the Chief of Staff, who will determine, in his/her sole discretion, whether that person should be excused from the investigation. The investigative process will not be deemed to be a "hearing" as that term is used in Article Seven. If the responsibility for investigation is delegated by the Medical Executive Committee, the responsible investigator(s) will report to the Medical Executive Committee as soon as practical. The term investigation does not apply to the usual activities of the Well-Being of Physicians and Physicians-in Training-Committee.

Early in any investigatory process, the Medical Staff member will be afforded the opportunity to meet informally with the charged officer, committee, or Chief of Service conducting the investigation. If, in the Medical Executive Committee's view, more than sixty (60) days is needed

for investigation, the Medical Executive Committee will advise the affected Medical Staff member and specify an appropriate time for completion of the investigation.

#### **6.4 MEDICAL EXECUTIVE COMMITTEE ACTION**

The Medical Executive Committee will act as soon as is practical after the conclusion of any investigation. Action taken by the Medical Executive Committee following the conclusion of any investigation may include, but is not limited to, the following actions:

- A. No corrective action.
- B. Proposed corrective action:
  - 1. Letter of admonition, reprimand or warning;
  - 2. Terms of probation including monitoring requirements or specific individual requirements of consultation;
  - 3. Reduction or revocation of clinical privileges;
  - 4. Suspension of clinical privileges until completion of specific conditions or requirements;
  - 5. Limitation of prerogatives related to the practitioner's delivery of safe patient care, treatment, and services;
  - 6. Suspension of Medical Staff membership for a specific period of time or without limit of time;
  - 7. Revocation of Medical Staff membership; or
  - 8. Other actions appropriate to the facts which prompted the investigation

Regardless of the status of any investigation, the MEC is authorized to take and implement any action required by the circumstances, including summary suspension or restriction of privileges at any time, in the exercise of its discretion pursuant to Section 6.6 below.

Unless the action of the Medical Executive Committee constitutes grounds for a hearing as defined in Article 7.2, the action will become effective upon the decision of the Medical Executive Committee.

#### **6.5 BOARD INITIATED ACTION**

Any recommendation by the Medical Executive Committee or the Board of Directors pursuant to Section 6.4 which constitutes grounds for a hearing as set forth in Section 7.2 will entitle the Medical Staff member to the rights specified in Article Seven. In such cases, the Chief of Staff will give the Medical Staff member written notice of the recommendation, the reasons for the proposed action, and of his/her right to request a hearing pursuant to the requirements in Section 7.3.A. A copy of the Bylaws detailing the hearing rights of the Staff member will also be provided to the affected Staff member.

If the Medical Executive Committee fails to investigate or initiate corrective action and the SHC Board of Directors determines that its failure to do so is contrary to the weight of the evidence then available, the SHC Board of Directors may, after consulting with the Medical Executive Committee, direct the Medical Executive Committee to investigate or initiate corrective action. The Medical Executive Committee will inform the Board of Directors of its action in response to such a directive. If the Medical Executive Committee fails to act after a directive from the SHC Board of Directors, the SHC Board of Directors may, in accordance with these Bylaws, after written notice to the Medical Executive Committee, take action directly against a Medical Staff member. The Board of Directors will inform the Medical Executive Committee in writing of what it has done.

## **6.6 SUMMARY SUSPENSION**

### **A. CRITERIA FOR INITIATION**

The Chief of Staff, the Vice Chief of Staff when acting for the Chief of staff, Medical Executive Committee, or the Chief of Service of which the affected Medical Staff member is a member, is empowered to restrict or suspend summarily without benefit of a hearing or personal appearance any or all privileges of a member of the Medical Staff if there is cause to believe that the Medical Staff member's conduct requires that immediate action be taken to protect the life of any patient or to reduce the likelihood of imminent danger to the health or safety of any individual. If the persons or body designated above fail, under the foregoing circumstances, to restrict or suspend a Medical Staff member's membership, or all or any portion of his/her clinical privileges, the SHC Board of Directors, or its designee, may, when necessary to protect the life of any patient or to reduce the likelihood of imminent danger to the health or safety of any individual, after reasonable attempts to contact the Medical Executive Committee, summarily restrict or suspend the Medical Staff member's membership or all or any portion of his/her clinical privileges. A summary restriction or suspension will be effective immediately upon imposition, provided, however, that a summary restriction or suspension imposed by the SHC Board of Directors, or its designee, must be ratified by the Medical Executive Committee within two (2) working days of its imposition, excluding weekends and holidays, or it will terminate automatically.

The person or body responsible for imposing a summary restriction or suspension will promptly give oral and written notice thereof to the Medical Staff member, Chief of Staff, President and CEO, as well as the SHC Board of Directors and Medical Executive Committee at their next meetings. The notice of the restriction or suspension given to the Medical Executive Committee will constitute a request for corrective action and the procedures set forth in Section 7.1 will be followed and documented in the Medical Staff member's credentialing and privileging file. In the event of any such restriction or suspension, the Medical Staff member's patients whose treatment by such member is terminated by the summary restriction or suspension will be assigned to another Medical Staff member by the Chief of Staff. The wishes of the patient will be considered, when feasible, in choosing the substitute Staff member.

### **B. MEDICAL EXECUTIVE COMMITTEE ACTION**

After imposition of a summary restriction or suspension the affected member of the Medical Staff may request an interview with an ad hoc panel authorized to represent the Medical Executive Committee. The panel will be selected by the Chief of Staff and will

not include the person, in the case of a restriction or suspension imposed by an individual, who imposed the summary restriction or suspension. Any such interview will not be deemed a "hearing" as that term is used in Article Seven. The interview will be convened as soon as reasonably possible under all of the circumstances. The ad hoc panel may thereafter modify, continue without limit of time, or terminate the terms of the summary restriction or suspension. The panel will give the Medical Staff member written notice of its recommendation and the reasons therefore with a copy to the Chief of Staff and Medical Executive Committee.

C. PROCEDURAL RIGHTS

Unless the ad hoc panel of the Medical Executive Committee terminates the restriction or suspension, it will remain in effect during the pendency of and the completion of the review process and of the hearing if a hearing is requested pursuant to 7.2 and pending any appeal to the SHC Board of Directors, unless the summary restriction or suspension is terminated by the Judicial Review Committee (see Section 7.3.B). The Medical Staff member will not be entitled to the procedural rights afforded by Article Seven until such time as action has been taken under Sections 6.1 through 6.5, and then only if the action constitutes grounds for a hearing as set forth in Section 7.2.

**6.7 AUTOMATIC SUSPENSION**

The following will result in automatic suspension or revocation of Medical Staff membership and/or clinical privileges and will not, unless otherwise expressly provided or required by law, entitle the affected Medical Staff member to the rights provided for in Article Seven of these Bylaws, or to any other procedural rights.

A. LICENSE

Whenever a Medical Staff member's license authorizing him/her to practice in this State is revoked, stayed, restricted, suspended, or the Medical Staff member is placed on probation by the State, the action and its terms will automatically apply to his/her SHC Medical Staff membership and/or privileges as appropriate. Whenever a Medical Staff member's license expires, he/she will be automatically suspended from practice until there is evidence of a licensure renewal. Medical Staff members so affected will not be entitled to the procedural rights afforded by Article Seven regarding such automatic action.

B. MEDICARE, MEDICAID SANCTIONS

Whenever a Medical Staff member has been involuntarily excluded from participation in the Medicare, Medicaid and other federally funded healthcare programs, he/she will be automatically suspended from practice until the member has provided evidence that the exclusion has been removed.

C. DRUG ENFORCEMENT ADMINISTRATION CERTIFICATE

Whenever a Medical Staff member's DEA certificate is revoked, suspended, stayed, restricted, or subject to probation, the action and its terms will automatically apply to his/her right to prescribe, dispense, or administer medications covered by the certificate.

Whenever a Medical Staff member's DEA certificate expires, the member's right to prescribe, dispense, or administer medications covered by the certificate will be automatically suspended until there is evidence of a certificate renewal. There will be no right to the hearing procedures afforded by Article Seven based upon such automatic action.

D. MEDICAL EXECUTIVE COMMITTEE DELIBERATION ON MATTERS INVOLVING LICENSE AND DRUG ENFORCEMENT ADMINISTRATION

As soon as practical after action is taken as described in Section 6.7.A, or in Section 6.7.C, the Medical Executive Committee will review and consider the facts upon which such action was predicated. The Medical Executive Committee may then recommend such further corrective action as may be appropriate based upon information disclosed or otherwise made available to it and/or it may direct that an investigation be undertaken pursuant to Sections 6.2 and 6.3 as appropriate.

E. MEDICAL RECORDS

For failure to comply with the Medical Record Regulations and Policies established by the Medical Staff Rules and Regulations or SHC Policies, a Medical Staff member's privileges to admit patients and to schedule procedures (except with respect to his/her patients already admitted to the Hospital) will be automatically suspended upon the expiration of seven (7) days after he/she is given written notice and will remain so suspended until all delinquent medical records are completed. A failure to complete the medical records within four (4) months after the date a suspension became effective pursuant to this Section will be deemed a voluntary resignation from the Medical Staff.

F. PROFESSIONAL LIABILITY

For failure to maintain the amount of professional liability insurance, or its equivalent, if any, required under Section 16.3.A, a practitioner's membership and clinical privileges will be automatically suspended and will remain suspended until the practitioner provides evidence to the Medical Executive Committee that he/she has secured professional liability coverage in the amount required under Section 16.3.A. A failure to provide such evidence within six (6) months after the date the automatic suspension became effective, will be deemed to be a voluntary resignation of the practitioner's Medical Staff membership. Medical Staff members on leave of absence are not subject to automatic suspension for failure to provide evidence of professional liability insurance.

G. FAILURE TO PAY DUES

For failure to pay any dues as required under Section 13.5, a Medical Staff member's Medical Staff membership and clinical privileges, after two written warnings of delinquency, spaced thirty (30) days apart, will be automatically suspended and will remain suspended until the Medical Staff member pays the delinquent dues. Failure to pay within sixty (60) days after the date of the automatic suspension will be deemed a voluntary resignation from the Medical Staff.

H. PROCEDURAL RIGHTS – MEDICAL RECORDS AND FAILURE TO PAY DUES AND/OR FEES

Medical Staff members whose clinical privileges are automatically suspended and/or who have resigned their Medical Staff membership pursuant to the provisions of 6.7.E (failure to comply with medical records), or 6.7.F (failure to pay dues and/or fees) will not be entitled to the procedural rights set forth in Article Seven, unless otherwise expressly provided.

I. CONVICTION OF A FELONY

If any member of the Medical Staff is convicted of a felony, his/her Medical Staff membership and privileges will be immediately and automatically terminated

J. NOTICE OF AUTOMATIC SUSPENSION/TERMINATION; TRANSFER OF PATIENTS

Whenever a Medical Staff member's privileges are automatically suspended/terminated in whole or in part, notice of such suspension/termination will be given by the Chief of Staff to the Medical Staff member, Chief of Service, as well as the SHC Board of Directors and the Medical Executive Committee at their next meetings. Giving of such notice will not, however, be required in order for the automatic suspension/termination to become effective. In the event of any such suspension/termination, the Medical Staff member's patients will be assigned to another Medical Staff member by the Chief of Staff. The wishes of the patient will be considered, when feasible, in choosing a substitute Staff member.

K. INCOMPLETE PROCTORING

Failure to comply with Medical Staff Proctoring Policy and Proctoring Guidelines in the required timeframe.

L. NON-COMPLIANCE WITH MEDICAL STAFF POLICIES

Failure to comply with Medical Staff policies.

**ARTICLE SEVEN:  
HEARINGS AND APPELLATE REVIEWS**

**7.1 PREAMBLE AND APPELLATE REVIEWS**

**A. INTRA-ORGANIZATIONAL REMEDIES**

The procedures provided for in this Article Seven are strictly quasi-judicial in nature and will not be utilized to hold notice and comment type hearings or to make legislative determinations, or determinations as to the substantive validity of Bylaws, Rules and Regulations. When a substantive validity question is the sole issue, the petitioner will be permitted a direct appeal and appearance in an executive session (voting members only) of the Medical Executive Committee. Only after the Medical Executive Committee has denied said appeal may the petitioner appeal directly to the SHC Board of Directors. Such appearance will not be considered a "hearing" under this Article and will be conducted in accordance with guidelines established by the SHC Board of Directors. A final determination by the SHC Board of Directors after such appeal will be a condition precedent to the petitioner's right to seek judicial review in a court of law.

**B. EXHAUSTION OF REMEDIES**

If an adverse ruling is made with respect to a Medical Staff member's membership, Staff status, or clinical privileges at any time, regardless of whether he/she is an applicant or a Medical Staff member, he/she must exhaust the remedies afforded by these Bylaws before resorting to formal legal action challenging the decision, the procedures used to arrive at it, or asserting any claim against SHC, or participants in the decision process; and the exclusive procedure for obtaining judicial review will be by Petition for Writ of Mandate pursuant to Part 3, Title 1, Chapter 2 of the California Code of Civil Procedure.

**C. DEFINITIONS**

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

1. "Notice" refers to a written communication delivered personally to the required addressee or sent by United States Postal Service, pursuant to Section 16.2, addressed to the required addressee at his/her address as it appears in the records of Medical Staff Services;
2. "Petitioner" refers to the Medical Staff member or applicant who has requested a hearing or appearance pursuant to Section 7.3 or 7.1.A; and
3. "Date of Receipt" of any notice or other communication will be deemed to be the date such notice or communication was delivered personally or electronically to the required addressee or, if delivered by mail, such notice or communication will be deemed received seventy-two (72) hours after being deposited, postage prepaid, in the United States mail.



## **7.2 GROUNDS FOR HEARING**

Any one or more of the following actions or recommended actions constitute grounds for a hearing unless otherwise specified in these Bylaws:

- A. Denial of Medical Staff membership.
- B. Denial of requested advancement in Medical Staff membership status.
- C. Denial of Medical Staff appointment.
- D. Demotion to lower Medical Staff category or membership status.
- E. Summary restriction or suspension of Medical Staff membership during the pendency of corrective action and hearing and appeals procedures.
- F. Expulsion from Medical Staff Membership
- G. Denial of requested privileges
- H. Reduction in privileges
- I. Summary restriction or suspension of Medical Staff membership and/or privileges during the pendency of corrective action and hearing and appeals procedures.
- J. Termination of privileges
- K. Requirement of consultation or proctoring when the reviewing physician has the authority to supervise, direct, or transfer care from the physician being monitored.
- L. Any other action which requires filing a report pursuant to California Business & Professions Code, Section 805, and with the National Practitioner Data Bank.

Recommendations of any of these actions constitute an “adverse recommendation” for the purposes of these Bylaws.

## **7.3 REQUESTS FOR HEARING**

### **A. NOTICE OF ACTION OR PROPOSED ACTION**

In all cases in which the Medical Executive Committee or authorized officer has, under these Bylaws, recommended or taken any of the actions constituting grounds for hearing as set forth in Section 7.2, the Medical Executive Committee or officer will give the affected Medical Staff member notice of the decision and of his/her right to request a hearing pursuant to Section 7.3.B, below.

B. REQUEST OF HEARING

The petitioner will have thirty (30) days following the date of receipt of notice to request a hearing by a Judicial Review Committee. The request will be sent to the Chief of Staff. If the petitioner does not request a hearing within thirty (30) days, he/she will be deemed to have waived his/her right to a hearing and accepted the decision. It will thereupon become the final action of the Medical Executive Committee and will be forwarded to the SHC Board of Directors

C. TIME AND PLACE FOR HEARING

The Chief of Staff will confirm a date for a hearing. Notice will be given to the petitioner of the time, place, and date of the hearing. The date of commencement of the hearing will not be more than ninety (90) days from the date of receipt of the request unless further delay is agreed upon by both the practitioner and the Medical Executive Committee; provided that a hearing for a practitioner under suspension will commence as soon as arrangements may reasonably be made.

D. NOTICE OF CHARGES

The Chief of Staff will advise the petitioner in writing of the acts or omissions with which the petitioner is charged including, if applicable, a list of the medical records or charts being questioned. The Chief of Staff and the petitioner will provide each other with a list of witnesses expected at that time to testify at the hearing. The Chief of Staff and the petitioner will notify each other of additions to the list. Witness lists must be exchanged at least ten (10) days prior to commencement of the hearing.

E. JUDICIAL REVIEW COMMITTEE

The Chief of Staff will select a Judicial Review Committee consisting of at least three (3) Medical Staff members, including one member who is a physician from the same specialty as the petitioner, with alternates as appropriate. The members selected to serve on the Judicial Review Committee will be impartial and will not have actively participated in the formal consideration of the matter at any previous level

F. FAILURE TO APPEAR

Failure of the petitioner to appear without good cause and proceed at a hearing will be deemed to constitute voluntary acceptance of the actions involved and waiver to any hearing rights, and it will thereupon become the final recommendation of the Medical Executive Committee. Such final recommendation will be subject on that basis alone to review and decision by the SHC Board of Directors.

G. POSTPONEMENTS AND EXTENSIONS

Postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by any affected person and will be permitted by the hearing officer, or the Chief of Staff before appointment of a hearing officer, on a showing of good cause.

## 7.4 HEARING PROCEDURE

### A. PRE-HEARING PROCEDURE

It will be the duty of the petitioner and the Medical Executive Committee to raise any procedural objections before the hearing so that decisions concerning such matters may be made expeditiously. Any such objections, when raised, will be preserved for consideration at any appellate review hearing which may subsequently be requested.

### B. THE HEARING OFFICER

The Chief of Staff will appoint an unbiased hearing officer to preside at the hearing. The hearing officer will be an attorney-at-law qualified to preside over a quasi-judicial hearing and, preferably, have experience in Medical Staff matters. The hearing officer will have the authority to (1) rule on questions of procedure; (2) rule on the admission and exclusion of evidence; (3) participate in the deliberations of the Judicial Review Committee but may not vote; (4) draft the findings and recommendations of the Judicial Review Committee as requested by the Committee; and (5) advise the Judicial Review Committee generally on the discharge of its functions.

### C. RECORD AND CONDUCT OF THE HEARING

The Judicial Review Committee will maintain a record of the hearing by a certified shorthand reporter. The cost of attendance of the shorthand reporter will be borne by the Hospital, but the cost of the transcript if any will be borne by the party requesting it. The hearing need not be conducted by technical rules of law relating to examination of witnesses or production of evidence except that irrelevant or unduly repetitious evidence will be excluded.

### D. RIGHTS OF THE PARTIES

At a hearing both sides have the right to representation by counsel or other person. If either the petitioner or the Medical Executive Committee elects not to be represented by counsel, this fact will be noted in the record by the hearing officer. Both sides may ask the Judicial Review Committee members questions relating to determining and to challenge for bias, call and examine witnesses, introduce exhibits, cross-examine witnesses, and otherwise rebut any evidence. The petitioner may be called by the Medical Executive Committee and examined as if under cross-examination.

### E. REPRESENTATION

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on conduct or professional competence. A practitioner may choose to be represented at the hearing by an attorney if he/she so wishes. If the practitioner chooses not to be so represented, the Medical Executive Committee will not have its attorney present at the hearing. The foregoing will not be deemed to deprive any party of its right to the assistance of legal counsel for the purpose of preparing for the hearing. If there is no counsel, the petitioner is entitled to be accompanied by and represented at such hearings only by a physician, dentist, podiatrist, or clinical psychologist licensed to practice in the State of California who is not also an attorney-at-law, and who is preferably a member in good standing of the Medical Staff. The body whose decision prompted the hearing will appoint a representative from the Medical Staff

or from the Board of Directors (whichever body's decision prompted the hearing), who will present its recommendation, action or decision, and the materials in support thereof, and examine witnesses.

**F. MISCELLANEOUS RULES**

Any relevant evidence, including hearsay, will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a written statement in support of his/her position and the Judicial Review Committee may request such a statement be filed following the conclusion of the presentation of oral testimony. The Judicial Review Committee may interrogate the witnesses or call additional witnesses at its discretion.

**G. BURDEN OF GOING FORWARD AND BURDEN OF PROOF**

The Medical Executive Committee must initially come forward with evidence in support of its decision. Subject to the foregoing, the petitioner will bear the ultimate burden of persuading the Judicial Review Committee, by the substantial weight of evidence provided at the hearing that the decision of the Medical Executive Committee lacked foundation in fact or was otherwise arbitrary, capricious, or unreasonable.

**H. ADJOURNMENT AND CONCLUSION**

The hearing may be adjourned and reconvened at the convenience of the participants without special notice. Upon receipt of all oral and written evidence and argument, the hearing will be closed. The Judicial Review Committee will thereupon conduct its deliberations and render a decision based on the record produced at the hearing including oral testimony, written statements, and all exhibits entered into evidence.

**I. DECISION OF THE JUDICIAL REVIEW COMMITTEE**

Within thirty (30) days after the close of the hearing the Judicial Review Committee will render a written decision which will contain findings of fact sufficient in detail to indicate the basis for the Judicial Review Committee's decision on each matter contained in the notice of charges. The decision will be delivered to the Medical Executive Committee, the Chief of Staff, the President and CEO, and the SHC Board of Directors and, by delivery of registered or certified mail, to the petitioner. The decision of the Judicial Review Committee will be considered final, subject only to the right of appeal as provided in Section 7.5.

**7.5 APPEALS TO THE STANFORD HEALTH CARE BOARD OF DIRECTORS**

**A. TIME FOR APPEAL**

Within fourteen (14) days after the date of notice of the Judicial Review Committee decision, either the petitioner, or the body whose decision prompted the hearing, may appeal to the SHC Board of Directors. No petitioner is entitled to more than one evidentiary hearing and one appellate review on any matter which has been the subject of adverse action or recommendation. All requests for appeal will be delivered to the

CEO in writing either in person, or by certified mail, return receipt requested, and will include a statement of the reasons for the appeal. If an appellate review is not requested within the fourteen (14) day period, both sides will be deemed to have accepted the Judicial Review Committee decision, and it will become the final recommendation of the Medical Executive Committee. Such final recommendation will be subject on that basis to final review and decision by the SHC Board of Directors.

**B. REASONS FOR APPEAL**

The reasons for an appeal from the Judicial Review Committee decision will be: (1) lack of compliance with the procedures required by these Bylaws at the hearing so as to deny the petitioner a fair hearing; and/or (2) action taken arbitrarily, unreasonably, or capriciously.

**C. TIME, PLACE AND NOTICE**

When an appeal is requested, the SHC Board of Directors will, within thirty (30) days after the receipt of the request for appeal, set a date for the conduct of an appellate review before the Board of Directors. The SHC Board of Directors will give both parties notice of the time, place and date of the appellate review. The date of appellate review will not be less than fifteen (15) nor more than ninety (90) days from the date of receipt of the request for appeal. If, however, the request for appellate review is from a petitioner who is under summary suspension then in effect, the appellate review will be held as soon as arrangements may be made, not to exceed sixty (60) days from the date of receipt of the request for appeal. The time for appellate review may be extended for good cause by the SHC Board of Directors, or appeal board (if any).

**D. APPEAL BOARD**

Whenever an appellate review is requested, the SHC Board of Directors may sit as the appeal board or may appoint an appeal board which will be composed of at least three (3) members of the SHC Board of Directors. Knowledge of the matter involved will not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. For purposes of this Section, participating in an initial decision to recommend adverse action will not be deemed to constitute participation in a prior hearing on the same matter.

**E. APPEAL PROCEDURE**

The proceedings on appeal will be based upon the Judicial Review Committee record. The appeal board may accept additional evidence, subject to a showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence. The appeal board may accept such evidence directly, subject to the same rights of cross-examination or confrontation provided at the Judicial Review Committee hearing, or may remand the matter to the Judicial Review Committee for the taking of such further evidence. Each party will have the right to present a written statement in support of his/her position on appeal and, in its sole discretion, the appeal board may allow each party or representative to appear personally and make oral argument. At the conclusion of oral argument, if allowed, the appeal board will conduct, at a time convenient to itself, deliberations outside the presence of the appellant and

respondent and their representatives. If an appeal board is appointed, the appeal board will present to the SHC Board of Directors its written recommendations as to whether the SHC Board of Directors should affirm, modify, or reverse the Judicial Review Committee decision, or remand the matter to the Judicial Review Committee or any other body or person for further review and decision. If no appeal board is appointed, the procedures outlined in this Subsection will apply to a hearing before the SHC Board of Directors.

#### F. DECISION BY STANFORD HEALTH CARE BOARD OF DIRECTORS

Within forty-five (45) days after the conclusion of the appellate review proceedings before the SHC Board of Directors, the Board of Directors will render a final decision in writing. The SHC Board of Directors may affirm, modify, or reverse the Judicial Review Committee decision, or remand the matter for further review and recommendation by the Judicial Review Committee or any other body or person. Any such further review by the Judicial Review Committee or other body or person will be conducted within a time frame set by the SHC Board of Directors and will not exceed sixty (60) days unless the parties agree to the contrary. The recommendation, based on further review, if any, by the Judicial Review Committee or other body or person will be submitted to the SHC Board of Directors for a final decision. Notice of the final decision of the SHC Board of Directors will be provided to the petitioner, Medical Executive Committee and the President and CEO.

**ARTICLE EIGHT:  
ADVANCED PRACTICE PROFESSIONALS (APP)**

**8.1 QUALIFICATIONS**

Advanced Practice Professionals (APPs) are defined in Section 2.4 of these Bylaws. APPs are not eligible for Medical Staff membership. APPs are eligible to apply for privileges to perform standardized procedures and/or protocols in the Hospital only if they:

- A. Hold a license, certificate, or other legal credential as required by California law that authorizes the APP to provide certain professional health services in a category of APPs that the Board of Directors has identified as eligible to apply for standardized procedures, privileges and/or protocols upon the recommendation of the Medical Executive Committee;
- B. Document their experience, background, qualifications, appropriate education and training, demonstrated ability, current clinical competence, judgment, and physical and mental health with sufficient adequacy to demonstrate that any patient treated by them would receive care of the generally recognized professional level of quality and efficiency established by the Medical Executive Committee and approved by the Board of Directors;
- C. Are determined by the Medical Executive Committee and the Board of Directors, on the basis of documented references, to adhere to the lawful ethics of their respective professions, to work cooperatively with Medical Staff members, nurses, Hospital administrative staff, and others so as to not adversely affect safe patient care, treatment, and services or Hospital operations, and to be willing to commit to and regularly assist the Medical Staff and the Board of Directors in fulfilling their obligations related to safe patient care, treatment, and services within the areas of their professional licensure, credentials and competence; and
- D. Maintain in force professional liability insurance in not less than the minimum amounts, if any, as from time to time may be determined by, and with an insurance carrier acceptable to, the Medical Executive Committee and the Board of Directors.

**8.2 DELINEATION OF CATEGORIES OF APPs ELIGIBLE FOR PRIVILEGES, STANDARDIZED PROCEDURES OR PROTOCOLS**

The categories of APPs, based on occupation or profession, eligible to apply for practice privileges in the Hospital, and the corresponding standardized procedures or protocols, prerogatives, terms and conditions for each APP category, will be designated by the Board of Directors based on the recommendations from the Medical Executive Committee that originate in the relevant Department and Clinical Service Committees for the designation of categories of APPs thus eligible. The Board of Directors will review the designation of categories of APPs eligible to apply for standardized procedures or protocols on the recommendation of the Medical Executive Committee.

**8.3 PROCEDURE FOR GRANTING PRIVILEGES, STANDARDIZED PROCEDURES OR PROTOCOLS**

An APP must apply for privileges to perform standardized procedures or protocols as outlined in the Authorization for Individuals to Provide Services as Advanced Practice Professionals Policy. Applications for privileges to perform standardized procedures or protocols will be submitted and processed in a manner parallel to that provided in Article Three and Four for applicants to the Medical Staff unless otherwise specified in the Rules and Regulations of the Department appropriate to the occupational or professional service to be performed by the APP. The Board of Directors must approve the granting of standardized procedures or protocols to each APP after review and recommendation by the Interdisciplinary Practice Committee, the Credentials Committee, and the Medical Executive Committee.

An APP who wishes to apply to a category that is not identified as being approved by the Board of Directors must submit a written request to Medical Staff Services asking that the Board of Directors consider identifying an additional category of APPs as eligible to apply for standardized procedures or protocols at the Hospital. All requests must be approved by the Interdisciplinary Practice Committee, The Credentials and Privileging Committee, Medical Executive Committee, and Board of Directors.

Each APP will be assigned to the Department and Clinical Service appropriate to his or her occupational or professional training, and will be subject to terms and conditions of these Bylaws and Rules and Regulations, and the Department Rules and Regulations as they may be logically applied to APPs and appropriately tailored to the particular practice of the APP. Each APP will be subject to the supervision or direction of an Active Medical Staff member in the appropriate specialty.

#### **8.4 ONGOING REVIEW OF APP PRACTICE**

APPs are subject to ongoing quality assurance, professional practice evaluation, and peer review as provided in Section 9.4 of these Bylaws, and applicable policies, through the Clinical Service to the extent these ongoing review principles and processes apply to the more limited practice of APPs.

#### **8.5 ADVERSE ACTION REVIEW PROCEDURES**

##### **A. CLINICAL PSYCHOLOGISTS**

Clinical Psychologists are entitled to the rights provided in Article Seven of the Medical Staff Bylaws.

##### **B. HEARING RIGHTS - APPS OTHER THAN CLINICAL PSYCHOLOGISTS**

1. The application of an APP for appointment, reappointment or specific privileges, standardized procedures or protocols may be denied by decision of the Medical Executive Committee. Additionally, an APP's privileges, standardized procedures or protocols may be terminated by the Chair of the applicable Clinical Service, the Chief of Staff, or the CEO. The APP has a right to challenge any action that would constitute grounds for a hearing under Section 7.2 of the Medical Staff Bylaws by filing a written grievance with the Chief of the applicable Clinical Service within fifteen (15) days of the notice of such action. Upon receipt of such a grievance, the Chief will review the matter and afford the affected APP the opportunity for an interview. The interview will either be with the Chief of the Clinical Service or before an ad hoc committee of no less than three individuals



designated by the Chief and whose members did not participate in the action under review. The reviewing individual or body, as appropriate and reasonably attainable, will include at least one APP holding the same or similar license or certificate as the affected APP. Such APP will also be appointed by the Chief of the Clinical Service. Before the interview, the APP will be informed of the general circumstances giving rise to the adverse action being contested and, at the interview, the APP may present information relevant thereto. A record of the interview will be made. A written report of the findings and recommendations will be made by the reviewing individual or entity and forwarded to the MEC which will act thereon.

2. After the interview, if the recommendation of the Clinical Service continues to be adverse to the APP, the APP may request an opportunity provide further information to the MEC prior to its decision on the matter. Should the APP wish to do so, he/she may present to the MEC written arguments relevant to the Clinical Service determination. There is no right for the APP to personally appear before the MEC unless permitted by the MEC on such terms and conditions as it will establish. After considering the APP's additional arguments, if any, the MEC will make a final written decision on the matter. The action of the MEC will be final, subject only to review and final decision by the Board of Directors.
3. The procedural rights afforded by this Section 8.5 are the exclusive procedural rights afforded to APPs unless otherwise required by law.

#### C. AUTOMATIC TERMINATION

The appointment of an APP will end automatically upon failure of the APP to meet any appointment standard. If the APP's supervising physician is no longer willing or able to provide any required supervision, the APP's privileges, standardized procedures or protocols will be automatically suspended. The APP will have thirty (30) days to obtain a qualified supervising physician, and if he/she does, the privileges, standardized procedures or protocols will be reinstated. Failure to re-obtain the required supervising physician within thirty (30) days will result in the automatic termination of APP status at SHC. None of the actions provided for under this Section 8.5.C. entitle the APP to hearing rights under Article Seven of the Medical Staff Bylaws.

## 8.6 RESPONSIBILITIES

Each APP must:

- A. Meet the responsibilities required by the Rules and Regulations of the relevant Department, and those responsibilities specified in Section 3.5 of these Bylaws as are deemed by the Medical Executive Committee to be applicable to the limited scope of practice of the APP;
- B. Retain appropriate responsibility within his area of professional competence for the care and supervision of each patient in the Hospital for whom he is providing services;
- C. Participate, as appropriate, in patient care audits and other quality review, evaluation and monitoring responsibilities required of APPs, and in discharging such other functions as may be required by the Medical Staff from time to time;

- D. Notify the Chief of Staff in writing immediately upon receiving notice of any adverse action by a state licensing agency, another hospital or health care facility, HMO, professional society or law enforcement agency including conviction of a misdemeanor or felony; and the filing or service of any professional liability suit or arbitration proceeding against the APP; and
- E. Abide by the Bylaws, Rules and Regulations of the Medical Staff, the Policies, Rules and Regulations of the Department in which he participates, and other policies of the Medical Staff and Hospital adopted by the Medical Executive Committee and Board of Directors.

**ARTICLE NINE:  
CLINICAL ORGANIZATION OF THE MEDICAL STAFF**

**9.1 CLINICAL SERVICES**

- A. The Medical Staff of SHC is organized into Clinical Services which correspond to the Departments of the Stanford University School of Medicine. The current Services are as follows:

Anesthesia  
Cardiothoracic Surgery  
Dermatology  
Medicine  
Neurology  
Neurosurgery  
Obstetrics & Gynecology  
Ophthalmology  
Orthopedics  
Otolaryngology  
Pathology  
Pediatrics  
Psychiatry  
Radiation Oncology  
Radiology  
Urology  
Surgery

Clinical Services may be created, eliminated, subdivided, or combined in accordance with changes in the Departments of the Stanford University School of Medicine, or by action of the Dean of the Stanford University School of Medicine with the concurrence of the Medical Executive Committee and the SHC Board of Directors.

- B. Each member of the Medical Staff will be assigned membership in at least one Clinical Service, but may also be granted membership and/or clinical privileges in other Clinical Services.
- C. Each Clinical Service is charged with the responsibility for implementing and conducting specific monitoring review and evaluation activities that contribute to the preservation and improvement of the quality of safe patient care, treatment, and services provided in the Service. To carry out this responsibility, each Service will participate in the:
1. Establishment of guidelines for the granting of specific clinical privileges within the Service;
  2. Development of recommendations regarding the need for pertinent continuing education programs that reflect the type and nature of services offered by SHC and the findings of performance improvement activities; and
  3. Overseeing of members' adherence to a) Medical Staff Bylaws, Policies, and Rules and Regulations; (b) requirements of the Service; (c) SHC Policies; (d)

sound principles of clinical practice; and (e) regulations designed to promote patient safety.

## 9.2 CHIEFS OF SERVICE

### A. SELECTION

The Chief or Acting Chief of each Clinical Service of the Medical Staff will ordinarily be the Chair or Acting Chair of the corresponding Department of the Stanford University School of Medicine and will be Board Certified, or have affirmatively established comparable competence through the credentialing process.

### B. RESPONSIBILITIES

Each Chief of Service will be accountable to the Chief of Staff and must:

1. Determine and manage the clinically related and administrative activities within his/her Clinical Service.
2. Where Service Rules and Regulations are desired, will be accountable for the development and implementation of those Rules and Regulations, ensuring that they support the overall Performance Improvement Plan of SHC directly pertaining to professional medical care within their Service. With the approval of a majority of the Medical Staff members of the Service, will submit such Service Rules and Regulations to the Medical Executive Committee.
3. Develop and implement Service programs for orientation of new members, credentials review and privileges delineation for initial appointment and reappointment, continuing medical education, utilization review, concurrent evaluation of practice, and retrospective evaluation of practice.
4. Continuously assess and improve the quality of care, treatment and services, and maintain quality improvement programs as appropriate.
5. Transmit to the appropriate authorities as required in these Bylaws, the Service's recommendations concerning appointment, reappointment, delineation of clinical privileges, and disciplinary action with respect to members of the Service.
6. Recommend to the Medical Executive Committee, through the Credentials Committee the criteria for clinical privileges that are relevant to the care provided in the Service.
7. Assess and recommend to the relevant SHC authority space issues, resource needs, and off-site sources for needed safe patient care, treatment, and services not provided by the Service or the organization.
8. Recommend a sufficient number of qualified and competent persons to provide patient care, treatment, and services.

9. Determine the qualifications and competence of Department or Service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.
10. Maintain continuing surveillance of the professional performance of all members with clinical privileges within the Service with appropriate documentation thereof.
11. Assist in developing and enforcing Medical Staff and SHC policies and procedures that guide and support the provision of patient care, treatment and services; the Medical Staff Bylaws and Rules and Regulations; and the requirements and Rules and Regulations (if any) of the Service.
12. Integrate the Service into the primary functions of the organization.
13. Coordinate and integrate interdepartmental and intradepartmental services.
14. Implement within the Clinical Service actions taken by the Medical Executive Committee.
15. Report to the Medical Staff, through its committee structure, on all professional and administrative activities within their Clinical Service.
16. Establish such committees, task forces, or other mechanisms as are necessary and desirable to perform properly the functions assigned to it.
17. Perform such other duties commensurate with his/her office as may from time to time be assigned by the Chief of Staff, the Medical Executive Committee or the SHC Board of Directors.

### **9.3 DEPUTY CHIEFS OF SERVICE**

#### **A. QUALIFICATIONS/NOMINATIONS**

##### **1. Qualifications**

The Deputy Chief of a Clinical Service, must, at the time of nomination and election, be a Community Physician and member of the Active Medical Staff in good standing. He or she must remain in good standing during his or her term of office.

In the event that there is no Medical Staff member in the Clinical Service both eligible and willing to serve as the Deputy Chief of the Service, the Chief of the Service may appoint a full time faculty member as the Deputy Chief, subject to approval by the majority of the Medical Executive Committee.

##### **2. Nominations**

The Chief of Staff will seek nominations for Deputy Chief.

## B. ELECTION

The Deputy Chief of each Clinical Service of the Medical Staff will be elected biennially by a plurality vote. The election will be conducted by secret ballot and in such a way that it is possible to track whether an individual cast a vote but not for whom the vote was cast. The eligible electorate is composed of the community physician members of the Active Medical Staff members of the Service.

## C. RESPONSIBILITIES

The Deputy Chief will serve together with the Chief of the Service and be responsible for monitoring the professional and administrative activities within the Service.

1. Serve as a liaison between the Service Chief and the community physicians of the Clinical Service.
2. Provide input on certain administrative decisions (e.g., access issues regarding clinical facilities) which may be of legitimate concern to community Medical Staff.
3. Participate in QA and QI activities within the Service, and serve as the liaison between the Service Chief and the community Medical Staff when concerns arise.
4. Participate in the development of those Service Rules and Regulations which are of legitimate concern to community members of the Medical Staff.
5. When revisions in privileging criteria for the Service are presented at Credentials Committee, represent any legitimate community Medical Staff concerns in that forum.
6. Represent community Medical Staff of the Clinical Service at meetings of the Medical Executive Committee and other relevant meetings of elected representatives of the Medical Staff.

## D. REMOVAL FROM OFFICE

1. The Deputy Chief of Service may be removed from office for any valid cause, including, but not limited to, failure to carry out the duties of his/her office or gross neglect or malfeasance in office.
2. The Deputy Chief of Service may be removed from office when:
  - a. A petition setting forth the deficiencies in performance of duties as Deputy Chief and calling for a vote on removal signed by at least 20% of the eligible electorate for Deputy Chief of the Service is presented to the Chief of Service;
  - and
  - b. Two-thirds (2/3) of the eligible electorate for Deputy Chief of the Service responding to the official request for a vote, vote for the Deputy Chief's removal.

#### **9.4 MEDICAL STAFF PEER REVIEW PRINCIPLES**

These principles outline the structure and process of Medical Staff peer review at SHC including the procedures for evaluating the Quality Assurance (QA) processes of departments and services and time lines for carrying out subsequent reviews. Quality Assurance is monitoring a process to identify possible deficits that have already occurred. Quality Improvement (QI) constitutes prospective amelioration in an existing process or service, focusing on improving the average performance. The processes of QA and QI are closely linked in these principles. The full text of these Principles can be found in the Medical Staff Policies & Procedures.

All members of the Medical Staff will participate in quality assurance and quality improvement activities of the Medical Staff and the Service of which they are a member. All members of the Medical Staff will receive education in quality assurance, quality improvement and confidentiality at the time of their appointment and reappointment.

**ARTICLE TEN:  
OFFICERS OF MEDICAL STAFF**

**10.1 TITLES OF OFFICERS**

There will be a Chief of Staff, Vice Chief of Staff, and Immediate Past Chief of Staff who will serve as Officers of the Medical Staff.

**10.2 QUALIFICATIONS**

Officers must be licensed physicians and members of the Active Medical Staff at the time of their nominations and election and must remain members in good standing during the term of their office. Failure to maintain such status will immediately create a vacancy in the office involved.

**10.3 TERM OF ELECTED OFFICE**

The Chief of Staff, Vice Chief of Staff and Immediate Past Chief of Staff will each serve three (3) year terms.

**10.4 NOMINATIONS**

**A. APPOINTMENT OF THE NOMINATION COMMITTEE:**

The Medical Executive Committee will appoint a nominating committee composed of the incoming, outgoing, and Immediate Past Chief of Staff, who will also recommend the following additional members: three (3) Service Chiefs, two (2) Medical Executive Committee members-at-large, and one (1) member of the Medical Staff who is not a Medical Executive Committee member. These additional members will be chosen with the goal of achieving diversity of specialty and practice site. The Medical Executive Committee may accept these recommendations or modify them (by majority vote) to arrive at a final composition. The committee will be chaired by the Immediate Past Chief of Staff.

**B. TASK OF THE NOMINATING COMMITTEE:**

Its charge is to nominate qualified and willing candidates for COS-Elect (i.e.; Vice COS) and for Medical Executive Committee Members-At-Large. The Committee will solicit names of eligible candidates from the Medical Staff. The Committee will then review the list of nominees, determine whether they are eligible and willing to serve, and will then decide on a list of recommended nominees. The preferred number of nominees for Vice COS will be 2, although the committee may elect to pass more or fewer names to the Medical Executive Committee. The nominating committee acts by majority vote of its entire membership, with absentee voting permitted. The Medical Executive Committee may accept the nominating committee's recommendations or modify them (by majority vote) to arrive at a final candidate slate.

**C. NOMINATION BY PETITION:**

An alternative means of access to the ballot is by petition of members of the Medical Staff. If, within two weeks of the Nominating Committee's communication of its decision on the slate of candidates (or, if the MEC removes a candidate recommended by the



Nominating Committee, within two weeks of that action), the Chief of Staff is presented with a petition endorsed by at least seventy-five (75) members of the Medical Staff with voting privileges as outlined in Article 3, and bearing the candidate's written consent, that candidate will be included on the ballot.

## **10.5 ELECTION**

The Vice-Chief of Staff will be elected by a majority vote of the eligible voting members of the Medical Staff, and will automatically succeed the Chief of Staff at the expiration of the Chief of Staff's term. If no candidate receives a majority vote, the two candidates with the most votes will automatically be entered into a run-off election, to be held as soon as is practicable.

The Chief of Staff will be a member of the Active Medical Staff, in good standing, who is able to meet the time commitments of the role. The Chief of Staff will not be eligible for re-election until serving a term as Immediate Past Chief of Staff.

## **10.6 RESPONSIBILITIES OF MEDICAL STAFF OFFICERS**

### **A. CHIEF OF STAFF**

#### **RESPONSIBILITIES**

The responsibilities of the Chief of Staff or his/her designee include, but are not limited to:

- a. Enforcing the Medical Staff Bylaws, Rules and Regulations, implementing sanctions when indicated, and ensuring compliance with procedural safeguards where corrective action has been warranted;
- b. Performing oversight of Medical Staff clinical activities within SHC, including quality improvement, credentialing and privileging, patient safety, and utilization management;
- c. Calling and arranging for all meetings of the Medical Staff and the Medical Executive Committee;
- d. Serving as chair of the Medical Executive Committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;
- e. Developing and implementing methods for Medical Staff Performance Improvement activities within SHC, including quality assurance, credentialing and privileging, and utilization management;
- f. Serving as an ex-officio member of all other Medical Staff committees, without vote, unless so designated by the Bylaws of the Medical Staff;
- g. Working collaboratively with SHC Administration and the SHC Board of Directors in all matters of mutual concern within SHC;

- h. Appointing, in consultation with the Medical Executive Committee, the members of all Medical Staff committees and designating the Chairs of the committees, unless otherwise provided for by these Bylaws;
- i. Representing the Medical Staff to the SHC Board of Directors, outside licensing and accreditation agencies, and the public;
- j. Communicating and representing the opinions, needs, and grievances of the Medical Staff to the Medical Executive Committee, the President and CEO, and the SHC Board of Directors.
- k. Appointing Associate Chiefs of Staff as may be necessary to fulfill the tasks of the Medical Staff after approval by the Medical Executive Committee.
- l. Being a spokesperson for the Medical Staff in external professional and public relations;
- m. Serving as liaison to the Hospital Board of Directors, the Executive Committee of the School of Medicine, the Graduate Medical Education Committee, and outside licensing or accreditation agencies.
- n. Performing such other functions as may be assigned to the Chief of Staff by these Bylaws, the Medical Staff, or by the Medical Executive Committee.
- o. Managing and monitoring Medical Staff funds including Medical Staff dues and budget for leadership stipends.
- p. In the interim between Medical Executive Committee meetings, performing those responsibilities of the Medical Executive Committee that, in his or her reasonable opinion, must be accomplished prior to the next regular or special meeting of the Medical Executive Committee;

## B. VICE- CHIEF OF STAFF

### RESPONSIBILITIES

The responsibilities of the Vice Chief of Staff or his/her designee include, but are not limited to:

- a. Assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff;
- b. Serve as Medical Staff Treasurer and Chair of the Medical Staff Finance Committee. Prepare regular financial reports and present to Medical Executive Committee.
- c. Serve as a voting member of the Medical Executive Committee.

- d. Serve as ex-officio member of all other Medical Staff Committees, without vote, unless so designated by the Bylaws of the Medical Staff.
- e. Perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws or by the Medical Executive Committee.

**C. ASSOCIATE CHIEF OF STAFF**

**RESPONSIBILITIES:**

Perform whatever work of the Medical Staff organization is delegated to him or her by the Chief of Staff and/or the Medical Executive Committee.

**D. IMMEDIATE PAST CHIEF OF STAFF**

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

**10.7 REMOVAL OF THE CHIEF OF STAFF, VICE CHIEF OF STAFF OR PAST CHIEF OF STAFF**

- A. The Chief of Staff, Vice Chief of Staff or Immediate Past Chief of Staff may be removed from office for any valid cause, including, but not limited to, failure to carry out the duties of his/her office, gross neglect or misfeasance in office, or serious acts of moral turpitude.
- B. The Chief of Staff, Vice Chief of Staff or Immediate Past Chief of Staff may be removed from office when:
  - 1. A petition setting forth the deficiencies in performance of duties of the Officer in question and calling for a vote on removal signed by at least seventy-five (75) members of the eligible voting members of the Medical Staff is presented to the Medical Executive Committee;
  - and
  - 2. Two-thirds (2/3) of the eligible voting members of the Medical Staff responding to the official request for a vote, vote for the Officer's removal.

**10.8 VACANCIES IN OFFICE**

- A. If the Chief of Staff is temporarily unable to fulfill the responsibilities of the office, the Vice Chief of Staff will assume these responsibilities until the Chief of Staff is able to resume those duties. If the Vice Chief of Staff is unable to assume these responsibilities, the Immediate Past Chief of Staff will assume these responsibilities until the Chief of Staff is able to resume these duties.

- B. If, for any reason, the Chief of Staff is unable to complete the elected term of office, the Vice Chief of Staff will assume the office of Chief of Staff and a new Medical Staff election will be held.
- C. If, for any reason, the Vice Chief of Staff is unable to complete the elected term of office, a new Medical Staff election will be held.
- D. In the event that the Vice Chief of Staff has served less than one year in that position, any Chief of Staff vacancy will be filled by the Immediate past Chief of Staff, with the Vice Chief of Staff succeeding to the position on reaching one year of service. Should the Immediate Past Chief of Staff be unable to serve, the prior Chief of Staff will serve. If neither of the past two Chiefs of Staff are able to serve, the Vice Chief will fill the vacancy.
- E. Similarly, a Vice Chief of Staff who is elected to fill a vacancy will not succeed to the Chief of Staff position until he or she has served as Vice Chief of Staff for one year.
- F. Once a Vice Chief of Staff fills a Chief of Staff vacancy, he or she will serve the remainder of that term and also, subsequently, the term for which originally elected.
- G. If unforeseen circumstances occur, they will be adjudicated by the MEC.

**ARTICLE ELEVEN:  
MEDICAL EXECUTIVE COMMITTEE**

**11.1 RESPONSIBILITIES**

The Medical Executive Committee is a committee of the Medical Staff that is empowered to act for the Medical Staff in the intervals between Medical Staff meetings. The Medical Staff delegates to the Medical Executive Committee broad authority to oversee the operations of the Medical Staff with the assistance of the Chief of Staff, and without limiting, this broad delegation of authority, the Medical Executive Committee shall perform in good faith the duties listed below:

- A. In addition to such other responsibilities as are set forth in these Bylaws, the Medical Executive Committee will:
1. Receive and act upon reports and recommendations from the Medical Staff Committees, Graduate Medical Education Committee, SHC Departments, Clinical Services, and ad hoc committees.
  2. Receive and act upon reports and recommendations from the Medical Staff Finance Committee.
  3. Receive and act upon all quality and utilization management monitoring reports including infection control; blood and transfusion; surgical case review; mental health services; medical records; case management; and clinical laboratory.
  4. Subject to the authority of the Medical Staff, determine all professional medical policies of SHC.
  5. With the Service Chiefs, set Service objectives for establishing, maintaining, and enforcing professional standards within the Hospital, for the continuing improvement of the quality of care rendered in the Hospital, and assisting in developing programs to achieve these objectives.
  6. Recommend to the SHC Board of Directors all matters relating to Medical Staff structure and mechanisms used to review credentials and to delineate clinical privileges for appointments and reappointments, recommend individuals for Medical Staff membership and clinical privileges and for Service assignments, and recommend mechanisms for termination and corrective action when appropriate.
  7. Request evaluations of practitioners privileged through the Medical Staff credentialing process in instances where there is doubt about an applicant's ability to perform the privileges requested.
  8. Recommend to the Board of Directors matters regarding the structure of the Medical Staff; and advise on sources of clinical services to be provided by consultation, contractual arrangements, or other agreements.
  9. Be responsible for creating the appropriate Medical Staff committee structure to carry out the necessary duties.

10. Be accountable to the SHC Board of Directors for the quality of medical care, and for the organization of performance improvement activities of the Medical Staff including the mechanism used to conduct, evaluate, and revise such activities, and reporting of outcomes of Medical Staff performance improvement programs with sufficient background and detail to assure the Board that quality of care is consistent with professional standards.
11. Take reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in Medical Staff corrective or review measures when warranted.
12. Assist in obtaining and maintenance of accreditation for the hospital, medical staff and their respective programs.
13. Inform the Medical Staff regarding the status of accreditation and licensure of the SHC and its programs.
14. Develop and maintain methods for the protection and care of patients and others in the event of internal or external disaster.
15. In accordance with Section 13.5.A, and in conjunction with the Medical Staff Finance Committee, establish the amount of annual dues, if any, for each category of Medical Staff membership and an annual budget for the Medical Staff Dues Account.
16. Resolve disputes regarding expenditures from the Medical Staff Dues Account.
17. Determine a processing fee, if any, to be charged to any applicant for Medical Staff membership.
18. Recommend the mechanism for corrective action and fair hearing procedures.
19. Establish the mechanisms for dispute resolution between medical staff members involving the care of a patient.
20. Recommend to the Board of Directors minimum requirements for malpractice insurance coverage for members of the Medical Staff.
21. Have the right to conduct a review of any SHC policy (existing or proposed) for its implications to the Medical Staff, and, if changes are deemed necessary, consult with the SHC Chief Medical Officer. If no agreement on changes is reached, the issue shall be referred to the Joint Conference Committee.
22. Take such other action as may reasonably be deemed necessary in the best interests of the Medical Staff and the Hospital.

The authority delegated by this Section may be removed by amendment of these Bylaws.

## REPORT OF MEDICAL EXECUTIVE COMMITTEE

The Medical Staff will be given access to a description of the activities and decisions of the Medical Executive Committee. In the event that at least 75 voting members of the Medical Staff sign a petition in opposition to a specific decision of the Medical Executive Committee, the Conflict Resolution process described in 17.9 will be invoked.

### 11.2 COMPOSITION

#### A. VOTING MEMBERSHIP

The voting membership of the Medical Executive Committee will consist of the Chief of Staff, who will serve as the Chairperson, Vice Chief of Staff, Immediate Past Chief of Staff, the Chiefs of each of the Clinical Services, the Deputy Chiefs, the Credentials Committee Chairperson, the Division Head of Emergency Services, Chair of QPSEC, Operating Room Medical Director, Medical Director of Critical Care, Medical Director of GME, and five (5) members at large elected by the eligible voting members of the Medical Staff. The Dean of the Stanford University School of Medicine, President and CEO, Chief Medical Officer, Vice Presidents of Patient Care Services, Clinical Services and Compliance will be ex-officio, non-voting members of the Medical Executive Committee. Voting members of the MEC may choose to send a representative in their absence. A representative nominated by the Association of Adjunct Clinical Faculty and approved by the Chief of Staff may be included as a non-voting member.

As set forth in this Section, the Medical Executive Committee includes physicians and may include other practitioners and any other individuals as determined by the medical staff. All physician members of the Medical Executive Committee must be Active members of the Medical Staff in good standing and the majority of voting members must be physicians who are actively practicing in the hospital.

#### B. ELECTED MEMBERSHIP

The procedure for electing the five (5) members-at-large from the Active Medical Staff to serve on the Medical Executive Committee will be as follows:

1. Nominations
  - a. The Nominating Committee will solicit names of eligible nominees from the Medical Staff. The Nominating Committee will then review the list of nominees, determine whether they are eligible to serve on the Medical Executive Committee and are willing to do so, and then submit a list of nominees to the Medical Executive Committee.
  - b. The Medical Executive Committee, after receiving recommendations from the Nominating Committee, will submit to the Medical Staff a list of qualified nominees for the elected positions on the Medical Executive Committee.
2. Election

The elected members-at-large will be those individuals receiving the highest

number of votes of the eligible voting members of the Medical Staff voting in the election.

3. The five (5) elected members-at-large will each serve three (3) year terms. They may not be re-elected until three years has passed since the end of their term. In order to provide an ongoing rotation, two (2) such members will be elected one year and three (3) the next.

#### C. REMOVAL FROM OFFICE

1. A member of the Medical Executive Committee may be removed from office for any valid cause, including, but not limited to, failure to carry out the duties of his/her office, gross neglect or misfeasance in office, or serious acts of moral turpitude.
2. Elected members-at-large of the Medical Executive Committee may be removed from office when:
  - a. A petition calling for a vote on removal signed by at least seventy-five (75) members of the eligible voting members of the Medical Staff is presented to the Chief of Staff;
  - and
  - b. Two-thirds (2/3) of the eligible voting members of the Medical Staff responding to the official request for a vote, vote for an elected member's removal.
3. Appointed members of the Medical Executive Committee may be removed from the Medical Executive Committee by:
  - a. A petition calling for a vote on removal signed by at least 50% of the eligible voting members of the Medical Executive Committee is presented to the Chief of Staff.
  - and
  - b. Two-thirds (2/3) of the eligible voting members of the Medical Executive Committee responding to the official request for a vote, vote for an appointed member's removal.

#### D. VACANCIES IN OFFICE

If an elected member-at-large of the Medical Executive Committee is unable to complete the elected term of office, the Chief of Staff will appoint a replacement to fill out the unexpired term.

#### E. QUORUM

Fifty percent of the voting membership of the Medical Executive Committee will be considered a quorum.



F. MANNER OF ACTION

Except as otherwise specified in these Bylaws, the action may be taken by a majority of the voting members present at a meeting at which a quorum is present; and a meeting at which a quorum is initially present may take action notwithstanding the withdrawal of members, if any action is approved by at least a majority of the required quorum for such a meeting.

G. MEETINGS

Meetings of the Medical Executive Committee will be held monthly, or at least ten (10) times per year, but more often whenever required by the Chief of Staff.

**ARTICLE TWELVE:  
COMMITTEES OF THE MEDICAL STAFF**

**12.1 APPOINTMENT TO MEDICAL STAFF STANDING COMMITTEES**

- A. Appointment and/or reappointment of members to Standing Committees of the Medical Staff and designation of Chairpersons of each such committee will be made by the Chief of Staff. The Chief of Staff will annually report to MEC on the composition of Medical Staff Committees and its Chairs. Committee members may be removed by a two-thirds (2/3) vote of the Medical Executive Committee. The Chief of Staff and the Vice Chief of Staff will be non-voting, ex-officio members of all committees, unless otherwise indicated.
- B. Unless otherwise stated, Standing Committees will include a broad representation of the Medical Staff; however, committees will consist of an appropriate number of individuals to be of an effective, yet manageable, size. Medical Staff members have a duty to actively participate in Staff Committees under Section 3.3.
- C. Each Standing Committee may, with the approval of the Chief of Staff, form subcommittees, task forces, or ad hoc committees as appropriate to carry out the charge of the Standing Committee. All such groups will be considered committees of the Medical Staff.
- D. Membership on Medical Staff Committees will be for a period of three (3) years and may be renewable.
- E. Chairs of all Medical Staff Committees will be appointed by the Chief of Staff for a period of three (3) years and may be renewable.

**12.2 DUTIES GENERALLY**

- A. Medical Staff Committees will include, but not be limited to, the Medical Staff Meeting as a committee of the whole, meetings of Clinical Services and Divisions, meetings of Committees established under this Article, and meetings of special or ad hoc committees created by the Medical Executive Committee, by the Clinical Services, or by the Committees described below. The Committees described in this Article will be the Standing Committees of the Medical Staff.
- B. All Standing Committees appointed under this Article will report and make recommendations to the Medical Executive Committee as outlined under each individual committee in 12.5.
- C. Each Committee will keep a record of the minutes of each of its meetings, including an attendance roster. A copy of the minutes, approved by the membership and signed by the Committee Chair, will be submitted to the Chief of Staff and will be kept on file.
- D. Quality assurance committees, when the subject of the peer review is an LPCH patient treated at SHC, will be comprised of physicians who have staff privileges at both hospitals, and the support personnel to these committees will be provided by SHC. Each committee of the Medical Staff at either hospital that performs the peer review function of

evaluating and improving the quality of patient care, treatment, and services will be designated as a joint SHC - LPCH quality assurance committee.

- E. Unless otherwise stated, meetings of all Standing Committees will be held at least semi-annually, but more often whenever required by the Chair or Chief of Staff.

### **12.3 SPECIAL COMMITTEES**

Special committees (sometimes called *ad hoc* committees) will be established on an “as needed” basis by the Chief of Staff and members will retain their appointments until discharged by the Chief of Staff.

### **12.4 QUORUM**

Thirty percent of the voting membership (but no less than three [3]) of the standing committee will be considered a quorum.

### **12.5 MANNER OF ACTION**

Except as otherwise specified in these Bylaws, the action of a majority of the members present and voting at a committee meeting at which a quorum is present will be the action of the group. A committee 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 a meeting, or such greater number as may be specifically required in these Bylaws.

Committee action may be conducted electronically (i.e. by telephone, email or internet conference), which will be deemed to constitute a meeting for the matters discussed and voted upon in that electronic conference.

### **12.6 CONDUCT OF MEETINGS**

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

### **12.7 HOUSESTAFF**

When appropriate, the Chief of Staff will appoint members of the Housestaff to serve on the Medical Staff committees.

### **12.8 MEDICAL STAFF STANDING COMMITTEES**

The Standing Committees of the Medical Staff of SHC will be the following:

- A. **BYLAWS COMMITTEE**

- 1. **Purpose**

- The purpose of the Bylaws Committee is to review the Medical Staff Bylaws and Rules and Regulations and to recommend revisions based on regulatory requirements or changes recommended by Medical Staff committees, or to change SHC’s current practice with respect to Medical Staff organization and functions.

2. Duties
  - a. Perform regular review of the Medical Staff Bylaws and Rules and Regulations.
  - b. Prepare correspondence to the Medical Staff regarding proposed revisions for review and vote.

3. Composition

Voting members will include the Immediate Past Chief of Staff who will act as Chair, the Chief of Staff, Vice Chief of Staff, and others as appointed by the Chief of Staff. The committee will be composed of both faculty and community physicians and should have at least six (6) members.

4. Meeting Frequency

The Committee will meet annually, but may meet more frequently as determined by the Chair.

5. Reporting

The Committee will report to the Medical Executive Committee.

## B. CARE IMPROVEMENT COMMITTEE

1. Purpose

The purpose of the Care Improvement Committee is to provide a forum for the Medical Staff to assess the quality, appropriateness, and efficacy of treatment services and processes. The committee will review the quality and appropriateness of treatment provided by members of the healthcare team. The goal of the peer review process is to continuously improve treatment services and processes within the system. The peer review process highlights the challenges that enhance or impede treatment providers as they strive to provide quality services. The Committee is responsible for overseeing the peer review process for the Medical Staff.

2. Duties

In addition to the items described in Section 12.2, "Duties Generally", the duties of the Care Improvement Committee include, but are not limited to:

- a. Identifying opportunities for improvement in quality of care and clinical performance in both the inpatient and outpatient settings.
- b. Reviewing or delegating to other appropriate committees or Departments, review of patient complaints, incident reports, or other matters involving quality of care and clinical performance, and ensuring that appropriate action is taken for identified problems.

3. Composition

The Chair will ordinarily be the Chief of Staff. Voting members will include the Chairs of the Professional Practice Evaluation Committees (or the designees of those Chairs), along with other members as determined by the Chief of Staff. Non-voting members will include the Chief Nursing Officer, the Chief Medical Officer, representatives from the Quality, Patient Safety and Effectiveness Department, Risk Management, Medical Staff Services, and others as determined by the Chief of Staff.

4. Meeting Frequency

The Committee will meet every other month, but may meet more frequently or be canceled as determined by the Chair.

5. Reporting

The Committee will report to the Medical Executive Committee, covering its activities and outcomes.

C. CATH ANGIO MEDICAL COMMITTEE

1. Purpose

The Cath Angio Medical Committee (CAMC) of SHC is the governing body for the Catheterization and Angiography Laboratories, and is responsible for providing oversight and taking action on issues related to the delivery of safe patient care, treatment and services in the Cath-Angio Region including the cath lab procedure rooms in the main hospital, the Cath Angio Pre-Procedure and Recovery (CAPR) and the Advanced Medicine Center labs. The committee recommends policies, procedures, and process improvements for appropriate delivery of high quality patient services for Adult and Pediatric Electrophysiology, Pediatric Cardiology, Interventional Adult Cardiology, Interventional Radiology, Vascular Surgery, Interventional Neuroradiology/Neurosurgery, and Pulmonary Hypertension evaluations.

2. Duties

In addition to the items described in Section 12.2 "Duties Generally", the duties of the CAMC include, but are not limited to:

- a. Overseeing quality improvement aspects of the Cath Angio Region, as applied to all cath-angio patient populations.
- b. Identifying new policies and procedures in the Cath Angio Region, and to revise existing ones.
- c. Making recommendations to SHC Administration and the Chief of Staff Office.
- d. Providing oversight for the Block Schedule, Operations, Finance and New Technology subcommittees.

- e. Serving as the authority for the allocation of block time in the Cath Angio Region.
- f. Collaborating efforts with the Cardiovascular Health Quality Council to enhance service operations

3. Composition

Voting membership of this committee will include the Medical Director of Cath Angio Lab, Division Chiefs or designees representing Interventional Radiology, Interventional Adult Cardiology, Interventional Neuroradiology/Neurosurgery, Vascular Surgery, Adult Electrophysiology, Pediatric Cardiology, Pediatric Electrophysiology, and representation from community interventional cardiologists. Non-voting membership includes the Vice President-Clinical Services, Director of Interventional/EP Services and representatives of Nursing.

4. Meeting Frequency

The Committee will meet monthly, but may meet more frequently or be canceled as determined by the Chair.

5. Reporting

The Committee will report to the Medical Executive Committee through the QPSEC covering its activities and outcomes.

D. COMMITTEE FOR PROFESSIONALISM

1. Purpose

The purpose of the Committee for Professionalism is to serve as a focus of expertise and as a resource for monitoring and improving professional behavior of the Medical Staff, both individually and collectively. Professional behavior is increasingly recognized as an essential component of high quality medical care. Inappropriate and disruptive behavior, along with less egregious failures to achieve the highest levels of professionalism in interactions with patients, families, and co-workers, can have a serious impact on the delivery of optimal medical care. The Committee is responsible for overseeing the process for addressing unprofessional behavior of medical staff members.

2. Duties

In addition to the items described in section 12.2, "Duties Generally", the duties of the Committee for Professionalism include, but are not limited to:

- a. Identifying opportunities for improvement in professional performance when problems arise in either inpatient or outpatient settings with an unusual number or severity of patient and family complaints, incident reports for other members of the health care team, or reports from other sources.

- b. Develop policies and procedures for the investigation of complaints or reports of unprofessional behavior, and the response of the medical staff to patterns of unprofessional behavior.
- c. Oversee interventions for medical staff members demonstrating unprofessional behavior.
- d. Identify resources to assist medical staff members to improve behavior patterns.
- e. Ensure the maintenance of a database of complaints and incidents sufficient to support the identification of patterns and trends of behavior.

### 3. Composition

Membership of the Committee, to the extent practical, will reflect the diversity of the Medical Staff with regard to specialty, mode of practice (community v. full time faculty), gender, ethnicity, etc. The Committee will also include the Chief of Staff, the Vice Chief of Staff, the immediate past Chief of Staff, and the Chief Medical Officer. The Committee will also have representation from SHC administration, Guest Services and Risk Management.

### 4. Meeting Frequency

The Committee will meet as necessary, generally monthly, but may meet more frequently or be cancelled as determined by the Chairperson.

### 5. Reporting

The Committee will report to the Medical Executive Committee.

## E. COMMITTEE FOR PROFESSIONAL SATISFACTION AND SUPPORT (SCPSS)

### 1. Purpose

The purpose of the Stanford Committee for Professional Satisfaction and Support (SCPSS) is to serve as a focus of expertise and as a resource for monitoring and improving the wellness and professional satisfaction of the Medical Staff, both individually and collectively. These are factors that are increasingly recognized as crucial elements necessary to achieve excellence in quality, safety, and patient satisfaction.

### 2. Duties

In addition to the items described in section 12.2, "Duties Generally", the duties of the Committee include, but are not limited to:

- a. Assessing the status of wellness and professional satisfaction at Stanford University Medical Center.

- b. Identifying opportunities and developing programs to improve wellness and professional satisfaction.
- c. Promoting a culture that values wellness and professional fulfillment.
- d. Coordinating relevant activities and resources across the medical center, while disseminating best practices.

3. Composition

Membership of the Committee, to the extent practical, will reflect the diversity of the Medical Staff with regard to specialty, mode of practice (community v. full time faculty), gender, ethnicity, etc. The Committee will also include the Chief of Staff, the Vice Chief of Staff, and the immediate Past Chief of Staff, and the Chief Medical Officer. Other members may be appointed at the discretion of the Chief of Staff. All members of the committee will have voting rights

4. Meeting Frequency

The Committee will normally meet monthly, but may meet more frequently or be cancelled as determined by the Chairperson.

5. Reporting

The Committee will report to the Medical Executive Committee.

F. CREDENTIALING AND PRIVILEGING COMMITTEE (Credentials Committee)

1. Purpose

The purpose of the Credentials Committee is to review the credentials of providers applying for initial appointment or reappointment to the Medical Staff at SHC, and to make recommendations for membership and delineation of privileges in compliance with the Medical Staff Bylaws, Credentialing Policies and Procedures, and Clinical Service requirements; review and approve new or revised credentials and privileges forms and processes; and review and approve credentialing policies and procedures. In addition, the Credentials Committee will review and act upon reports from the Interdisciplinary Practice Committee (IDPC) of appointment and evaluations of Advanced Practice Professionals. The IDPC is a subcommittee of the Credentials Committee and is accountable to the Medical Executive Committee and the Board of Directors through the Credentials Committee.

2. Duties

In addition to the items described in Section 12.2, "Duties Generally", the duties of the Credentials Committee include, but are not limited to:

- a. Reviewing the credentials of applicants and making recommendations for membership and delineation of privileges in compliance with these Bylaws.



- b. Reviewing reports from the Interdisciplinary Practice Committee on Advanced Practice Professionals.
- c. Reporting to the Medical Executive Committee on individual applicants for Medical Staff membership or privileges, including specific consideration of the recommendations from the Chiefs of Services in which such applicant requests privileges, appointment, reappointment, and assignment of members to various Departments or Services as provided by these Bylaws.
- d. When appropriate, interviewing a member or applicant and/or the Chief of the involved Service when differences arise concerning appointment, reappointment, or change in privileges, and attempt to resolve such differences.
- e. Developing, reviewing, and revising credentialing and privileging forms and processes, and review and approve credentialing policies and procedures.

3. Composition

Voting membership will include at least eight (8) members of the Medical Staff, who will be chosen to ensure representation from major clinical areas. Non-voting members include the VP for Clinical Services; the Director of Medical Staff Services; and representation from the Interdisciplinary Practice Committee and the Quality Patient Safety and Effectiveness Department

4. Meeting Frequency

The Committee will meet monthly, but may meet more frequently or be canceled as determined by the Chairman.

5. Reporting

The Committee will make a monthly report to the Medical Executive Committee covering its activities and recommendations.

G. ETHICS COMMITTEE

1. Purpose

The purpose of the Ethics Committee is to provide advice, consultation, guidance and education about the ethical aspects of the provision of medical treatment. The Committee's role is advisory in nature and will not usurp the decision-making prerogative of attending physicians and their patients

2. Duties

In addition to the items described in Section 12.2, "Duties Generally", the duties of the Ethics Committee include, but are not limited to:

- a. Providing timely advice and consultative services, on request, to improve understanding, facilitate deliberation, and assist in the resolution of specific clinical ethical issues and value conflicts.
- b. Making recommendations that would address chronic or recurring ethical issues of a systemic nature.
- c. Generating and reviewing hospital and institutional policies that involve ethical issues.
- d. Developing and fostering collaborative relationships with LPCH and local hospital Ethics Committees, as well as county and professional medical societies, as appropriate.
- e. Providing medical ethics education to the members of the Committee, SHC, and the wider community.

3. Composition

Voting membership of this committee will include members of the Medical Staff and representatives from SHC Administration, Nursing, other health care professionals, chaplaincy, housestaff, and one or more lay members of the community. SHC legal services will provide staff support for the Committee. The Committee may invite consultations from practitioners in various specialties on particular issues.

4. Meeting Frequency

The Committee will meet monthly, but may meet more frequently or cancel occasional monthly meetings, as determined by the Chair(s).

5. Reporting

The Committee will make a report to the Medical Executive Committee, through QPSEC, covering its activities and outcomes.

H. HEALTH INFORMATION MANAGEMENT COMMITTEE

1. Purpose

The purpose of the HIM Committee is to provide physician-based oversight to the acquisition, implementation, and use of Information Technology and Management Services, especially in regards to improving the overall quality of patient care, treatment, and services at SHC. The Committee is accountable to the Medical Executive Committee, through the QPSEC, and serves as a forum to identify important health information management and technology issues and develop plans and actions to address these concerns. The Committee will

operate by authorizing a set of working sub-committees which will focus on specific areas of concern. These sub-committees will report to the HIM Committee on a regular basis.

2. Duties

In addition to the items described in Section 12.2, "Duties Generally", the duties of the HIM Committee include, but are not limited to:

- a. Developing and updating the SHC Information Management Plan.
- b. Evaluating the process of computerizing health information at SHC.
- c. Ensuring that SHC implements information privacy and security policies and management control procedures.
- d. Reviewing and approving the development and implementation of medical record forms at SHC
- e. Monitoring how the SHC medical community documents patient care and taking actions to improve the effectiveness and usefulness of clinical documentation.
- f. Providing feedback to HIM and IT Departmental operations.

3. Composition

Voting membership on the HIM Committee will include representatives from the Medical Staff. Non-voting membership will include representatives from Hospital Administration, Clinic Administration, the department of Health Information Management Services, the department of Information Management and Technology, and Nursing Administration, as determined by the Chief of Staff.

4. Meeting Frequency

The Committee will meet quarterly, but may meet more frequently or be canceled as determined by the Chair.

5. Reporting

The Committee will report to the Medical Executive Committee, through the QPSEC, covering its activities and outcomes.

I. ICU CONTINUING QUALITY IMPROVEMENT (ICU CQI) COMMITTEE

1. Purpose

The purpose of the ICU CQI Committee is to improve the quality of care, treatment, and services for SHC's patients, to provide a forum for SHC Medical Staff and employees, and to provide oversight and take action on issues related to the critical care services to patients in the intensive care units, cardiac care

units, and trauma units. In addition, the committee is charged with recommending policies, procedures, and process improvements for appropriate delivery of critical care services including oversight and evaluation of the code blue process throughout the hospital. The Committee is accountable to the Medical Executive Committee, through the QPSEC, and its scope includes the care provided in the East and North Intensive Care Units and in the Coronary Care Unit. Important problems and issues relating to care in these units will be evaluated and solutions identified.

2. Duties

In addition to the items described in Section 12.2, "Duties Generally", the duties of the ICU CQI Committee include, but are not limited to such items as are described in the Committee Charter.

3. Composition

Voting membership of this committee will include the Medical Directors of the Medical/Surgical Intensive Care Unit E2, North ICU, and a broad representation of the specialties using the Intensive Care Units. It will include, at a minimum, representation from Nursing, SHC Administration, Medical Service, Surgical Service, Anesthesia, and Cardiovascular Surgery.

4. Meeting Frequency

The Committee will meet quarterly, but may meet more frequently or be canceled as determined by the Chairman. Subcommittees of the Critical Care Committee, supplemented by additional members as required, will meet at least monthly.

5. Reporting

The Committee will make a report to the Medical Executive Committee, through QPSEC, covering its activities and outcomes.

J. INFECTION CONTROL COMMITTEE

1. Purpose

The Infection Control Committee oversees, in conjunction with the Infection Control and Epidemiology Department, the program for surveillance, prevention, and control of infection for SHC departments/services, medical and nursing staffs, and administration. The scope of this commitment includes care of patients, personnel health, and the environment.

2. Duties

In addition to the items described in Section 12.2, "Duties Generally", the duties of the Infection Control Committee include, but are not limited to:

- a. Evaluating and approving the type and scope of surveillance activities, based on trend analysis of surveillance, effectiveness of prevention and control measure, and procedure instituted.
- b. Approving actions to prevent or control infection, based on evaluation of trends and analysis of nosocomial infections, and of the infection potential among patients and hospital personnel.
- c. Reviewing nosocomial infections where there is potential for prevention or intervention to reduce the risk of future occurrence. Special focus is given to infections due to unusual pathogens and clusters.
- d. Reviewing and approving, at least every three years, all policies and procedures related to the infection surveillance, prevention, and control activities in all departments/services.
- e. Assisting Occupational Health and Safety in formulating and evaluating policies and procedures regarding exposures and communicable diseases among employees.
- f. Reviewing and evaluating plans for renovation of existing facilities and plans for construction of new facilities to incorporate sound infection control principles into the design and to promote implementation of aspergillosis prevention policies and monitoring compliance systems in all phases of construction/renovation plans.
- g. Educating, where required, the Medical Staff and Hospital staff on the detection and control of infections.

### 3. Composition

Committee membership is interdisciplinary and includes representatives from Administration, Medical Staff, Patient Care Services Department and Infection Control. Voting rights on policies specific to medical staff will be limited to the medical staff members of the committee. Voting on other policies and procedures will be open to all members of the committee.

Members of the Infection Control Committee are responsible for:

- a. Bringing clinical, administrative, or epidemiological expertise to the Committee.
- b. Participating in data evaluation.
- c. Reviewing and approving infection control policies and procedures.

### 4. Meeting Frequency

The Committee will meet quarterly, but may meet more frequently or be canceled as determined by the Chair.

5. Reporting

The Committee will make a quarterly report to the Quality Improvement and Patient Safety Committee and the Medical Executive Committee concerning current activities of the Infection Control Department and the Infection Control Committee.

K. INTERDISCIPLINARY PRACTICE COMMITTEE (IDPC) – sub-committee of Credentialing and Privileging Committee.

1. Purpose

The Interdisciplinary Practice Committee (IDPC) exists to provide medical staff oversight to non-medical staff practitioners (i.e. APPs) as well as to fulfill State of California requirements related to performance of standardized procedures by advanced practice nurses and privileging of health care professionals who are not members of the medical staff organization of SHC but who are required to be privileged by the Joint Commission. The committee is responsible for recommending appointments and reappointments of Advanced Practice Professionals, delineation of staff privileges and practice protocols. The membership will be consistent with the requirements set forth by Title 22 Section 70706.

2. Duties

- a. Reviewing and recommending approval of credentialing, privileges and standard procedures and protocols to the Medical Executive Committee.
- b. Developing, reviewing and revising credentialing and privileging forms for all Advanced Practice Professionals who are practicing at SHC.
- c. Interviewing a member, supervising physician, or service chief when appropriate concerning appointment, reappointment, or change in privileges, and attempt to resolve any conflicts which may arise.

3. Composition

The voting membership of this committee will include, as a minimum, the Director of Nursing (or Designee) , the administrator (or designee) and an equal number of physicians appointed by the Chief of Staff, and registered nurses appointed by the Director of Nursing (or Designee). Licensed or certified health professionals other than registered nurses who are performing or will perform functions under standardized procedures will also be included in the committee.

4. Meeting frequency

Meetings are held at least quarterly. Some meetings will be held electronically.

5. Reporting

Will report monthly or as needed to the Credentialing and Privileging Committee.

L. JOINT CONFERENCE COMMITTEE

1. Composition

The Joint Conference Committee will be composed of an equal number of members of the Board of Directors and of the Medical Executive Committee, and the Medical Staff Members will at least include the Chief of Staff, the Vice Chief of Staff, and the Past Chief of Staff. The Hospital President and Chief Executive Officer will be a non-voting ex officio member. The chairperson of the committee will alternate yearly between the SHC Board of Directors (even years) and the Medical Staff (odd years).

2. Duties

The Joint Conference Committee will constitute a forum for the discussion of matters of Hospital and Medical Staff policy, practice, and planning, including discussions and, if necessary, informal dispute resolution, relating to disputes between the Hospital and Medical Staff relative to Medical Staff self-governance. The Joint Conference Committee will also serve as a forum for interaction between the Board of Directors and the Medical Staff on such other matters as may be referred by the Medical Executive Committee or the Board of Directors. The Joint Conference Committee will exercise other responsibilities set forth in these Bylaws.

3. Meetings

The Joint Conference Committee will meet as needed and will transmit written reports of its activities to the Medical Executive Committee and to the Board of Directors.

M. OPERATING ROOM MEDICAL COMMITTEE

1. Purpose

The Operating Room Medical Committee (ORMC) of SHC is a sub-committee of the Perioperative Services Medical Committee (PSMC) and is responsible for working with the PSMC in its role to provide oversight of safe patient care in the perioperative region; and to recommend policies, procedures, and process improvements, and ensure adherence to regulatory body requirements for appropriate delivery of surgical and interventional services to patients.

2. Duties

The duties of the ORMC include, but are not limited to:

- a. Overseeing quality improvement aspects of the Operating Room Region, as applied to all surgical patient populations.

b. Identifying new policies and procedures in the Operating Room Region, and to revise existing ones.

c. Making recommendations to the PSMC.

3. Composition

Voting membership of this committee will include the Medical Director(s) of the Operating Room, Administrative Director and Directors of the Perioperative Region, and representatives from surgical and anesthesiology services nursing managers.

4. Meeting Frequency

The Committee will meet quarterly, but may meet more frequently or be canceled as determined by the Chair.

5. Reporting

The Committee will report quarterly to the PSMC.

M. PERIOPERATIVE SERVICES MEDICAL COMMITTEE

6. Purpose

The Perioperative Services Medical Committee (PSMC) of SHC is responsible for providing oversight and taking action on issues related to the delivery of safe patient care, treatment, services, and surgical services in the Perioperative Region; and recommending policies, procedures, and process improvements for appropriate delivery of surgical services including adherence to regulatory body requirements.

7. Duties

In addition to the items described in Section 12.2 "Duties Generally", the duties of the ORMC include, but are not limited to:

d. Overseeing quality improvement aspects of the Perioperative Region, as applied to all surgical patient populations.

e. Identifying new policies and procedures in the Operating Room Region, and to revise existing ones.

f. Making recommendations to SHC Administration and the Chief of Staff office.

g. Providing oversight for the Ad Hoc Block Subcommittee.



h. Serving as the authority for the allocation of block time in the Operating Room Region.

8. Composition

Voting membership of this committee will include the Medical Director(s) of the Inpatient Operating Room, Administrative Director of Perioperative Services, the Service Chiefs of the Departments of Anesthesia and Surgery, the Chiefs of the surgical divisions and/or designees, representation from community surgeons and anesthesiologists, and the Administrative Director of the Operating Room and ASC.

9. Meeting Frequency

The Committee will meet monthly, but may meet more frequently or be canceled as determined by the Chair.

10. Reporting

The Committee will report to the Medical Executive Committee, through the QPSEC covering its activities and outcomes.

## N. PHARMACY AND THERAPEUTICS COMMITTEE

### 1. Purpose

The purpose of the Pharmacy and Therapeutics Committee is to provide oversight and take action on issues related to the medication use process, and to formulate and review policies and procedures related to the medication management process including selection, regulation, compliance, distribution, storage, administration and safe use of drugs within SHC.

### 2. Duties

The duties of the Pharmacy and Therapeutics Committee include, but are not limited to:

- a. Managing the Drug Formulary system which involves evaluating clinical data on medications requested for addition, and regularly evaluating current medications for possible deletion. Criteria will include, but are not limited to, indication for use, effectiveness, risks (including propensity for medication errors, abuse potential, and sentinel events), and costs. Before a medication is added to the Formulary, the patient monitoring criteria are established and are part of the approval and communication process. The Drug Formulary is on-line with access from any clinical workstation throughout the organization.
- b. Reviewing the Formulary on an annual basis for emerging safety and efficacy information.
- c. Providing Medical Staff oversight for the entire medication management process (Selection and Procurement, Storage, Ordering and Transcribing, Preparing and Dispensing, Administering and Monitoring) across the continuum of care (inpatient, outpatient, and home care).
- d. Providing input and approval for all medication management process procedures.
- e. Providing input and approval for any new, revised, or updated policies related to the medication management procedures.
- f. Evaluating the medication management system or risk points and identifying areas to improve safety.
- g. Ensuring that minutes are forwarded to the Medical Executive Committee, through the QPSEC, following approval by the Committee.
- h. Communicating committee activities to the Nursing, Medical, Pharmacy, and other appropriate staff.

3. Composition

Voting membership of this committee will include members of the Medical Staff chosen to ensure representation of a broad range of services/individuals, in order to provide input relating to P&T issues, and the Director of Pharmacy Services. The Committee membership will also include non-voting representatives from the Nursing Service, Hospital Administration, and others as appropriate. The Medication Safety, Antibiotic, and Parenteral/Enteral Nutrition Committees are subcommittees of the Pharmacy and Therapeutics Committee with their minutes being approved by the Pharmacy and Therapeutics Committee.

4. Meeting Frequency

The Committee will meet every other month, but may meet more frequently or be canceled as determined by the Chair.

5. Reporting

The Committee will make a report to the Medical Executive Committee, through QPSEC, covering its activities and outcomes.

O. QUALITY, PATIENT SAFETY AND EFFECTIVENESS COMMITTEE (QPSEC)

1. Purpose

The Quality, Patient Safety, and Effectiveness Committee (QPSEC) is responsible for overseeing performance improvement activities. This committee provides guidance and support for hospital-wide performance improvement and patient safety efforts and is responsible to the Medical Executive Committee and the Quality and Service Committee of the Board of Directors.

2. Duties

The QPSEC is responsible for the following functions:

- a. Fostering a culture that promotes a commitment to continually improving the quality of patient care and services and reducing healthcare errors;
- b. Providing education to key personnel, as needed, on the approaches and methods of performance improvement teams and activities.
- c. Assessing and prioritizing process improvement projects.
- d. Monitoring, measuring, and evaluating the progress of Performance Improvement Teams.
- e. Managing the flow of information to ensure follow-up.

- f. Reporting performance improvement activities to the Medical Executive Committee and to the Quality and Service Committee of the Board of Directors.
- g. Assigning process improvement activities to the appropriate cross-functional teams.
- h. Assisting and providing guidance to teams as needed.
- i. Assisting and coordinating departments and teams in the transition to Hospital-wide team efforts in performance improvement and patient safety activities.

3. Composition

Members are appointed by the Chief of Staff. The membership is interdisciplinary, composed of physicians and administrators. Non-voting members will include; VP's of Ambulatory Care, Clinical Services, Patient Care Services; VP of Quality, Medical Staff Services; Medical Director, OR; Chief Operating Officer; Medical Director of Infection Control, and Chief Medical Officer.

4. Meeting Frequency

This committee meets monthly, at least ten times a year, but may meet more frequently or be canceled as determined by the Chair.

5. Reporting

The Committee will make a monthly report to the Medical Executive Committee covering its activities and outcomes.

P. WELL-BEING OF PHYSICIANS AND PHYSICIANS-IN-TRAINING

1. Purpose

The purpose of the Medical Staff Committee on Well-Being of Physicians and Physicians-in-Training is to provide a forum focusing on:

- a. The matter of the impaired physician or physician-in-training at SHC and LPCH. (Impairment is defined for this purpose to be difficulties arising from a medical condition or the aging process, mental illness or disorder, or the abuse of alcohol or other drugs by any physician or physician-in-training.)
- b. Disruptive or other inappropriate behavior of Medical Staff members or physicians-in-training.

2. Duties

In addition to the items described in Section 12.2, "Duties Generally", the duties of the Medical Staff Committee on Well-Being of Physicians and Physicians-in-Training include, but are not limited to:

- a. Compiling a resource list of organizations and individuals who can provide professional assistance to the impaired person; reviewing and investigating reports of physician impairment and/or behavior problems and assisting physicians in correcting these problems.
- b. Developing a protocol to guide department heads in responding to specific instances of impairment. If appropriate, making recommendations to the Chief of Staff and/or the Medical Executive Committee involving individual impaired physicians and physicians-in-training, and individual behavior problems involving Medical Staff members.
- c. Serving as a statistical resource for such information as incidence, mode of discovery, therapy and long-term follow-up of cases of an informational and educational resource for physician impairment and behavior problems.
- d. Sponsoring and/or publicizing educational programs, when appropriate, that deal with issues of impairment; and develop policies to implement these duties.
- e. Establishing and monitoring the efforts of a Physician Support Panel with responsibility for dealing directly and confidentially with impaired physicians and physicians in training.

3. Composition

Voting membership of this committee will include at least five (5) members of the Medical Staff, including representation from the Medical Staff of LPCH, and will also have representatives from SHC Administration and legal services as non-voting members.

4. Meeting Frequency

The Committee will meet as necessary, but at least quarterly, but may meet more frequently or be canceled as determined by the Chairman.

5. Reporting

The Committee will make an annual report to the Medical Executive Committee covering its activities and outcomes, in accordance with the schedule established by Medical Staff Services.

**ARTICLE THIRTEEN:  
MEETINGS, DUES AND FEES**

**13.1 MEETINGS OF THE MEDICAL STAFF**

**A. REGULAR MEETINGS**

Regular meetings of the Medical Staff may be held at least once a year as recommended by the Chief of Staff. Members of the Medical Staff will be encouraged, but not required, to attend these meetings.

**B. SPECIAL MEETINGS**

Special meetings of the Medical Staff may be called at any time by the Medical Executive Committee or Chief of Staff. The Chief of Staff must call a special meeting of the Medical Staff whenever he/she is presented with a written request for such a meeting, signed by at least seventy-five (75) members of the Medical Staff. No business will be transacted at any special meeting except that stated in the meeting notice.

**C. NOTICE**

Notice of the date, time, and place of the Medical Staff meetings will be sent to each member via email, at least one (1) week prior to the scheduled date of the meeting.

**13.2 CLINICAL SERVICE MEETINGS**

Clinical Services may meet as an organized committee of the Medical Staff as provided in the Clinical Service Rules and Regulations to receive, review, and consider patient care review findings, peer review issues, and other evaluation and monitoring activities of the Service. Attendance requirements for these meetings will be outlined in the Clinical Service Rules and Regulations.

**13.3 MINUTES**

Minutes will be kept of all required meetings of the Medical Staff, the Medical Executive Committee, and the Clinical Services, and will be filed with the Medical Staff Services Department.

**13.4 ATTENDANCE REQUIREMENTS**

To foster quality professional interaction and awareness of items of general interest to the Medical Staff, as well as applicable standards and policies, each Active Staff member is encouraged, but not required, to attend meetings of the Medical Staff.

## **13.5 DUES AND FEES**

### **A. DUES**

1. The Medical Executive Committee will establish the amount of annual dues, if any, for each category of Medical Staff, based on recommendations from the Finance Committee.
2. Medical Staff dues will be separately accounted for in a Medical Staff Dues Account to be used, as appropriate, for the purposes of the Medical Staff.
3. Expenditures from the Medical Staff Dues Account will be limited to the annual budget approved by the Medical Executive Committee. Any dispute regarding expenditures from the Medical Staff Dues Account will be resolved by the Medical Executive Committee.
4. Non-budgeted expenditures will require the approval of the Finance Committee.
5. The Finance Committee will be composed of the Chief of Staff and Vice Chief of Staff.

### **B. PROCESSING FEES**

When making initial application and reapplication for Medical Staff membership, the applicant will be charged a processing fee as determined by the Medical Executive Committee. Processing fees will be accounted for separately and used to support the functions of the Medical Staff Services Department, such as credentialing.

**ARTICLE FOURTEEN:  
CONFIDENTIALITY AND IMMUNITIES**

**14.1 CONFIDENTIALITY OF INFORMATION**

**A. CONFIDENTIALITY OF INFORMATION GENERAL**

Medical Staff, Clinical Services, and Medical Staff Committee minutes, files, and records, including information regarding any member or applicant to this Medical Staff will, to the fullest extent permitted by law, be confidential. Dissemination of such information and records will only be made where expressly required by law, in the authorized conduct of Medical Staff proceedings, pursuant to officially adopted policies of the Medical Staff, including the authorization of representatives of SHC and the Medical Staff to solicit and provide information bearing upon a physician's, dentist's, podiatrist's, clinical PhD in pathology, clinical psychologists, or Advanced Practice Professional's ability and qualifications; or by express approval of the Medical Executive Committee.

**B. BREACH OF CONFIDENTIALITY**

Effective peer review, the consideration of the qualifications of Medical Staff members and applicants to perform specific procedures, and the evaluation and improvement of the quality of care rendered in SHC must be based on free and candid discussions. Any breach of confidentiality of the records, discussions, or deliberations of the Medical Staff Services or Committees is considered outside appropriate standards of conduct for this Medical Staff, disruptive to the operations of the SHC, and detrimental to quality patient care, treatment, and services. Further, all patient care, treatment, and services records and related activities will be kept confidential and not be disclosed inappropriately by any member of the Medical Staff. Any such breach of confidentiality is grounds for immediate removal from committee service and will be a basis for corrective action as specified in Article 6 of these Bylaws.

**14.2 ACTIVITIES AND INFORMATION COVERED**

The confidentiality described in this Article will apply to all acts, communications, reports, or disclosures undertaken in connection with this or any other health care facilities or organization's activities.

**14.3 IMMUNITY FROM LIABILITY FOR ACTIONS TAKEN AND INFORMATION PROVIDED**

Each representative of the Medical Staff and/or SHC, acting pursuant to these Bylaws will be exempt, to the fullest extent permitted by law, from liability to an applicant or Medical Staff member for damages or other relief for any action taken, or statements or recommendations made within the scope of his/her duties, or for providing information concerning any 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 SHC.



#### **14.4 INDEMNITY AND DEFENSE**

SHC will indemnify and defend Medical Staff members for their good faith participation in peer review and committee activities within the scope of their duties pursuant to these Bylaws.

**ARTICLE FIFTEEN:  
ORGANIZED HEALTH CARE ARRANGEMENT WITH SHC**

SHC, together with all members of the Medical Staff, Housestaff, Fellows, Advanced Practice Professionals (APP) , and non-physician health care providers who provide clinical services at SHC (collectively, for the purposes of this Article Fifteen only, "SHC Staff"), constitutes an Organized Health Care Arrangement (OHCA) under the HIPAA Privacy Regulations. Accordingly, SHC and SHC Staff will issue a joint notice of privacy practices, as permitted under the HIPAA Privacy Regulations, and each member of the SHC Staff will abide by the terms of this joint notice with respect to Protected Health Information he or she may receive in connection with his or her participation in professional activities of the OHCA. SHC and SHC Staff may share Protected Health Information with each other as necessary to carry out treatment, payment or health care operations functions relating to the OHCA.

## **ARTICLE SIXTEEN: GENERAL PROVISIONS**

### **16.1 ACCEPTANCE OF PRINCIPLES**

All members of any class or category, by application for membership in this Medical Staff, do hereby agree to be bound by the provisions of these Bylaws, a copy of which will be given in a timely fashion to each member on initial application, and a copy of each amendment thereto promptly after adoption. Any violation of these Bylaws will subject the applicant or member to such disciplinary action as the Medical Executive Committee or the SHC Board of Directors direct.

### **16.2 NOTICES**

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests, and other communications required or permitted to be served on or given to a party or parties by another, pursuant to these Bylaws, will be in writing and will be delivered personally or by United States Postal Service. In the case of notice to the SHC Board of Directors, Medical Staff, or officers of committees thereof, the notice will be addressed as follows:

Stanford Health Care  
Medical Staff Services, MC 5238  
300 Pasteur Drive  
Stanford, California 94305

In the case of a notice by SHC or Medical Executive Committee to an applicant, Medical Staff member, or other party, the notice will be addressed to the business address as it appears in the records of Medical Staff Services at SHC. If personally delivered, such notice will be effective upon delivery to the person or to such address, and if mailed as provided for above, such notice will be effective three (3) days after it is placed in the mail. Any party may change its address as indicated above, by giving written notice of such change to the other party in the manner set forth.

### **16.3 PROFESSIONAL LIABILITY INSURANCE**

#### **A. PROFESSIONAL LIABILITY INSURANCE**

Each member granted Staff membership or privileges at SHC will maintain in force professional liability insurance in a form of coverage and in not less than the minimum amounts, if any, as from time to time may be determined by the SHC Board of Directors on the recommendation of the Medical Executive Committee, or will provide other proof of financial responsibility in such manner as the SHC Board of Directors may from time to time establish.

#### **B. DISPOSITION AND/OR FINAL JUDGMENT**

Each member of the Medical Staff must report to Medical Staff Services the filing or service of any professional liability suit against the member, the disposition (including

settlement) and/or final judgment in professional liability cases in which they are involved within thirty (30) days of disposition and/or final judgment.

#### **16.4 DISCLOSURE OF INTEREST**

All nominees for election or appointment to Medical Staff Officer positions or other offices, leadership positions, Medical Staff or Hospital committees, or the Medical Executive Committee must, at least thirty (30) days prior to the date of appointment or election, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff, as outlined in the Conflict of Interest for Medical Staff policy. The Medical Executive Committee must 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 must be disclosed in writing and circulated with the ballot.

At the time they assume the office, leadership position, or committee membership, and on an annual basis thereafter, practitioners in these positions will be required to sign a Conflict of Interest and Confidentiality statement.

**ARTICLE SEVENTEEN:  
ADOPTION AND AMENDMENT OF MEDICAL STAFF BYLAWS, RULES AND  
REGULATIONS, AND POLICIES AND PROCEDURES**

**17.1 EFFECT AND OBLIGATION OF MEDICAL STAFF DOCUMENTS**

These Bylaws describe the fundamental principles of Medical Staff self-governance and accountability to the Board of Directors. Accordingly, the key standards for Medical Staff membership, appointment, reappointment, and privileging are set out in these Bylaws. Additional provisions including, but not limited to, detailed procedures for implementing these Medical Staff standards may be set out in the Medical Staff's Rules and Regulations, or in the Medical Staff's Policies and Procedures adopted or approved as described below. Applicants and members of the Medical Staff will be governed by such Rules and Regulations and Policies and Procedures as are properly initiated and adopted.

The Medical Staff Bylaws, Rules and Regulations, Policies and Procedures and SHC's Bylaws and Policies are compatible with each other and compliant with law and regulation. The Medical Staff complies with and enforces the Medical Staff's Bylaws, Rules and Regulations, and Policies and Procedures by taking action or by recommending action to the Board of Directors as appropriate and as provided for in these Bylaws. The Board of Directors upholds the Medical Staff's Bylaws, Rules and Regulations, and Policies and Procedures which it has approved. If there is a conflict between the Medical Staff's Bylaws and the Medical Staff's Rules and Regulations and/or the Medical Staff's Policies and Procedures, the Medical Staff's Bylaws will prevail. If there is a conflict between the Medical Staff's Rules and Regulations and the Medical Staff's Policies and Procedures, the Medical Staff's Rules and Regulations will prevail.

**17.2 ADOPTION AND AMENDMENT OF MEDICAL STAFF BYLAWS AND RULES AND REGULATIONS**

**A. General Responsibility**

The Medical Staff is responsible for developing and adopting those Bylaws and Rules and Regulations that relate to the proper conduct of the Medical Staff's organizational activities, and embody the specific standards and level of practice that are required of each Member and other Practitioners who exercise Privileges or provide patient care at the Hospital. Adoption or amendment of Medical Staff Bylaws cannot be delegated.

**B. Formulation**

Proposed amendments of the Bylaws and Rules and Regulations may be formulated and recommended to the Medical Staff, for recommendation to the Board of Directors, by: (1) the Bylaws Committee through the Medical Executive Committee; (2) by the Medical Executive Committee; or (3) upon written petition signed by at least 75 voting members of the Active Staff Members in good standing who are eligible to vote.

**C. Adoption**

The Medical Staff's Bylaws and Rules and Regulations may be adopted, amended, or repealed by an affirmative vote of the majority of the eligible voting members of the Medical Staff responding in a ballot, and will become effective when approved by SHC's Board of Directors. The procedure for distributing, returning, and counting ballots will be

determined by the Medical Executive Committee; provided that a notice informing the Medical Staff of the proposed bylaw amendments will be sent to every Active Medical Staff member at least thirty (30) days prior to the voting deadline.

### **17.3 APPROVAL**

The Medical Staff's Bylaws and/or Rules and Regulations will become effective upon approval of the Board of Directors, which approval must not be withheld unreasonably. If approval is withheld, the reasons for doing so will be specified by the Board of Directors in writing, and will be forwarded to the Chief of Staff, the Medical Executive Committee, and the Bylaws Committee. Once approved by the Board of Directors, all Medical Staff members will be notified and the revised Bylaws and/or Rules and Regulations will be made available to them.

### **17.4 TECHNICAL CORRECTIONS**

The Medical Executive Committee has the power to adopt such corrections to the Bylaws and Rules and Regulations as are, in its judgment, technical modifications or clarifications, such as reorganization or renumbering, or corrections necessary to correct punctuation, spelling, or other errors of grammar or expression or inaccurate cross-references. The Medical Executive Committee may delegate this responsibility to the Chief of Staff or designee. Substantive amendments are not permitted by this Section. Corrections may be effected by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such corrections will be communicated in writing to the Medical Staff and the Board of Directors. Such corrections are effective upon adoption by the Medical Executive Committee and will be permanent provided, however, they may be rescinded by vote of the Medical Staff or Board of Directors within ninety (90) consecutive days after adoption by the Medical Executive Committee.

### **17.5 URGENT AMENDMENT TO RULES AND REGULATIONS**

In the event that urgent action is required to comply with law or regulation, the Medical Staff hereby authorizes the Medical Executive Committee to provisionally adopt a Rule and Regulation and forward it to the Board of Directors for approval and immediate implementation, subject to the following. If the Medical Staff did not receive prior notice of the proposed Rule and Regulation, the Medical Staff will be notified of the provisionally-adopted and approved Rule and Regulation, and may, by petition signed by at least 75 voting members of the Medical Staff require the Rule and Regulation to be submitted for possible recall through the Conflict Management process set forth in Section 16.9. In that event, the approved Rule and Regulation will remain effective until such time as a superseding Rule and Regulation meeting the requirements of the law or regulation that precipitated the initial urgency has been approved pursuant to any applicable provision of this Section.

## **17.6 MEDICAL STAFF POLICIES AND PROCEDURES**

By this Section, the Medical Staff delegates to the Medical Executive Committee the authority to initiate, adopt, and/or amend those Medical Staff Policies and Procedures it deems necessary for the proper conduct of the Medical Staff's work. Proposals for the adoption or amendment of Medical Staff Policies and Procedures may be initiated by the Medical Executive Committee or submitted to the Medical Executive Committee by the Chief of Staff, the Bylaws Committee, or upon timely written petition signed by at least 75 members of the Medical Staff in good standing who are entitled to vote. Proposals for the adoption or amendment of Medical Staff Policies and Procedures may be effected by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. Following adoption, such Policies and Procedures will become effective upon approval of the Board of Directors, which approval must not be withheld unreasonably. If approval is withheld, the reasons for doing so will be specified by the Board of Directors in writing, and will be forwarded to the Chief of Staff, the Medical Executive Committee and Bylaws Committee. Once approved by the Board of Directors, all Medical Staff members will be notified and the revised Policies and Procedures will be made available to them.

## **17.7 EXCLUSIVITY**

The mechanisms described herein are the sole methods for the initiation, adoption, amendment, or repeal of the Medical Staff's Bylaws, Rules and Regulations, and Policies and Procedures. However, nothing in this Section is intended, nor will it be construed to prevent, direct communication by the Medical Staff to the Board of Directors of any proposed or existing Bylaw, Rule and Regulation, and/or Policy and Procedure. However, the Board of Directors must establish the method for any such communication. Unilateral amendment of these Bylaws and/or Rules and Regulations by the Medical Staff, Medical Executive Committee or Board of Directors is not permitted.

## **17.8 CURRENT MEDICAL STAFF BYLAWS, RULES AND REGULATIONS, MEDICAL STAFF POLICIES AND PROCEDURES, AND CLINICAL SERVICE RULES AND REGULATIONS**

All Medical Staff Rules and Regulations, and Policies and Procedures that are in effect immediately preceding the adoption of these Bylaws, and that are not inconsistent with these Bylaws, will be considered as Rules and Regulations and Policies and Procedures adopted in accordance with these Bylaws and will continue in effect until amended pursuant to these Bylaws.

## **17.9 CONFLICT MANAGEMENT**

There is a defined process to manage and resolve conflicts between the Medical Staff and the Medical Executive Committee regarding proposals to adopt Rules and Regulations, Policies and Procedures, or other issues of significance to the Medical Staff. Such conflicts may be identified by a petition signed by at least seventy-five (75) members of the Active Medical Staff. When such conflicts are identified, the Chief of Staff must call a Special Meeting of the Medical Staff as provided in Section 13.1.B of these Bylaws. The sole issue for any such Special Meeting will be the issue in conflict which will be resolved as provided in Section 13.1 of these Bylaws.

The Medical Staff is responsible to the Stanford Healthcare (SHC) Board of Directors for the professional medical care performed at SHC and the quality of medical care rendered. In accordance with the Bylaws of the Medical Staff, the following Rules and Regulations pertaining to professional care are hereby adopted. Individual Clinical Services may adopt Service-specific Rules governing both practice in the Service and the professional medical care to be rendered by members of the Service. These documents are complementary.

## 1. PATIENT TYPES AND ADMISSION OF PATIENTS

### A. *Description*

The Hospital is a general acute care hospital that responds to the medical needs of patients who present for care. In addition, the Hospital manages a set of primary care and specialty clinics. The Hospital accepts for care patients suffering from all types of disease dependent upon available facilities, personnel, and licensure.

### B. *Definitions*

Patient encounters at SHC fall into three general categories: inpatient, emergency, and outpatient. These are based on the service provided as well as on specific regulatory requirements such as Title 22 of the California Code of Regulations and the Medicare Conditions of Participation.

- 1). Inpatient: A person who has been admitted to the hospital for bed occupancy for purposes of receiving care. A person is considered an inpatient if formally admitted to a licensed inpatient bed with the expectation of remaining overnight, even if it later develops that the patient can be discharged before midnight. [\(Medicare's two midnight rule applies for reimbursement of these patients.\)](#)
- 2). Emergency: The provision of emergency medical care in specifically designated areas of the hospital which is staffed and equipped at all times to provide prompt care for any patient presenting urgent medical conditions.
- 3). Outpatient: A person who has not been admitted to the hospital as an inpatient and who is not receiving emergency services but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital.
  - a. Hospitalized Episodes for Outpatients
    - (1) Ambulatory Care Procedure: Outpatient procedures that are generally invasive, including same-day surgeries, angiograms, bronchoscopies, and endoscopies
    - (2) Observation: Those services furnished on the hospital's premises, including the use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition.
  - b. Other Outpatient Episodes/Services



- (1) Clinic Visits: Encounters during which diagnoses and other related information are provided by the physician who performs the examination or who is overseeing the activities of an Advanced Practice Professional
- (2) Diagnostic and Treatment Services: Services such as laboratory and radiological studies, chemotherapy, radiation therapy, and physical therapy, which are performed based on the order of a qualified physician who is also responsible for providing the patient's diagnosis and other clinical justification for the test or therapy.
- (3) Referred Specimen Services: Services rendered when a specimen is sent by an external (SHC or non-SHC) physician's office, hospital, or other institution for evaluation or consultation when the patient does not present to SHC for service

C. *Admission Criteria*

Patients may be admitted to the Hospital as inpatients, accepted for outpatient hospital registration, or accepted for observation services or ambulatory care procedures only by a qualified member of the Medical Staff who has been granted the privilege to admit patients to the Hospital or order procedures in accordance with state law and criteria for standards of medical care established by the Medical Staff. All patients must be under the direct care or supervision of a member of the Medical Staff.

- 1). Only those practitioners authorized in accordance with the Bylaws of the Medical Staff may admit patients to the Hospital. The patient's attending physician will execute, or cause to be executed, all physician responsibilities related to the admission and discharge of patients as expressed in the Hospital's Policies and Procedures governing admitting and discharging of patients from the Hospital.
- 2). The admit order must specify the admission type: (a) Observation, (b) Outpatient Surgery, or (c) Inpatient.
- 3). A change in admission type requires a new order; however, a patient's status cannot change from Inpatient to Observation.
- 4). Except in emergencies, no patient may be admitted to the Hospital without a recorded provisional diagnosis. In the case of an emergency, a diagnosis must be recorded as soon as possible.
- 5). Patients who are treated at Stanford Health Care for diseases diagnosed on the basis of histological sections or the morphological assessment of fine needle aspirates, bone marrow aspirates, or peripheral blood, and when the proposed treatment depends on the interpretation of these specimens, must have such diagnoses confirmed by a Medical Staff member with Pathology privileges, before initiation of therapy, except when urgent therapy is indicated. If the pathology specimens cannot be obtained because they have been destroyed, no longer exist, or have been irrevocably lost or cannot be obtained through reasonable efforts, this should be documented in the medical record.
- 6). It is the responsibility of the Medical Staff member to report all cases of reportable diseases in accordance with Title 17 of the California Code of

## 2. MEDICAL RECORDS

### A. *Definitions*

A medical record consists of medical information that is specific to the patient, that is pertinent to the patient's care and treatment, and that is in the custody of the Hospital's Health Information Management Services Department. The information contained in the medical record, and any other patient-specific information, must be treated in accordance with all applicable legal and ethical rules related to the confidentiality of patient medical information.

### B. *Access*

Access to confidential materials by members of the Medical and other staffs of the Hospital, Hospital employees, and others is only permissible when the person seeking access is involved in the care of the patient or is engaged in peer review, risk management, Medical Staff credentialing, approved research, educational pursuit, or other specifically authorized activity. This requirement applies irrespective of the form in which confidential materials are maintained or stored and applies equally to information stored in hard copy form or electronically stored as follows:

- a. Traditional Paper Chart: legal record prior to 1/29/97. These charts are stored off-site and are retrievable by HIMS.
- b. Electronic Record: legal record from 1/29/97 to present. Any and all (electronic and/or handwritten) documents generated during a patient's stay that have been scanned or directly entered (from 4/25/08). The Electronic Record is stored in EPIC.

### C. *Required Medical Record Elements*

Elements required in a medical record include identification data; appropriate comprehensive history and physical examination; reports and consultations; clinical laboratory, radiology and other special reports; provisional diagnosis; medical or surgical treatments; operative reports; anesthesiology records; pathological findings; progress notes; final diagnosis; discharge notes; clinical summary; autopsy report; and other pertinent information such as Patient Advance Directives and Consent Forms.

### D. *Documentation Rules*

- 1). Unless otherwise stated in these Rules and Regulations, the content, form, nomenclature, permitted abbreviations, and timeliness requirements of all portions of and entries in the patient's medical record must be as stated in the Hospital's Policies and Procedures governing medical records.

- 2) Entries must be legible and authenticated by the individual making the entry. Authentication is defined as written or electronic signature, timed and dated.
- 3). The attending physician is responsible for the timely preparation and completion of the patient Medical Record. Medical Record entries must be authenticated within two weeks following the patient's discharge.
- 4). Medical student entries must include identification of student status and be counter-signed by a supervising physician.
- 5). All entries must be dated and timed. Entries that are time sensitive in the delivery or documentation of care should be timed using the 24 hour clock. The following entries must be timed using 24 hour clock:
  - a. Orders
  - b. Post-operative note immediately following surgery
  - c. Forms that specify a time documentation requirement
  - c. Administration of medications
  - e. Restraint and/or seclusion application and removal
  - f. Emergency Room log of patient arrival, discharge
  - g. Anesthesia note immediately prior to induction
- 6) Symbols and abbreviations may not be used on the face sheet or in the final diagnosis, but may be used within the medical record when approved by the Medical Staff.
- 7) A list of permitted and **not** permitted symbols and abbreviations has been approved by the Medical Staff. Use of **not** approved symbols and abbreviations has the potential to negatively impact patient care. No order for medications will be completed if the order contains a symbol or abbreviation on the **not** permitted list until the physician has been contacted for order clarification. The Pharmacy and Therapeutics Committee and the HIMS Committee will monitor compliance with these requirements.
- 8) A clinic note should be entered into the medical record or dictated for each visit or consult within 24 hours of the encounter.
- 9) All clinic visit documentation must conform with the Centers for Medicare and Medicaid Services (CMS) 95 or 97 Documentation Guidelines for Evaluation and Management Services (regardless of payer), including:
  - a. Chief complaint or reason for visit
  - b. History of present illness
  - c. Review of systems and pain evaluation
  - d. Past family and social history
  - e. Physical examination
  - f. Assessment and plan
- 10) A focused medical assessment must be documented prior to or at the time of an invasive procedure that does not require anesthesia or moderate sedation, and should include:
  - a. Presenting diagnosis/condition

- b. Description of symptoms
- c. Significant past medical history
- d. Current medications
- e. Any drug allergies
- f. Indications for the procedure
- g. Focused physical exam as indicated
- h. Proposed treatment or procedures

11) Orders:

- a. Orders for ancillary and diagnostic services must include the diagnosis (ICD code) and, as necessary, other appropriate information about the patient's diagnosis, or the sign(s) or symptom(s) providing the justification for the service / treatment.
- b. An order for medication must comply with the Medical Staff's approved Policies and Procedures which govern the content of, and nomenclature and abbreviations permitted and **not** permitted in medication orders, both generally and for specific types of medications.
- c. For treatment orders, an explanation must be provided as appropriate.

12) Documentation of phone consultations must be included in the legal medical record.

13) All clinical e-mail correspondence with patients must be maintained with the legal, medical record in accordance with SHC policy "Electronic Mail Use Between Provider and Patient". This should include the patient's initial question and the clinical response.

14) Summary lists must be initiated by the third visit to a primary care provider.

- a. Patients receiving continuing Primary Care at Stanford Clinics will have summary lists in their medical record. The summary lists will contain major and ongoing medical diagnosis/conditions, history of major surgical and invasive procedures, allergies, ongoing medications, and date of last revision. The summary lists will be maintained as part of the permanent medical record.
- b. The summary lists will be revised when the medical condition/diagnosis changes, medications are discontinued or changed, the patient has undergone additional surgical procedures and/or when there is a change in allergy status.

15) Education and instructions provided to the patient and family should be documented in the record.

### 3. CONSENT AND DISCLOSURE

#### A. *Informed Consent*

Unless an emergency exists, no care or treatment may be rendered to any patient in the Hospital, Emergency Department, or Clinics without a written consent signed by the

patient or his/her properly designated representative. In an emergency situation, when immediate services are required to alleviate or prevent severe pain, disability, or death, and the patient lacks capacity to give consent for the services required, the physician recommending treatment to the patient must follow Hospital policies and procedures regarding obtaining consent from a properly designated representative, such as a surrogate, or providing treatment pursuant to the emergency exception if applicable. Except in an emergency situation as defined above, proper informed consent is a prerequisite to any procedure or treatment that is considered complex based on medical judgment, and includes, but is not limited to the following situations:

1. Operative procedures
2. Invasive procedures that have the potential for serious risks and adverse reactions
3. Blood transfusions or other use of blood products
4. Planned use of moderate sedation
5. Electroconvulsive therapy

The informed consent discussion should include at least information about the specific procedure or treatment, the reasonably foreseeable risks and benefits of the treatment, and the reasonable alternatives for care and treatment. Further information on what is required in the discussion and what must be documented is found in the Administrative Manual policy *Informed Consent*.

In all surgical procedures, the physician in whose name the permission for the operation is obtained must participate in person or as a member of the operating team and must be present during the critical portion(s) of the procedure. Such participation may not be delegated without the informed consent of the patient or the patient's properly designated representative.

**B. *Disclosure of Unanticipated Outcomes and Medical Errors***

1) Definitions:

- a) Adverse Event: A detrimental effect from a diagnostic test, defect, failure and/or error within the healthcare system, medical treatment or surgical intervention
- b) Unanticipated Outcome: A result that differs significantly from the anticipated result of a treatment or procedure

2) Disclosure

The attending physician responsible for the patient's care, or his/her designee as appointed by the Chief of Staff, will serve as the primary communicator of an unanticipated outcome or adverse event to the patient and/or family/legal guardian. The person designated as the primary communicator with the patient/family must document in the progress notes of the patient's medical record what was communicated to the patient/family and any response or other discussion.

**C. *Sterilization***

Sterilization procedures are to be performed only in accordance with applicable federal and State law, and must adhere to the procedures outlined in the SHC Informed Consent for Sterilization or Hysterectomy policy. Physicians planning to perform sterilization

procedures must carefully reference these requirements and should seek advice from Risk Management to ensure that all elements of the consent process are met whenever there are any concerns about the consent process.

#### **4. RESEARCH**

- A. Any research project conducted in the Hospital or Clinics involving human subjects must be approved by the Administrative Panel on Human Subjects in Medical Research (the Investigational Review Board or “IRB”) of Stanford University School of Medicine.
- B. The Medical Staff Member who is participating as a Principal Investigator in a research protocol involving human subjects is responsible for submitting the research protocol for approval to the IRB of Stanford University School of Medicine and complying with all IRB requirements relating to the provision of care and treatment of a patient under an approved research protocol.
- C. All research projects must be conducted in accordance with the Medical Staff Policy on Clinical Research, and any applicable SHC policy. Confidentiality is maintained in accordance with SHC HIPAA Research policy.
- D. If there is uncertainty as to whether a proposed plan of care should be designated as research (vs. “innovative care”), the SUMC Innovative Care Guidelines should be consulted.

#### **5. PATIENT ASSESSMENT**

- A. *H&P Requirements* (Must be documented by a member of the SHC medical staff, housestaff, or an Advanced Practice Professional with the appropriate privileges.)
  - 1. A history and physical examination (H&P) must be completed no more than 30 days before or 24 hours after inpatient or outpatient admission. If the H&P was completed within 30 days before admission, an updated examination must be completed and documented within 24 hours after admission.
  - 2. The H&P must be completed for every patient prior to surgery, or a procedure requiring anesthesia services, except in emergencies. In all cases, except for emergencies, the H&P or update must be completed and documented before the surgery or procedure takes place, even if that surgery occurs less than 24 hours after admission or registration.
  - 3. The History and Physical shall include, at minimum, the following components and any other information deemed to be relevant by the examining provider:
    - Chief Complaint
    - History of Present Illness
    - Medications and Medication Allergies
    - Review of Systems
    - Physical Examination
    - Assessment Including Provisional Diagnosis

- Treatment Plan

4. The H&P update shall indicate that the H&P was reviewed, the patient was examined, any changes that have occurred, or that “no changes” have occurred in the patient’s condition. In the case of a surgical update, it shall also confirm that indications for the procedure are still present.
5. In addition to the H&P requirements above, patients undergoing sedation or anesthesia care must also have a Pre-Anesthesia Assessment. The assessment is performed and documented prior to the induction of sedation/anesthesia and considers data from other assessments.
6. The H&P requirement does not apply for Emergency Surgery; however an H&P must be documented as soon as possible after surgery.

## 6. PLANNING CARE, TREATMENT AND SERVICES

### A. Orders

All orders for treatment must be in writing or entered into the electronic medical record, dated and timed, and signed by the issuing practitioner, and should include the issuing practitioner’s pager number. Orders written by an individual who is not a medical staff member, housestaff member, or Advanced Practice Professional (NP or PA) authorized to enter orders must be cosigned by the supervising physician prior to implementation.

### B. Verbal/Telephone Orders

Verbal/telephone orders may be issued by members of the medical staff, housestaff, or Advanced Practice Professionals authorized to write orders to licensed nursing personnel (RN’s) and registered pharmacists. Verbal/telephone orders appropriate to their discipline may be given to any licensed physical therapist, occupational therapist, speech-language pathologist, registered laboratory technologist, registered MRI technologist, registered nuclear medicine technologist, registered sonographer, registered x-ray technologist, or dietician.

Verbal/telephone orders may be issued only if the circumstances are such that an immediate order is required and it would be impractical for the prescriber issuing the order to do so in writing.

- 1) Verbal/telephone orders are appropriate in the following situations:
  - a. Emergency
  - b. If person placing the order is physically unavailable
  - c. If the physician/clinician is performing a procedure
- 2) The ordering provider must identify him/herself using the Epic logon (SID) number, and the nurse will read back this identifier as a part of the order transcription process. The nurse will enter the SID into Epic to document the ordering provider.

- 3) Prescribers must remain on the telephone to allow the receiver of the order to write out the complete order and for the receiver to read it back to the prescriber.
- 4) Verbal/telephone orders must be signed within 48 hours by the prescribing practitioner or by attending or covering physician. Members of a Physician Team may cosign verbal orders for any other member of that team if they are sufficiently familiar with the clinical circumstances and appropriateness of the order. (See SHC Physician Order Policy).

## 7. MEDICATIONS

An order for medication must comply with the Medical Staff approved Medication Policies and Procedures which govern the content of abbreviations and nomenclature permitted in medication orders, both generally and for specific types of medications.

- A. Complete medication orders must include the name of the drug, dosage, frequency of administration, route of administration, date, time, and signature of the prescriber. There should be a documented diagnosis, condition, or indication for each medication ordered.
- B. Orders documented by medical students must be reviewed and counter-signed by a physician prior to implementation.
- C. Medications brought by or with the patient to SHC may not be administered to the patient unless all of the following conditions are met:
  - 1) The drugs have been specifically ordered by the patient's physician and the order entered in the patient's medical record. The order must include the drug name, dosage, frequency, and route.
  - 2) The drugs have been positively identified and examined for lack of deterioration by the pharmacist or physician and have been re-labeled, if necessary, by the pharmacist to provide adequate identification for those responsible for administering the drug.
- D. Upon transfer of the patient to the Operating Room, all medication orders are canceled and must be rewritten. It is not acceptable to write a statement such as "Resume all medications orders"; complete orders for each medication must be documented. If there is a change in Service (e.g. Medicine, Surgery) and/or the physician responsible for the patient, all orders for the patient must be reviewed by the new Service and/or physician, and reaffirmed or discontinued via order documented in the patient's chart.
- E. Only those drugs listed in the SHC Drug Formulary may be administered to inpatients, with the exception of (1) those obtained by the Non-Formulary Drug Procedure; (2) those employed in research protocols approved by Stanford University Medical Center's Administrative Panel on Human Subjects in Medical Research; (3) those employed for purposes of direct therapeutic benefit to a particular patient in an emergency, when approved by the Chief of Staff or the Chief's designee, or (4) those brought by or with the patient to SHC, if all of the conditions in 7.C above have been met. Investigational drugs may be used in accordance with applicable State and federal laws and regulations as well as policies adopted by the Pharmacy and Therapeutics Committee. (See Stanford



Health Care Administrative Manual for detailed procedures and policy for the handling and administration of investigational drugs).

- F. Medication ordering and administration must comply with all the Medication Administration Requirements Procedures such as using patient specific information, monitoring the effects of the medications, not using SHC unapproved abbreviations, etc.
- G. In the following areas (Radiology, Nuclear Medicine, MRI, Emergency Room, Operating Room, Post Anesthesia Care Unit, Cardiac Catheterization, Dialysis, Endoscopy, Bronchoscopy, Echo, Life Flight, and Ambulatory Clinics) the Licensed Independent Practitioner controls the ordering, preparation, and administration of medications.
- H. The Physician is responsible for ensuring that an indication or diagnosis is present in the medical record for every medication prescribed.

## **8. PROVIDING CARE, TREATMENT AND SERVICES**

### *A. Daily Care of Patients*

A hospitalized patient must be seen by the attending physician or a member of the housestaff, or appropriate covering physician, at least daily or more frequently as required by the patient's condition or circumstances.

A progress note must be documented on each patient daily in sufficient detail to allow formulation of a reasonable picture of the patient's clinical status at the time of observation.

### *B. Follow-Up on Outpatient Test*

An attending physician who orders medical tests on an SHC outpatient must ensure that the results of such tests are reviewed (by a physician or appropriated Advanced Practice Professional) no later than 2 business days after those results appear in the electronic medical record (or are made available via fax, mail or other means).

### *C. Consultations*

- 1). It is the responsibility of the Medical Staff through the Chiefs of Services and Medical Directors to see that members obtain consultations when appropriate and when requested by the Chiefs of Services, Medical Directors, or Chief of Staff. Services may specify the minimum criteria as to when a consultation is required. In addition to any criteria for consultation in the Clinical Service Rules and Regulations, a consultation is obligatory in the event that the patient requires a scope of care that is outside the expertise and/or clinical privileges of the attending practitioner, or if there is some uncertainty as to the appropriate course of treatment for a given patient. Consultations must show evidence in the Medical Record of the consultant's review of the patient's record, his/her pertinent findings on the examination of the patient, and the consultant's opinion and recommendations. In case of emergencies, a nurse is authorized to seek appropriate medical consultation if the responsible attending or housestaff physician is not available.

- 2). Two types of consultations may be obtained. Each involves different levels of patient care management and overall responsibility on the part of the consultant.
  - a. "Consultation only" is ordered when the attending physician wishes the consultant to review the patient's records and pertinent findings to render an opinion and make treatment recommendations. The consultant is not directly involved in patient management, does not place orders in the chart, or have overall responsibility for the patient's care.
  - b. "Consultation and management" is ordered when the requesting attending physician wishes the consultant to place orders in the chart and participate directly in patient care management.
- 3). Patients who exhibit significant psychiatric illness with acute exacerbation of symptoms or new onset of symptoms while hospitalized will be referred for an evaluation by a psychiatrist on the medical staff as outlined in the Service Rules and Regulations and hospital policy, if the attending physician believes that management of the patient is beyond his/her scope of practice. Patients with alcohol/drug abuse/intoxication/dependence will be referred for psychiatric evaluation if the attending physician believes management of the patient is beyond his/her scope of practice. Consultation will involve diagnostic evaluation, acute management suggestions and assistance, and referral for outpatient treatment as indicated.

*E. Sedation and Anesthesia*

- 1). Prior to sedation and anesthesia a pre-anesthesia evaluation must be completed, including:
  - a. A focused H&P with particular attention to
    - (1) Any history of adverse or allergic drug reactions with anesthesia or sedation
    - (2) NPO status
    - (3) Level of consciousness
    - (4) Airway assessment
    - (5) Brief description of the planned procedure(s)
    - (6) Planned anesthesia type, including risks, benefits, and alternatives
  - b. Determination of ASA classification
- 2). At the time of sedation and anesthesia:
  - a. Prior to induction of anesthesia or sedation vital signs and oxygen saturation must be updated.
  - b. Immediately prior to the use of moderate or deep sedation or the induction of anesthesia, re-evaluation of the focused H&P must be done.
  - c. Physiological parameters including (but not limited to) vital signs and oxygen saturation must be measured and assessed throughout anesthesia and documented on the anesthesia record or procedure room

record.

- 3) A post anesthesia follow up report by the individual who administered the sedation or anesthesia must be documented within 48 hours after the procedure that necessitated sedation or anesthesia and should
  - (a) Be recorded on the Anesthesia Assessment Form.
  - (b) Specifically document any intra-operative or postoperative anesthesia complications.

*F. Operative Care of Patients*

- 1) Either a full operative or procedure report, or a brief operative or procedure note must be documented immediately following surgery or a procedure (inpatient or outpatient) that requires anesthesia, or deep or moderate sedation before the patient is transferred to the next level of care. If the practitioner performing the operation or procedure accompanies the patient from the operating room to the next area of care, the note can be written in the next area of care. Documentation may be performed by any member of the operative team (LIP, NP, or PA). The brief operative or procedure note must include the following elements:
  - a. The name(s) of primary surgeon and assistants
  - b. Post-operative diagnosis
  - c. Procedure performed
  - d. Estimated blood loss, or indicate "none", if there was no blood loss
  - e. Complications or indicate "none", if there were no complications.
- 2) A full operative or procedure report must be documented or dictated for transcription within 24 hours after surgery. The report should contain:
  - a. Pre-op diagnosis
  - b. Post-op diagnosis
  - c. Operations performed
  - d. Principal surgeon, assistant surgeons, type of anesthesia administered
  - e. Intra-operative findings
  - f. Description of the procedures performed
  - g. Intra-operative complications, if any
  - h. Specimens removed
  - i. Estimated blood loss
  - j. Type of anesthesia or sedation
  - k. Date and time of procedure
- 3) The documentation of reports required by this section may be delegated to a member of the housestaff, an NP or a PA who was present and directly participated during the entire surgery or procedure. The level of involvement of the attending physician (e.g. "was present and directly participated during the entire procedure") must be clearly documented by either the housestaff or by the attending physician. If the housestaff provides the documentation, the attending physician must document an attestation statement confirming his/her level of involvement.

## 9. COORDINATING CARE AND TREATMENT

### A. *Discharge/Death*

- 1). Patients may be discharged only on the order of the responsible physician or allied health practitioner. It is the responsibility of the attending physician, dentist, or podiatrist to plan discharge in a timely and coordinated fashion. The responsible practitioner is obligated to communicate to a referring doctor all appropriate medical information and provide the same information to any institution or agency to which a patient is referred following discharge from the hospital. For patients who have been in the hospital for a period of more than 48 hours, the patient's discharge summary should either be documented in the medical record or dictated within 48 hours of discharge. For patients with a stay less than 48 hours the final progress note may serve as the discharge summary and must contain the outcome of hospitalization, the case disposition, and any provisions for follow-up care. All inpatient deaths must have a death summary regardless of length of stay. The discharge or death summary must be completed by the discharging practitioner within fourteen (14) days of discharge.
- 2) If a patient leaves SHC against medical advice, this must be documented in the patient's medical record and the patient should be asked to sign the appropriate release form.
- 3) Discharge Summary
  - a. The Discharge Summary can be directly entered in the electronic health record or dictated for transcription.
  - b. The content of the discharge summary should be consistent with the rest of the record and includes:
    - (1) Admitting date and reason for hospitalization
    - (2) Discharge date
    - (3) Final diagnoses
    - (4) Succinct summary of significant findings, treatment provided and patient outcome
    - (5) Documentation of all procedures performed during current hospitalization and complications (if any)
    - (6) Condition of patient upon discharge and to where the patient is discharged
    - (7) Discharge medication, follow-up plan, and specific instructions given to the patient and/or family, particularly in relation to activity, diet, medication, and rehabilitation potential
- 4) Death Summary
  - a. The Death Summary is entered in the electronic health record or dictated for transcription.
  - b. The content of the death summary should be consistent with the rest of the record and includes:
    - (1) Admitting date and reason for hospitalization
    - (2) Date of Death
    - (3) Final diagnoses
    - (4) Succinct summary of significant findings, treatment provided and patient outcome

- (5) Goals of Care – if patient was placed on DNR/palliative/comfort/hospice care status
- (6) Documentation of all procedures performed during current hospitalization and complications (if any)

**B. Patient Death**

In the event of death, the patient must be pronounced dead by a licensed physician. The physician pronouncing the death is responsible for determining whether the death is reportable to the County Coroner's Office and must make such reports in accordance with the applicable California laws. The body may not be released from SHC until an appropriate entry by a licensed physician has been made and signed in the patient's medical record. Policies with respect to the release of bodies must conform to California law.

**10. RULES PERTAINING TO SPECIFIC PATIENT SITUATIONS**

**A. Autopsy**

Unless otherwise required by the Coroner, an autopsy may be performed only with a written consent, signed in accordance with applicable law. In the event of a patient death in the Hospital, the physician/Service is expected to attempt to obtain permission to perform an autopsy from the appropriate legally authorized person.

Autopsies are performed by the SHC Pathology Department. The Medical Staff, and specifically the attending physician, should be notified of the time and place an autopsy is performed. The complete post-mortem report should be made part of the medical record within three (3) months.

**B. Suicidal Patient**

For the protection of patients, the Medical and Nursing Staffs, and SHC, the following standards are to be met in the care of the patient who is determined to be potentially suicidal:

- 1) Psychiatric consultation must be obtained immediately (or as soon as the patient's condition permits if the suicide attempt has rendered him/her unconscious) after a patient has threatened suicide or made a suicide attempt.
- 2) Prior to the consultation, the physician in charge of the care should evaluate the type of immediate care the patient requires and write the appropriate orders which might include one or more of the orders described in the SHC "Emotionally Distressed/Suicidal/Alcohol and/or Substance Abuse Patient Plan of Care" policy.
- 3) If a patient's medical history or symptoms suggest a problem with alcohol and/or other drugs, the attending physician is encouraged to seek information and/or consultation regarding alcohol and drug treatment services to assist with detoxification, referral to community resources or treatment sources, and other support.

**C. Restraints and Seclusion**

A restraint or seclusion may only be used if needed to improve the patient's well-being or to protect the safety of other persons, and less restrictive interventions have been determined to be ineffective.

A member of the medical staff, housestaff, or an Advanced Practice Practitioner with the appropriate privileges may order restraints.

The order for restraint or seclusion must comply with the medical staff approved Hospital policy on restraints and seclusion. Standards for restraint and seclusion care exist in the SHC policy for Restraint and Seclusion. Seclusion may only be used in the psychiatry unit and the Emergency Department.

The use of restraints and seclusion to manage violent or self-destructive behavior requires the practitioner to evaluate the individual in person within *one hour* of restraint or seclusion application.

The use of restraints for safety concerns in the delivery of the patient's medical-surgical care (i.e. for non-violent patients or patients who are not self-destructive) requires a physician or LIP order prior to application of restraints. If a physician/LIP is unavailable, and an RN who has successfully demonstrated competence in assessment for restraint has applied restraints for patient protection, a verbal or written order must be placed within 12 hours of the application of the restraint. The patient must be examined by a physician within 24 hours of the initiation of the restraint, and a written order entered into the medical record.

Hospital policy specifies the time within which an order must be obtained after each use of restraint or seclusion and the maximum time for the use of either intervention. PRN orders are not allowed. Restraints are time-limited to no more than one calendar day or 24 hours from the original order. The physician/LIP must do a face-to-face examination of the patient and renew the order at least once each calendar day or 24 hour period from when the order was initiated that the restraint is required.

*D. Organ and Tissue Donation*

Members of the Medical Staff are expected to follow the SHC Organ and Tissue Donation for Brain Dead Patients Policy and the Organ Donation after Cardiac Death Policy. These policies state that the California Tissue Donation Network is to be contacted for assessment and potential discussion of donation with the patient's family at or near the time of imminent brain death.

*E. Tissue Specimens*

All tissue specimens that are clinically relevant to the indication for the procedure during which they were removed, or to subsequent therapy, must be examined by a Medical Staff member with privileges to examine such specimens at SHC to the extent necessary to arrive at a tissue diagnosis. The findings of that examination must be documented by the medical staff member in the patient's medical record.

## **11. TRANSFER OF PATIENT**

If the attending physician transfers the care of a patient to another SHC Medical Staff member, the transferring attending physician should clearly document the transfer of responsibility in the medical record to the accepting attending physician.

## **12. CLINICAL SERVICE POLICIES AND PROCEDURES**

Each Clinical Service may develop policies and procedures to be administered routinely to all patients admitted to their Service. This does not preclude the Medical Executive Committee from adopting similar policies regarding procedures to be administered to all patients admitted to the Hospital. Where clinical service and medical staff rules appear inconsistent, medical staff rules will supersede service rules.

## **13. EMERGENCY SERVICES**

- A. The provision of emergency medical services occurs through the Emergency Department of SHC, which is organized and directed by a member of the Medical Staff who is trained and experienced in Emergency Medicine. The Emergency Department is staffed by housestaff and members of the Medical Staff.
- B. A medical record must be kept for every patient and becomes part of the SHC legal medical record.
- C. A Medical Staff member, or a member of the housestaff under the direct supervision of an SHC Medical Staff member, may determine the need to transfer a patient to another medical facility. This must be done in accordance with EMTALA guidelines and the practitioner making the determination must complete and sign all forms related to the transfer including a transfer statement
- D. On call physicians will respond in person to emergency consultation requests within 30 minutes if on call in-hospital and within 60 minutes if on call outside the hospital. Longer response times are acceptable if agreeable to the requesting physician. In specialties (e.g., radiology, pathology) where direct examination of the patient is often not clinically indicated, the physician must view the relevant images, specimens or other clinical materials within the specified time limits

## **14. CONFLICT OF CARE RESOLUTION**

All members of the health care team have a duty to advocate for the patient through the organizational chain of command when they have concerns about a patient's care. The chain of command involves administrative and clinical lines of authority which are established to ensure effective conflict resolution in patient care situations. In all cases, the final authority in the chain of command on patient care decisions rests with the Chief of Staff or the Chief of Staff designee.

## **15. SUPERVISION OF HOUSESTAFF**

All members of the Housestaff are under the supervision of the Medical Staff. Members of the Medical Staff exercise that supervision under the guidelines established by the Graduate Medical Education Program. Medical Staff members who serve as housestaff supervisors must be licensed independent practitioners, and must hold clinical privileges that reflect the patient care, treatment, and service responsibilities given to the housestaff. Housestaff, who are approved to provide patient care, treatment, and services, may write orders unless otherwise specified in the Bylaws, Medical Staff Rules and Regulations, or Service requirements. However, supervising members of the Medical Staff are responsible for the patient care, treatment, services, safety and quality, and documentation activities of the residents they supervise. The Graduate Medical Education Committee must provide regular reports of the activities of the Graduate Medical Education Program to the Medical Executive Committee, which will communicate this report to the SHC Board of Directors.

## 16. CONFIDENTIALITY

- A. All members of the Medical Staff, Advanced Practice Professionals associated with the Medical Staff, and their respective employees and agents, must maintain the confidentiality, privacy and security of all Protected Health Information in records maintained by SHC or by business associates of SHC, in accordance with any and all privacy and security policies and procedures adopted by SHC to comply with current federal, state and local laws and regulations, including, but not limited to, the HIPAA Privacy Regulations. Protected Health Information may not be requested, accessed, used, shared, removed, released, or disclosed except in accordance with SHC's health information privacy policies and applicable law. Medical record information about a patient whom a Medical Staff member is treating can be furnished by the medical staff member to any health care provider within the facility who has responsibility for that patient's care. This applies to general patients, psychiatric patients, and substance abuse patients as defined by the California Confidentiality of Medical Information Act and the Health Insurance Portability and Accountability Act of 1996.
- B. The use of electronic signature or rubber stamp signature is acceptable only if the practitioner whose signature the electronic signature or rubber stamp represents is the only person who has possession of the electronic UserID and password combination or rubber stamp, and is the only one who uses it.
- C. All electronic data pertaining to the medical care of individual patients is a part of the legal medical record and confidential to the same extent as other SHC medical records. Passwords used by a member of the Medical Staff to access SHC computers may be used only by such member, who may not disclose the password to any other individual (except to authorized security staff of the computer system). The use of a member's passwords is equivalent to the electronic signature of the member. The member may not permit any practitioner, resident, or other person to use his/her passwords to access SHC computers or computerized medical information. Any misuse may, in addition to any sanctions approved by the Medical Staff and/or the SHC Board of Directors regarding security measures, be a violation of state and federal law and may result in denial of payment under Medicare and Medi-Cal.



**Approvals:**

Medical Executive Committee  
Board of Directors

3/7/0on, 4/7/10, 8/3/11, 7/2015  
3/14/07, 5/12/10, 11/14/12, 5/14/14. 7/2015