***MEDICAL STAFF BYLAWS***
***AND***
***RULES AND REGULATIONS***

***OF***

***LUCILE PACKARD***
***CHILDREN'S HOSPITAL STANFORD***

*Palo Alto, CA 94304*

***Revisions:***

***June, 1992***
***March, 1994***
***June, 1995***
***October, 1997***
***June, 1998***
***March, 2000***
***July, 2000***
***November, 2000***
***April, 2003***
***June, 2004***
***May, 2006***
***December, 2008***
***February 2010***
***February 2011***
***June 2011***
***Sept 2011***
***Oct 2012***
***Jan 2014***
***Mar 2015***
***May 2016***
***December 2016***
***April 2018***
***Feb 2020***
***Mar 2021***
***Aug 2022***
***Sept 2023***
***September 2024***

**LUCILE PACKARD CHILDREN'S HOSPITAL STANFORD**
**BOARD OF DIRECTORS**

**SUBJECT:**
**Bylaws, Rules and Regulations of the Medical Staff**
**Effective Aug 2022**

**RESOLUTION:**

WHEREAS, the revised Bylaws, Rules and Regulations of the Medical Staff of Lucile Packard Children's Hospital Stanford have been presented to this Board for approval;

WHEREAS, these revised Bylaws, Rules and Regulations have received the affirmative vote of the majority of the Medical Board members and received the affirmative vote, conducted by electronic or mail ballot, of a majority of the eligible voting members of the Medical Staff of Lucile Packard Children's Hospital Stanford responding;

NOW THEREFORE, BE IT RESOLVED, that the Board of Directors Lucile Packard Children's Hospital Stanford approves the amended Bylaws, Rules and Regulations of the Medical Staff of Lucile Packard Children's Hospital Stanford;

FURTHER RESOLVED, that by reason of such approval, Lucile Packard Children's Hospital Stanford of Directors does not relinquish or delegate its authority to adopt other conditions or criteria relating to Staff membership or privileges. The Board's authority and responsibility in this regard are lodged in it by reason of the laws of the State of California, the Articles of Incorporation, and the Corporate Bylaws of Stanford Health Care.

**LUCILE PACKARD CHILDREN'S HOSPITAL STANFORD**
**MEDICAL STAFF BYLAWS AND**
**RULES & REGULATIONS**

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BYLAWS

**BYLAWS OF THE MEDICAL STAFF**

**LUCILE PACKARD CHILDREN'S HOSPITAL STANFORD**

## PREAMBLE

***WHEREAS, LUCILE PACKARD CHILDREN'S HOSPITAL STANFORD (the Hospital)*** is a non-profit corporation organized under the laws of the State of California; and

***WHEREAS***, its purpose is to operate and maintain an acute care hospital (Hospital) providing safe patient care, treatment and services for infants, children, adolescents, pregnant women, and other adults who have chronic illnesses unique in origin to childhood, and furthering education and research; and

***WHEREAS***, it is recognized that the Medical Staff is responsible to the Hospital Board of Directors for the professional medical care performed in the Hospital and the quality of medical care rendered;

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

## ARTICLE ONE
## NAME AND PURPOSES

### 1.1 NAME

The name of the organization shall be the Medical Staff of the Lucile Packard Children's Hospital Stanford. The organized medical staff is accountable to the governing body of the Hospital.

### 1.2 PURPOSES

The purposes of the Medical Staff are:

A. To strive to ensure that all patients admitted to, or treated in, the Hospital shall receive patient-focused quality care without regard to race, creed, color, sex, age, national origin, ancestry, economic status, educational background, marital status, disability, sexual orientation, or source of payment.

B. To promote education and research that will maintain ethical and scientific standards of medical care and will lead to continuous advancement in professional knowledge and skill, and to maintain high standards for the quality of care for all patients; both as a world-wide referral center and as an acute care community children's and obstetric hospital.

C. To develop and maintain rules of self-governance and conduct of the Medical Staff that assure the quality of professional care performed within LPCHS, 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 Board of Directors and the President and CEO of the Hospital or their designees.

E. To approve and amend the Medical Staff Bylaws, and to supervise and ensure compliance with these Bylaws, Rules and Regulations of the Medical Staff, and with Hospital policies approved and published by the Board of Directors.

F. To provide oversight of care, treatment, and services provided by practitioners with privileges, provide for a uniform quality of safe patient care, treatment, and services; report to, and be accountable to, the governing body.

G. To provide a means for effective communication among the Medical Staff, Hospital Board, and Administration on issues of mutual concern.

H. To maintain professional, collegial relationships within the Medical Staff.

### 1.3 SELF GOVERNANCE

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

A. Establishing in these Bylaws and Rules and Regulations the criteria and standards for Medical Staff membership and privileges and enforcing those criteria and standards.

B. Establishing in the Bylaws and Rules and Regulations clinical criteria and standards to oversee and manage quality improvement, utilization review, and other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff and its committees and departments, and review and analysis of patient medical records.

C. Selecting and removing Medical Staff

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 Governing Body, which approval shall not be unreasonably withheld.

## ARTICLE TWO
## DEFINITIONS

### 2.1 ADMITTING PRIVILEGES

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

### 2.2 ADJUNCT CLINICAL FACULTY (ACF)

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

### 2.3 ADVANCE PRACTICE PROFESSIONALS (APPs)

Individuals who hold a valid license, certificate, or other legal credential as required by California law that authorizes the provision of complex 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 and Clinical Service Rules and Regulations, and the Allied Health Professional Guidelines. APPs may not be members of the LPCHS Medical Staff but are eligible for practice prerogatives.

### 2.4 ASSOCIATE CHIEF MEDICAL OFFICER (ACMO)

The ACMO(s) is appointed by the Chief Medical Officer (CMO) in consultation with the Surgeon in Chief and Physician in Chief and will be responsible for partnering with the CMO and the President of the Medical Staff and Medical Executive Committee for Medical Staff issues at LPCHS. The ACMO(s) will have direct accountability to the CMO.

### 2.5 ATTENDING PHYSICIAN

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

### 2.6 BOARD COMMITTEE

A duly authorized Committee of the Board of Directors.

### 2.7 BOARD OF DIRECTORS

The Board of Directors is the governing body of the Hospital.

### 2.8 CHIEF OF CLINICAL SERVICE

The Chief or Acting Chief of each Clinical Service who shall be appointed by the appropriate Department Chair of the Stanford University School of Medicine after consultation with Dean of

the University's School of Medicine, the Hospital's President and CEO or his/her/their designee, and CMO.

## 2.9 CHIEF MEDICAL OFFICER

The Chief Medical Officer of the Corporation (Lucile Packard Children's Hospital at Stanford) shall be appointed by the President and Chief Executive Officer of the Corporation following consultation with the Dean of the University's School of Medicine. The Chief Medical Officer shall be an associate dean and full-time faculty member of the School of Medicine. The CMO shall be responsible for oversight of the clinical care related issues of all of the medical staff of the Corporation, in conjunction with the President of the Medical Staff and the Medical Executive Committee. The CMO shall report to the President and CEO and work closely with the Dean of the School of Medicine and the School's clinical department chairs on matters affecting the faculty practice, the Hospital's strategic direction, operational matters, and educational and research activities. The CMO shall be subject to removal by the President and CEO following consultation with the Dean of the School of Medicine.

## 2.10 CLINICS

The clinics owned and operated under the LPCHS License in which faculty from the Stanford University School of Medicine provide patient care.

## 2.11 CLINICAL PRIVILEGES (PRIVILEGES)

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

## 2.12 DEPARTMENT HEAD (PEDIATRIC MEDICINE)

The Head of the Department of Pediatric Medicine of the Hospital shall be the person who serves from time-to-time as the Chair of the Pediatrics Department of the Stanford University School of Medicine and shall be responsible for the clinical work of the Department of Pediatric Medicine.

## 2.13 DEPARTMENT HEAD (OTHER THAN PEDIATRIC MEDICINE)

The Head of each Department of the Hospital, other than the Department of Pediatric Medicine, shall be appointed by the President and CEO upon the recommendation of the Dean of the Stanford University's School of Medicine after consultation with the relevant Stanford University School of Medicine's Department Chairs, and Hospital's CMO. The Head of each Department of the Hospital is responsible for the clinical work of the Department.

## 2.14 DESIGNEE

Any reference to an individual holding a duly authorized office under these Bylaws includes, unless otherwise indicated, the authorized 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, without voting rights unless otherwise expressly provided.

## 2.17 FELLOW

A physician registered as a post graduate fellow in the Stanford University School of Medicine. There are ACGME accredited Fellows and non-ACGME fellows, as some fellowships are accredited by the ACGME (Accreditation Council for Graduate Medical Education), and others are not accredited by the ACGME.

## 2.18 HIPAA PRIVACY REGULATIONS

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

## 2.19 HOSPITAL

Hospital means the Lucile Packard Children's Hospital Stanford, including the Hospital's Ambulatory Care Center, all outside licensed facilities administered by LPCHS and, for the purposes of these Bylaws, facilities provided for the Hospital by Stanford Health Care.

## 2.20 HOSPITAL POLICIES

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

## 2.21 HOUSESTAFF

A physician who is in a Stanford Hospital & Clinics-approved Residency program.

## 2.22 IMMEDIATE PAST PRESIDENT OF THE MEDICAL STAFF

The physician who just finished the most recent term of elected President of the Medical Staff.

## 2.23 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 policy of the medical staff.

## 2.24 INVESTIGATION

Investigation means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a member of the Medical Staff and does not include activity of the Well Being of Physicians Committee.

## 2.25 LICENSED INDEPENDENT PRACTITIONERS

Licensed independent practitioners provide medical care to patients, in accordance with state licensure laws, without supervision by a physician.

## 2.26 LUCILE PACKARD CHILDRENS HOSPITAL STANFORD (LPCHS)

The Hospital and Clinics.

## 2.27 MEDICAL EXECUTIVE COMMITTEE

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

## 2.28 MEDICAL DIRECTOR(S)

Physician member(s) of the Active Medical Staff serving the Hospital to provide medical direction in specific clinical unit(s) of the Hospital. Responsibilities may include both administrative and clinical duties.

## 2.29 MEDICAL STAFF

The formal organization of all licensed physicians, dentists, clinical psychologists, and podiatrists who may practice independently and are granted recognition as members under the terms of these Bylaws. The Medical Staff provides oversight of care, treatment, and services provided by its members, and provides for a uniform quality of patient care, treatment and services. It is self-governing, and reports to, and is accountable to, the Board of Directors.

## 2.30 MEDICAL STAFF YEAR

The period from September 1 to August 31.

## 2.31 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 this facility.

## 2.32 MEDICO-ADMINISTRATIVE OFFICER

A practitioner, employed by or otherwise serving the Hospital on a full- or part-time basis, whose duties include certain responsibilities which are both administrative and clinical in nature. Clinical responsibilities, as used herein, are those responsibilities which require a practitioner to exercise clinical judgment with respect to patient care, including the supervision of professional activities of other practitioners. Medical Directors are included in this category.

## 2.33 ORGANIZED HEALTH CARE ARRANGEMENT (OHCA)

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

## 2.34 PEER RECOMMENDATION

Information submitted by an individual(s) in the same professional discipline as the applicant reflecting their perception of the practitioner's clinical practice, ability to work as part of a team, citizenship, and ethical behavior, or the documented peer evaluation of practitioner-specific data collected from various sources for the purpose of evaluating current competence.

## 2.35 PHYSICIAN

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

## 2.36 PHYSICIAN IN CHIEF

The Physician in Chief shall be the person who serves from time-to-time as the Chair of the Department of Pediatrics of the Stanford University School of Medicine. He/she shall work closely with the President and CEO of the Hospital, CMO, and Surgeon in Chief on matters affecting faculty and School of Medicine affairs, the Hospital's strategic direction, and educational and research activities. He/she will have direct accountability to the Dean of the School of Medicine and the President and CEO of the Hospital.

## 2.37 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 or Advance Practice Provider and/or who exercises clinical privileges in this Hospital.

## 2.38 PREROGATIVE

The participatory right 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 and by other Hospital and Medical Staff Rules, Regulations, or policies.

## 2.39 PRESIDENT AND CHIEF EXECUTIVE OFFICER (CEO) OF THE HOSPITAL

The individual appointed from time-to-time by the Board of Directors to serve as the President and CEO of the Hospital or his/her/their authorized representative, who shall direct the overall management of the Hospital.

## 2.40 PRESIDENT OF THE MEDICAL STAFF

The principal elected officer of the Medical Staff who shall serve for a term of two (2) years, as the representative of the Medical Staff.

## 2.41 PROCTOR

An Active member, in good standing, of the Medical Staff of the Hospital or Stanford Health Care with privileges in the specialty area being proctored.

## 2.42 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.

## 2.43 SURGEON IN CHIEF

The Surgeon in Chief shall be appointed by the President and CEO. The Dean of the School of Medicine will be consulted in the appointment. He/she shall work closely with the President and CEO of the Hospital, CMO and the Physician in Chief on matters affecting faculty and School of Medicine affairs, the Hospital's strategic direction, and educational and research activities. The Surgeon in Chief shall have direct accountability to the Dean of the School of Medicine and the President and CEO of the Hospital.

## 2.44 VICE-PRESIDENT OF THE MEDICAL STAFF

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

## ARTICLE THREE
## MEDICAL STAFF MEMBERSHIP AND CLASSIFICATION

### 3.1 MEMBERSHIP

Membership on the Medical Staff of the Hospital shall be extended to physicians, dentists, clinical psychologists, and podiatrists who continuously meet the qualifications, standards and requirements set forth in these Bylaws and who are appointed by the Board of Directors. Membership on the Medical Staff or clinical privileges shall not be denied or granted on the basis of race, creed, religion, color, age, sex, national origin, ancestry, economic status, marital status, disability, or sexual orientation. The preceding sentence shall not justify the granting of membership on the Medical Staff to any person who is not competent to render care of the generally recognized professional level of quality established by the Medical Executive Committee and Board of Directors, and provided the Hospital provides the services within the proposed setting.

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

Members of the Housestaff of LPCHS, or of any other hospital, shall not be eligible for membership on the Medical Staff. Fellows of the Stanford University School of Medicine shall not be eligible for membership on the Medical Staff in the area of their Fellowship. Housestaff and Fellows shall be under the supervision of the Head of the Clinical Department and attending physician(s). A Service Chief may request privileges for trainees of the Stanford University Medical School 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 President of the Medical Staff and Medical Executive Committee. 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. Practitioners in a non-ACGME program (a program not accredited by the Accreditation Council for Graduate Medical Education) are overseen by GME (Office of Graduate Medical Education) of the School of Medicine and may only be credentialed if functioning as an attending physician based on completion of requisite training for that specialty.

### 3.2 EFFECT OF OTHER AFFILIATIONS

No physician, dentist, clinical psychologist, or podiatrist shall 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 LPCHS, or had, or presently has, staff membership or privileges at this Hospital or at another health care facility. Medical staff membership or clinical privileges shall not be

conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, IPA, PPO, PHO, hospital-sponsored foundation, or on a practitioner's opting in or out of Medicare and MediCal participation.

## 3.3 CLASSIFICATION

The Medical Staff shall constitute a unified staff and divided into Active, Courtesy, Refer and Follow, Affiliate, Teaching Only, Honorary, Telehealth Only, and Retired categories. Each time medical staff membership is granted or renewed, the member's staff category shall be determined, or at other times as deemed appropriate by the Medical Executive Committee. For the purposes of the below qualification, patient contact includes documentation in the patient record related to admissions, treatments, consults, teaching, and supervision of physicians in training, outpatient clinic visits, and outpatient surgery and procedures. Referrals alone are not considered patient contact.

A. ACTIVE MEDICAL STAFF

1. Qualifications

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

a. Meet the qualifications set forth in Section 3.5

b. Are able to provide continuous care, treatment and services to their patients in the Hospital, as defined in the relevant Department's Policies and Rules and Regulations

c. Regularly admit, or are otherwise regularly involved in, the care of patients in this hospital (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 shall be to:

a. Admit, treat, or perform services on Hospital 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's 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 limited license practitioner's license that may be present or may arise during hospitalization. Limited license practitioner members may write orders to the extent allowed in the Rules and Regulations of the Medical Staff and their Department, but not beyond the scope of their license.

c. Vote on all matters presented at general and special meetings of the Medical Staff, of Departments and Clinical Services of which they are members, of Medical Staff, Department, or Clinical Service committees of which they are members, and in elections of Medical Staff Services Departments (based on eligibility).

d. Hold office in the Medical Staff organization and in the Department, Service and committees of which they are members

3. Responsibilities

Each member of the Active Staff shall:

a. Meet the requirements of Medical Staff membership defined in Section 3.5

b. Pay dues as determined in accordance with Section 11.1.A.1.o

c. Satisfy any requirements set forth in these Bylaws or in the Departmental Rules and Regulations for attendance at meetings

d. Satisfy requirements of the Rules and Regulations of the Department of which he/she is a member

e. Actively participate in Staff committees, in performance improvement activities, 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

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 shall be automatically transferred to the appropriate category, if any, for which the member is qualified.

B. COURTESY STAFF

1. Qualifications

The Courtesy Staff shall consist of physicians, dentists, clinical psychologists, and podiatrists who:

a. Meet the requirements set forth in Section 3.5 and in the Credentialing policies in regard to activity requirements.

b. Are able to provide continuous care to their patients in the Hospital as defined in the relevant Department's Rules and Regulations

c. Do not utilize this Hospital as a principal hospital in their practice and are not regularly involved in Medical Staff functions

d. Are members in good standing of the Active Medical Staff of another facility in California. If not members of another facility, chart review will be required at time of appointment or reappointment. Exceptions to this requirement may be made by the Medical Executive Committee for good cause.

e. Have a minimum of three (3) and maximum of ten (10) patient contacts per year at this facility. Multiple interactions during a single hospital stay constitute a single patient contact.

f. Surgeons in this medical staff category must have active privileges at SHC.

2. Prerogatives

The Prerogatives of a Courtesy Staff member shall be 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 limited license practitioner's patients and for the care of any medical problem beyond the scope of the limited license practitioner's license that may be present or may arise during hospitalization. Limited license practitioners may write orders to the extent allowed in the Rules and Regulations of the Medical Staff and their Department but not beyond the scope of their license.

c. Attend meetings of the Medical Staff, Department, and Clinical Service committees of which he/she is a member; but may not vote or hold office in the Medical Staff, Departments or Clinical Services of which he/she is a member

3. Responsibilities

A member of the Courtesy Staff shall:

a. Pay dues as determined in accordance with Section 11.1.A.1.o

b. Provide patient activity and quality review information from primary facility as requested at time of reappointment.

c. Satisfy any requirements set forth in these Bylaws or in the Departmental Rules and Regulations for attendance at meetings

d. Satisfy requirements of the Rules and Regulations of the Department of which he/she is a member

e. Actively participate in Staff committees, in 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

4. Limitation:

Courtesy staff members who regularly admit or care for more than ten (10) patients per year at the hospital shall, upon review of the Medical Executive Committee, be obligated to seek appointment to the appropriate staff category.

C. TEACHING ONLY STAFF

1. Qualifications:

Teaching Only Staff should consist of Physicians who:

a. Meet the criteria set forth in section 3.5 and in the Credentialing policy in regard to activity requirements.
b. Have at least eleven (11) contacts at SCH per year documented by attestation by their Service Chief.
c. Holds a current teaching appointment Medicine (Faculty, Emeritus Faculty, Clinical Educator or Adjunct Clinical Faculty) within the Stanford University School of Medicine.
d. Their Department Chair or Division Chief would attest to their ongoing teaching activities and provide the attestation as to their activity at time of reappointment.

2. Prerogatives

Prerogatives of the Teaching Only Staff are:

a. To teach in the clinics or to make rounds on inpatient units with students and other trainees in the course of their teaching activities, but not to treat patients or provide formal consultation, both of which would require privileges as Active or Courtesy members of the staff at LPCH.
b. Attend meetings of the Medical Staff, Department, and Clinical Service committees but not vote or hold office in the Medical Staff, Department, and Clinical Service of which he/she is a member.

3. Responsibilities

Responsibilities of the Teaching Only Staff are to:

a. Meet the basic Medical Staff requirements 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. Attending meetings of the Medical Staff or Clinical Service committees of which he/she is a member.
e. Teaching Only Staff will be exempt from paying Medical Staff dues but will pay credentialing fees in accordance with Section 13.5.B.

D. SHC STAFF CATEGORY

1. Qualifications

The SHC Staff consists of those physicians who:

a. Meet the membership criteria set forth in Section 3.5.
b. Are members of the Active, Courtesy or Provisional Medical Staff or APP staff at SHC.
c. Are called to LPCHS periodically to render care to **adult** patients treated at or admitted to this facility.
d. This category does not apply to practitioners who periodically provide care to pediatric patients at LPCHS. SHC providers wishing to treat or provide care to pediatric patients must apply to the Active or Courtesy Category and meet the requirements and criteria set for pediatric care." See Urgent patient care privileges section in the bylaws to obtain emergency privileges.

2. Prerogatives

a. Consult, treat and otherwise care for adult patients at this facility only on request of the patient's attending physician.
b. Exercise all adult clinical privileges held at SHC (excluding admitting privileges). Privileges are automatically granted by a favorable determination regarding Staff membership in this category. OPPE and FPPE at SHC will be shared with and accepted by LPCHS with respect to membership determination and all clinical privileges held at SHC.
c. To exercise such additional clinical privileges beyond the privileges delineated in 2 b above as are granted through the standard clinical privilege approval process of the LPCHS Medical Staff.

3. Responsibilities

a. Satisfy the requirements of the member's Service.
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.

E. REFER AND FOLLOW

Shall consist of those staff members who do not plan to admit or treat patients at LPCHS but who wish to visit their patients while in the hospital and document such visits in the Medical Record. There shall be no limitation to the number of contacts allowed to refer and follow, and physicians in this Medical Staff category may subsequently apply for privileges in another Medical Staff category at any time. Membership in this category is not required for physicians who refer patients to other members of the Medical Staff. Referring physicians who are not members of the Medical Staff may continue to access their patient's record via the Physician Portal.

1. Prerogatives of Refer and Follow Staff: Members of the Refer and Follow Staff may
   a. Visit and follow his or her referred patients while in the Hospital.
   b. May document their visit and any communications with members of the hospital staff or Medical Staff in the Medical Record.
   c. Access the electronic medical record (EPIC) both remotely and at the Hospital.
   d. Attend meetings of the General Staff and of the Service of which he/she is a member.
   e. Pay application fees as established by the Board.
   f. Be reappointed to the Medical Staff every two years, as required of other categories of Medical Staff membership.
   g. Serve as ex-officio members of Medical Staff Committee (excluding MEC).

2. Limitations of the Refer and Follow Staff. A Refer and Follow staff member may not:
   a. Have responsibility for any aspect of the clinical care of a hospitalized patient.
   b. Write, electronically enter, or give verbal orders.
   c. Perform any procedures.
   d. Hold office at any level in the staff organization or be chairperson of any committee or be elected as a Member at Large to the Medical Executive Committee.

F. AFFILIATE STAFF

The Affiliate Medical Staff shall consist of Medical Staff who do not have patient activity at Lucile Packard Children's Hospital Stanford, but who are providers under the LPCHS managed care contracts or other contractual arrangements or are affiliated with Packard Children's Health Alliance (PCHA) and need to be credentialed and recredentialed through LPCHS. This category also applies to faculty members who practice outside LPCHS (and so do not require privileges here) but who require credentialing to enable coverage by SUMIT malpractice insurance and/or for billing purposes.

1. Qualifications
   a. Meet the Membership Criteria set forth in Section 3.5

b. Do not admit or treat patients at LPCHS
c. May hold a teaching appointment within the Stanford School of medicine or be a member of the provider group under the LPCHS health plan contracts

2. Prerogatives

The Prerogatives of an Affiliate member shall be:
a. May not serve as a voting member of the Medical Staff or Service committees.
b. May attend meetings of the Medical Staff and his/her/their 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. Shall be exempt from paying medical staff dues.
e. Must meet all requirements of Medical Staff and health plan contracts. If applicable.

## G. HOUSESTAFF

A member of the Housestaff does not have independent privileges to admit or treat patients at LPCHS. The Housestaff are employees of Stanford Health Care, and their scope of practice is defined by the Graduate Medical Education Program. Specific policies and procedures governing the oversight of Housestaff within LPCHS 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 LPCHS policies. They are not subject to fees or dues. An official list of current Housestaff Members will be kept in the Graduate Medical Education Office.

## H. FELLOWS

A Fellow does not have independent privileges to admit or treat patients at LPCHS and is not eligible for Medical Staff membership in the area of his/her/their Fellowship. The Fellows are employees of Stanford Health Care, 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 LPCHS 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 LPCHS policies. They are not subject to fees or dues. An official list of current Fellows will be kept in the Graduate Medical Education Office. Refer to Definition of Fellow (2.18)

## I. HONORARY MEDICAL STAFF

The Honorary Medical Staff shall consist of those individuals who, in the judgment of the CMO, the President of the Medical Staff, and the Medical Executive Committee, are distinguished practitioners whose contributions to the Hospital, or whose recognized professional eminence, merit special recognition.

Members of the Honorary Medical Staff shall be eligible to receive Medical Staff meeting notices and to attend Medical Staff, Department and Clinical Service meetings and, with the consent of the Stanford University School of Medicine, to utilize Lane Library. They shall not have privileges to admit or treat patients in the Hospital, nor are they eligible to vote or hold office in this Medical Staff organization.

They shall not be required to pay Staff dues or to attend meetings of the Medical Staff or their Department or Clinical Service.

## J. RETIRED MEDICAL STAFF

Practitioners who are on the Medical Staff of the Hospital and 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 physicians shall be eligible to receive Medical Staff meeting notices and to attend Medical Staff, Department and Clinical Service meetings and, with the consent of the Stanford University School of Medicine, to utilize Lane Library. They shall not have privileges to admit or treat patients in the Hospital, nor are they eligible to vote or hold office in this Medical Staff organization. They shall not be required to pay Staff dues or to attend meetings of the Medical Staff, or their Department or Clinical Service.

## K. TELEHEALTH ONLY

Telehealth shall consist of practitioners who only use remote health care technology to deliver clinical services. Telehealth providers may, from a distance, prescribe, consult, render diagnosis, provide radiologic interpretation, or deliver other health care services. Patient consent to the participation of the Telehealth Practitioner shall be obtained and recorded in the patient's medical record.

1. Qualifications
   a. Meet the Membership Criteria set forth in Section 3.5

2. Prerogatives

   The prerogatives of a Telehealth member shall be:

   a. May only exercise patient care services from a distant site.
   b. May not act as the primary Practitioner responsible for the patient's care.
   c. May not admit patients to the hospital or exercise clinical privileges.
   d. May not serve as a voting member of the Medical Staff or Service committees.

e. May not hold office within the Medical Staff or Service
f. May attend meetings of the Medical Staff and his/her/their Service without vote.

3. Responsibilities
   a. Meet the basic responsibilities of Medical Staff membership defined in Section 3.5.
   b. Not assume the functions and responsibilities of other staff status categories.
   c. Not be responsible for the care of unassigned patients, including the care of staff cases or emergency service care.
   d. Satisfy the requirements of the Service of which he/she is a member and provide telemedicine services at the request of the Medical Staff.
   e. Participate in quality assessment and monitoring activities as assigned by the department or committee chairs.
   f. Are not required to meet the attendance requirements of Article Twelve
   g. Shall pay medical staff dues.
   h. The assigned department for the telehealth provider will have a process in place to ensure monitoring of clinical activities and quality of services.
   i. As these providers do not provide face to face patient care, they are exempt from items required for hospital physicians who present to the hospital (i.e., flu/OHS).

## 3.4 PROVISIONAL STATUS

All initial Medical Staff appointees to the Active, Courtesy, and/or Telehealth Staff, or appointees to the Active, Courtesy, and/or Telehealth Staff, after termination of a prior appointment, shall be in a provisional status. Active, Courtesy, and/or Telehealth Staff members in provisional status shall be assigned to a Clinical Service in which their performance shall be evaluated to determine their eligibility for advancement to non-provisional status in the Active, Courtesy, and/or Telehealth Staff. The requirements of this Section 3.4 shall not apply to reappointees when there has been no prior termination of appointment, or to Honorary and Retired appointees.

### A. QUALIFICATIONS

Active and Courtesy Staff members in provisional status shall 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 or Courtesy member in provisional status who does not qualify for advancement to non-provisional status within twelve (12) months. Following the initial

appointment and the individual so notified; provided, however, that such termination of appointment shall not be contingent upon notification. If a member in provisional status has insufficient patient activity, the practitioner may submit a reasonable plan to increase patient activity Service Chief and Credentials Committee and/or its designee. If the plan is accepted, a six-month reappointment may be granted with the expectation that volume will increase during this timeframe or another category may be offered, if appropriate. If the plan is not satisfactory and it is still determined that the qualifications for membership and privileges were not met, a voluntary resignation will be processed.

A member may immediately re-apply as a new applicant for privileges and the previous proctoring will be re-instituted if the applicant has re-applied within six months. The Member shall 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 shall be entitled to the procedures set forth in Article Seven, if advancement was denied for a medical disciplinary cause or reason.

C. PREROGATIVES & RESPONSIBILITIES

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

D. PROCTORING (FPPE)

1. Each member in provisional status shall complete such proctoring (Focused Professional Practice Evaluation – FPPE) as may be required by the Clinical Department/Service. Proctoring shall be in accordance with criteria set forth in the appropriate Clinical Department Rules and Regulations, and/or the Proctoring Guidelines Policy, and may include direct observation of performance and/or chart review. In cases where there is a new procedure that has not been performed and no one else has that privilege, discussions with other individuals involved in the care of each patient including assistants at surgery, nursing, and administrative personnel may be accepted. A Member shall remain in provisional status subject to completion of proctoring. Documentation attesting to completion of proctoring shall be signed by the proctor or Service Chief.

2. Medical Staff members who change Medical Staff classification to one of greater clinical responsibility, or who are granted additional privileges, shall also complete a period of proctoring as assigned by the Service Chief and approved by the Credentials Committee.

3. Proctoring shall be performed by a member in good standing of the Medical Staff of LPCHS, with privileges in the specialty area being proctored. Each Clinical Service shall establish, in its proctoring guidelines, a term of, and process for, proctoring. Proctoring policy and guidelines are subject to approval by the Credentials and Privileges Committee. Requirements for proctoring may be increased, beyond those specified on a Service's privilege form, as deemed necessary by the Medical

Executive Committee upon the recommendation of 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 by the Service Chief with concurrence of the Credentials Committee and approval by the Board of Directors.

If, at the time of reappointment, it is determined that a sufficient amount of clinical activity has not occurred to evaluate a practitioner's professional competence, proctoring may be imposed by the Service Chief with the concurrence of the Credentials Committee and approval by the Board of Directors. Such proctoring shall not entitle the practitioner to the procedures set forth in Article Seven.

If an initial appointee fails to receive the documentation required in Subsection D.1 above within the proctoring term, his/her/their 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 receive 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 Privileges committee could grant up to a 3-month extension. If privileges are terminated or suspended based on non-completion of the proctoring requirement it does not constitute a fair hearing addressed in Article Seven of the Fair Hearing Section of these Bylaws. Suspension longer than 90 days will result in voluntary withdrawal of membership and privileges from the medical staff unless a further extension is granted by the Credentials and Privileges Committee.

## 3.5 REQUIREMENTS FOR MEDICAL STAFF MEMBERSHIP AND PRIVILEGES

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

A. BASIC REQUIREMENTS

1. Current, unrestricted certificate or license to practice medicine, surgery, dentistry, clinical psychology, or podiatry in the State of California (or licensure exemption allowed by a State of CA licensing Board).

2. Eligible to participate in the Medicare, Medicaid and other federally sponsored health programs.

3. Each Medical Staff member granted clinical privileges in the Hospital shall maintain 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 reserve the right to reject any particular insurance carrier solely at their joint discretion.

4. Maintenance of full DEA Registration (inclusive of schedule II-V controlled substance coverage). Exemptions include Pathologists, Psychologists, Non-Interventional Radiologists, members in the Refer and Follow Category, members in the Affiliate Category as well as Dentists and Orthodontists. Other individuals may apply for an exemption from DEA registration or for a reduced controlled substance schedule coverage with the approval of their service chief. Exemption must be approved by Credentials committee. DEA Licensure is required for all physician assistants regardless of scope of service. DEA licensure is required for Nurse Practitioners if it is within their scope of service as defined by their APP manager and chief physician.

5. Obtain and Maintain Board Certification (Dentists and Psychologists are excluded from this requirement because of the absence of widely accepted Boards in these professions.)

    a. To be granted new or renewed privileges in a specialty or sub-specialty recognized by the American Board of Medical Specialties, the American Osteopathic Association Board, or the Council on Podiatric Medical Education's Joint Committee on the Recognition of Specialty Boards (JCRSB), applicants must hold certification, or be eligible for (as defined by the relevant Board) and actively pursuing initial certification. If the applicant has attained initial certification, the applicant must be deemed, by the Board or Sub-Board for that specialty or subspecialty, to be meeting its requirements for Maintenance of Certification (MOC).

    b. A practitioner who does not meet these basic qualifications is ineligible to apply for Medical Staff membership, and the application shall not be accepted for review, except that members of the 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 shall 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 shall be reviewed by the Medical Executive Committee and the Board of Directors, which shall have the sole discretion regarding whether or not to consider any changes in the basic qualifications or to grant a waiver pursuant to Section 3.9.

    c. Failure to Achieve or Revocation of Board Certification

    Applicants who fail to achieve initial Board certification within the time limit following completion of training imposed by the applicant's specialty Board (i.e. are no longer Board Eligible), will not be granted initial or renewed privileges. In the event that the certifying Board has revoked Board certification for cause, medical staff privileges will also be denied or

revoked; revocation may be stayed while an active appeal of the Board's revocation is in process.

D. Practice or Certification in Multiple Specialties or Subspecialties, or a combination of a Specialty and a Subspecialty

Medical staff members who request privileges in multiple clinical Services must hold and maintain certification in all areas in which they are requesting privileges. (For example, a pediatric cardiologist who also has a general pediatric clinic must maintain Board certification in both Cardiology and General Pediatrics.)

Medical staff members who hold initial Board certification in multiple specialties are only required to meet requirements for Maintenance of Certification for specialties in which they hold privileges. (For example, a physician who is Board certified in pulmonology, cardiology, and critical care but has privileges in only the Pulmonology Service, is only required to maintain certification in that subspecialty.)

Subspecialists who hold privileges only in their subspecialty need not maintain privileges nor participate in Maintenance of Certification in their primary specialty.

e. Exceptions

1. Practice prior to adoption of these requirements: Members of the medical staff who held privileges as of August 2014, completed their relevant training before 2010, and were never Board certified will not be required to become Board certified or to meet the requirements of MOC to maintain their current privileges.

2. Permanent Certificates: Applicants who hold permanent certificates are encouraged but not required to fulfill requirements for Maintenance of Certification in their specialty or subspecialty.

3. Foreign Training and Certification. An equivalent foreign certification deemed acceptable by the Credentials and Privileging Committee may be accepted in lieu of the requirement for initial Board certification and MOC.

4. Failure to Meet the Requirements of MOC: Applicants with time-limited certification who have obtained initial certification but who are not currently meeting requirements for Maintenance of Certification (MOC), as defined by the relevant Board, may appeal to the Credentials and Privileging Committee for an extension of privileges for a limited period of time while remedying this deficiency. The time limit will generally be less than 1 year but will be reviewed on a case-by-case basis with full consideration of the timing and logistics of the actions necessary to remedy the deficiency and fulfill the requirements mandated by the relevant Board or Sub-Board.

5. The creation of a new Board or Sub-Board: Applicants who have been actively practicing in a specialty or subspecialty for which a new Board certification is created will not be required to obtain or maintain certification in that new specialty or subspecialty. Applicants who complete training in a specialty or subspecialty for which a new Board or Sub-Board has been created *after* the creation of said new Board or Sub-Board will be eligible for privileges in that specialty or subspecialty only if they meet the requirements for initial certification and MOC as outlined above.

6. Limited Privileges within a Subspecialty: Notwithstanding any of the above, and with the approval of the Credentials and Privileging Committee, a subspecialty service may define privileges of limited scope within the subspecialty that can be granted only to physicians certified and maintaining certification in the governing specialty.

7.For pediatric hospital medicine, board certification in either Pediatrics or Pediatric Hospital Medicine are acceptable for privileges.

8. Other: Unanticipated situations may arise where specified requirements and deadlines may not be appropriate. Such cases will be adjudicated by the Credentials and Privileging Committee, which can recommend exceptions to these requirements for final approval by the Medical Executive Committee. Denial of exceptions may be appealed to the Medical Executive Committee.

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

   a. The ability to work cooperatively with others in the provision of care, treatment, and services.

   b. Relevant education, training and/or experience; and

c. 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 Lucile Packard Children's Hospital Stanford Board of Directors.

2. Their pledge to provide patients with continuous care that meets the professional standards established by the Medical Staff of this Hospital.

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 to cooperate or participate 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 hospital performance improvement, utilization review and peer review, proctoring, and attend the required number of Medical Staff, Clinical Department, and Clinical Service meetings.

6. Their promise to prepare and complete, in a timely, accurate and legible manner, the medical and other required records for all patients the member in any way provides care to while in the Hospital. This includes assuring the completion of a physical examination and medical history on all patients within 24 hours after admission or immediately before. This requirement may be satisfied by a complete history and physical that has been performed within the 30 days prior to admission (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 President of the Medical Staff and CMO in writing within thirty (30) days 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, and the filing or service of any professional liability suit against the member, or 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.

8. Their promise to notify the President of the Medical Staff and CMO in writing immediately of any change or termination of malpractice insurance coverage.

9. Their promise to provide to the President of the Medical Staff and the CMO, in writing immediately, information as to details of any prior or pending government agency or third-party payer proceeding or litigation challenging or sanctioning applicant's patient admission, treatment, discharge, charging, collection, or utilization practices, including, but not limited to, Medicare and Medi-Cal fraud and abuse proceedings and convictions.

10. Their promise to abide by the Medical Staff Bylaws, Rules and Regulations; the Policies, Rules and Regulations of the Department of which they are a member, and other policies of the Medical Staff and LPCHS, the Bylaws of the Hospital; and all policies and regulations adopted by the Board of Directors; policies regarding discrimination and harassment; the LPCHS Code of Conduct; and the 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 Departments and Clinical Services of which they are members.

14. Their promise to participate in emergency or other Clinical Service coverage as specified in the Rules and Regulations of the Departments of which they are members and any consultation panel responsibilities as may be determined by the Medical Executive Committee, President of the Medical Staff, CMO, Department Head, or Service Chief.

15. Their promise to participate in quality assurance and quality improvement activities of the Medical Staff and the Clinical Service of which they are a member, and to hold knowledge of the content of these activities as strictly confidential.

16. Their promise to notify the President of the Medical Staff and CMO in writing within thirty (30) days of any change in clinical privileges at other hospitals, whether voluntary or involuntary.

17. Their promise to provide a valid mailing address and email address to the Medical Staff Services Department to be used for communication of Medical

Staff business, and to notify the Medical Staff Services Department of any changes to the mailing or email address.

## 3.6 DURATION OF APPOINTMENT TO THE MEDICAL STAFF

Appointment and reappointment to the Medical Staff shall be for a period of not more than two (2) years. This provision shall not apply to members who have no patient care responsibility or prerogatives (i.e., Honorary or Retired Staff members).

## 3.7 MODIFICATION OF MEMBERSHIP

Upon recommendation of the Credentials Committee, or Department Head, 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 member of the Medical Staff who is appointed to perform clinical or administrative duties or a combination of both (e.g., CMO, Department Head, Chief of Service, Director of Laboratory, Medical Director) must be a member in good standing of the Medical Staff and shall be subject to the same credentialing procedures as are all other applicants for membership and clinical privileges.

## 3.9 TERMINATION SUSPENSION OR ADMINISTRATIVE LEAVEOF FACULTY APPOINTMENTS

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 on the basis of appointment to a clinical 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/their faculty or Clinician Educator category, effective the last date of said appointment.. Appointment to the Courtesy Teaching category will terminate if the Adjunct Clinical Faculty (ACF) appointment ends. A Medical Staff member who intends to remain on the Medical Staff of the Hospital, after termination of their Faculty, Clinician Educator or Courtesy Teaching appointment, is expected to notify the MSSD of their intention to remain on the Medical Staff within 30 days of the termination of the faculty appointment. The provider may request a modification of membership category under Section 3.7 with said request necessitating approval by the Credentials Committee.

Privileges will be suspended at the end of the faculty appointment unless and until the member provides proof of new malpractice coverage. If the administrative suspension has not been lifted within 30 days following the termination of the faculty appointment, the provider will be considered to have resigned from the Medical Staff and will be asked to complete a new application for privileges should they wish to then rejoin the Medical Staff.

Similarly, during any period of suspension or administrative leave from the School of Medicine, the member's medical staff membership and privileges will be deemed suspended as well. This rule also applies to ACF appointments. It is the responsibility of the division/service chief to report any administrative leave to the MEC and Credentials Committee. The requirement to report does not apply to medical leave.

Membership and privileges may be reinstated upon notification to the MSSD of the end of such leave by the faculty member and confirmation by the Service Chief to the effect that the faculty member remains in good standing and that there is no information available to the Service Chief that would indicate the faculty member is not eligible for Medical Staff membership and privileges.

## 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 Medical Executive Committee, upon determination that such waiver will serve the best interests of the patients and of the Hospital, with the approval of the Board of Directors.

## 3.11 HARASSMENT PROHIBITED

Harassment by a Medical Staff member against any individual (i.e., against another Medical Staff member, House Staff, 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, gender, or sexual orientation shall not be tolerated.

"Harassment" is verbal or physical conduct that denigrates or shows hostility or aversion toward an individual because of his/her/their, race, religion, color, national origin, ancestry, age, disability, medical disability, marital status, sex, gender, or sexual orientation or that of his/her/their 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, 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, 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 (1) submission or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion or other aspects of employment; or (2) this conduct interferes with the individual's employment or creates an intimidating, hostile or offensive work environment. Sexual harassment also includes conduct which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities, or which interferes with the educational process of medical and/or graduate students.

All allegations of harassment shall 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 AND REAPPOINTMENT TO THE MEDICAL STAFF

### 4.1 PROCEDURE FOR APPLICATION FOR CREDENTIALING AND PRIVILEGING

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

A. Be subject to the application and reappointment process set forth in the Credentialing Policy and Procedures. Such policies and procedures 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 Credentialing Department on the forms prescribed for the purpose by the Medical Executive Committee; properly completed means that all provisions have been completed (blanks filled in, boxes checked as needed, all questions answered, all signatures in place) 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 Medical Staff Services Department 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 conduct a background check.

F. Submit any information requested by the President of the Medical Staff, Credentials Committee, Medical Executive Committee or Board of Directors pertaining to current competence, appropriate education and training in the applicant's field.

G. 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 bearing on the applicant's qualifications.

H. Authorize the release of all records and documents that in the judgment of the President of the Medical 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.

I. 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.

J. 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/her and the status of such matters.

K. Submit any information regarding any past, present or current exclusion from a federal health care program.

L. Submit relevant information pertaining to the applicant's physical and mental health.

M. Submit information pertaining to his/her/their 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.

N. 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 the Rules and Regulations of the Department in which he/she is requesting membership, 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.

O. Agree to appear for such interviews and provide such additional information as may be requested by the President of the Medical Staff, Department Head, Service Chief, Credentials Committee, Medical Executive Committee, or Board of Directors.

P. 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.

Q. 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.

R. Failure to pay credentialing fees for initial application or for reappointment application, by the specified deadline, as required under Section 3.5, 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 voluntary resignation.

## 4.2 APPLICANT’S RESPONSIBILITY

The applicant for appointment, reappointment, advancement or transfer, shall have the responsibility of producing complete, accurate and adequate information for a proper evaluation of his/her/their 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, and for resolving any doubts about these matters, and of providing any

additional information requested by the President of the Medical Staff, Chair of the Credentials Committee, or the Medical Staff Services Department. This responsibility 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 shall be grounds for denial of the application or subsequent termination, suspension or limitation of membership or privileges under Article Six of these Bylaws. The President of the Medical Staff or Medical Staff Services Department shall notify the applicant of any areas of incompletion and/or failure of others to respond to such information collection or verification efforts within 30 days of when the initial application is received, and it shall then be the applicant's obligation to obtain all the required information. Failure to complete the application and/or submit any additional requested information within thirty (30) days of a request therefore by the President of the Medical Staff or Medical Staff Services Department may, in the sole discretion of the President of the Medical Staff, be deemed a voluntary withdrawal of the application and not subject to challenge under Article Seven of these Bylaws. Once the Medical Staff Services Department receives a completed application, the application is acted upon with 3 business days.

## 4.3 CONSIDERATION OF APPLICATION

A. The procedure for consideration of appointment to the Medical Staff shall be outlined in the Credentialing Policy and Procedures. Current professional licensure is verified through the primary source, and all other verifications are gathered from the primary source whenever feasible.

B. After an examination of the completed application, the report of the Department Head/Service Chief and all supporting material, the Credentials Committee shall transmit a written report to the Medical Executive Committee, along with supporting materials, which shall indicate on the basis of its evaluation of the applicant's current clinical 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 Department or Clinical Service

C. Upon receipt of the recommendations of the Credentials Committee, the Medical Executive Committee shall review this information; conduct any further investigation regarding the applicant's character, competence, health, and ethics which it deems appropriate.

1. Provide the Lucile Packard Children's Hospital Stanford 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 Lucile Packard Children's Hospital Stanford 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 Lucile Packard Children's Hospital Stanford Board of Directors with a recommendation that the applicant is not appointed to the Medical Staff.

D. In the event that the Medical Executive Committee acts C.2 or C.3 above, the applicant shall be notified of the adverse recommendation and of his/her/their right to request a hearing under Article Seven. No final action shall be taken by the Board of Directors until the applicant has waived or exhausted his/her/their hearing rights.

E. Upon receipt of the completed application, supporting information, and recommendation from the Medical Executive Committee, the Board of Directors shall act upon the application and shall 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 shall approve the specific clinical privileges granted the Medical Staff member. The Board of Directors shall give great weight to the actions and recommendations of the Medical Executive Committee and, in no event, shall act in an arbitrary and capricious manner. When the LPCHS Board of Directors has adopted the decision, it shall be considered the final decision of the Hospital.

F. All decisions by the Board of Directors approving or disapproving the appointment or reappointment of an applicant shall be forwarded, in writing, to the applicant with a copy to the President of the Medical Staff and CMO.

G. In the event of an unwarranted delay in the application process, the Board of Directors may act on a properly completed application without the recommendation of the Medical Executive Committee, Credentials Committee, and/or Department Head upon request of the applicant. For the purpose of this Section, unless specifically waived in writing by the applicant, unwarranted delay shall mean one hundred and eighty days (180) from the date that the properly completed application has been received. In all cases the decision to appoint or reappoint shall be based upon the same information as is usually considered by the Department Head, Credentials Committee, and Medical Executive Committee.

H. The LPCHS Board of Directors may establish a committee, with a quorum of two, consisting of at least two physician members of the LPCHS Board of Directors, for the purpose of acting on its behalf on the credentials and privileges of physicians as well as their reappointments to the Medical Staff of LPCHS between meetings of the LPCHS 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 shall be reported to, and confirmed by, the LPCHS Board of Directors at its next regular meeting.

I. Should the 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 Section 4.3.G. above, the applicant shall be notified of the preliminary adverse decision and of his/her/their right to request a hearing under Article Seven. No final action shall be taken

by the Board of Directors until after the applicant has waived or exhausted his/her/their hearing rights.

J. Any time periods specified in this Section 4.3 are to assist those named in accomplishing their tasks and shall not be deemed to create any right of the applicant to have his/her/their application processed within those periods.

K. 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, shall 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. LEAVE STATUS

A Medical Staff member may obtain a voluntary leave by submitting a written request to the President of the Medical Staff or CMO stating the reason(s) for the leave and the approximate length anticipated. Alternatively, should the President of the Medical Staff or CMO determine that a member should be on a leave of absence, he/she/they may place the member on leave **without prior approval of the Medical Executive Committee**. All leaves must be approved ratified by the Medical Executive Committee **in the normal course of the credentials process**. During the leave of absence, the member's clinical privileges are suspended.

B. LENGTH OF LEAVE

A leave of absence may last for a minimum of sixty (60) days and a maximum of one (1) year. A leave may be renewed for up to a maximum, total period of two (2) years. If the member's medical staff appointment ends during a period of leave, he/she may be reappointed while on leave through the normal reappointment process.

C. TERMINATION OF LEAVE

At least thirty (30) days prior to a desired return to practice, the member may request reinstatement of his/her/their clinical privileges by submitting a written request to the Medical Staff Credentials Committee. The member will provide a written summary of his/her/their activities during the leave and provide documentation of fitness to resume clinical practice, if applicable. The member will respond to any questions from the Credentials Committee. Thereafter, the Credentials Committee will provide a recommendation to the Medical Executive Committee. A member may resume clinical practice/have privileges reinstated only on approval of the Medical Executive Committee.

D. TERMINATION OF MEDICAL STAFF MEMBERSHIP

Failure to request termination of a leave/resumption of clinical practice by the end of a leave period will be deemed a voluntary resignation of Medical Staff membership. Continuation of a leave while questions from the Credentials Committee or Medical Executive Committee are resolved after a request for reinstatement will not entitle the member to the hearing rights under Article IX of the Medical Staff Bylaws. A denial of instatement by the Medical Executive Committee or a reinstatement with privilege limitations will entitle the member to the procedural rights under Article IX only if the action is reportable to the Medical Board of California (Section 805 report).

## 4.5 REAPPOINTMENT TO THE MEDICAL STAFF

A. Reappointment to the Medical Staff shall occur biennially. Staff members whose appointments are scheduled to expire shall receive notification and shall 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 Procedures.

B. The reapplication shall in all respects be processed in the same manner as applies under Sections 4.1 through 4.3 for applications for appointment to the Medical Staff, and the applicant shall 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 of 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 shall not result in any hearing rights.

C. The properly completed reapplication form and all necessary documentation shall be forwarded to the Department/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 Department/Service shall 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 Department/Service are reviewed by the Credentials Committee and forwarded to the Medical Executive Committee. The Medical Executive Committee forwards recommendations to the Board of Directors for reappointment.

D. If a completed reappointment packet is not returned within the time period specified, the member will be processed as a voluntary resignation effective on the date his/her/their appointment expires, except in the event of an ongoing formal review of the Medical Staff member’s conduct and such other penalties as may be imposed by the Medical Executive Committee, subject to Board of Directors approval. If the applicant wishes to re-establish membership and privileges, he/she will be required to reapply as a new applicant and be assessed all relative application fees.

E. A subsequent request for Medical Staff membership received from a member who has voluntarily resigned in this manner shall 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 shall 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 Board of Directors of LPCHS may designate a verification service to serve as a designee of the Medical Staff, the President of the Medical Staff, the Medical Staff Services Department, the President and CEO, and the LPCHS 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 shall be limited to collecting verified, objective data, and the Medical Staff and LPCHS 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 President of the Medical Staff, the Medical Staff Services Department, the President and CEO and/or the LPCHS Board of Directors to use the services of documentation and verification service for the limited purposed described in this Section.

## ARTICLE FIVE
## CLINICAL PRIVILEGES

### 5.1 PRIVILEGES EXTENDED TO THE MEDICAL STAFF

A. Members of the Medical Staff shall be entitled to exercise only those delineated clinical privileges specifically granted to them by the Medical Executive Committee and the LPCHS Board of Directors in accordance with these Bylaws. All clinical privileges shall be requested and processed pursuant to the procedures outlined in Article Five. A mechanism is in place which allows assessment of whether an individual with clinical privileges provides services within the scope of those privileges granted.

B. Each Department/Service shall define the privileges delineation and criteria that shall be used 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 Board of Directors are provisional and subject to the terms of Sections 3.4 above.

B. Each Department shall 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 shall 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 shall 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 shall make an objective and evidence-based decision with regards to each request for privileges. Requests for clinical privileges shall be evaluated on the basis of the member's education, training, experience, current demonstrated professional competence and judgment, evidence of current proficiency in 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.

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 determinations 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 shall also be based on peer recommendations which address the applicant's.

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

When available, relevant practitioner-specific data as compared to aggregate data and mortality and morbidity data shall 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 shall 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 CMO or President of the Medical Staff, as the designee of the President and CEO of the Hospital, may, with the evaluation and written approval of the appropriate Service Chief, grant temporary clinical privileges to a qualified practitioner under the circumstances and subject to the conditions 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 Chief will assign proctors as appropriate.

### A. WHILE WAITING APPROVAL BY THE GOVERNING BODY

Temporary privileges for new applicants may be granted while awaiting review and approval by the Medical Executive Committee and governing body 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 Medical Board of California information
- 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. VISITING TEMPORARY PRIVILEGES (Urgent/Important Patient Care)

Temporary privileges are granted to meet an important patient care need for the time period defined in the medical staff bylaws. An important patient care need is typically defined by the requirement for services that are not currently offered or that no practitioner in the hospital is currently able to perform. The temporary privileges are granted only for specific privileges/procedures that must be performed on an emergent basis. Upon receipt of a written request for specific temporary privileges, an individual otherwise eligible for Medical Staff privileges, but who may not be an applicant for membership, may be granted temporary privileges for the care of one or more specific patients. Such privileges shall 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 privileges within the limitations of California Business and Professions Code Section 2060 are not subject to this limitation. Such privileges shall be subject to the requirements set forth in the Credentialing Policy and Procedures. Temporary Privileges based on urgent/important patient care need require the following verifications:

- Temporary privilege request
- Licensure
- National Practitioner Data Bank (NPDB)
- Current Competence (method of verification will be determined by the Credentialing of the Medical Staff and Advanced Practice Professionals policy).
- Proof of current malpractice insurance with coverage amounts as defined in Bylaws.

C. 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 Head of the Department to which the practitioner is assigned shall be responsible for monitoring the performance of the practitioner granted temporary privileges, or for designating a Department member who shall assume this responsibility. Special requirements of consultation and reporting may be imposed by that Head. 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/their temporary privileges.

## 5.7 DENIAL AND TERMINATION OF 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 temporary privileges granted, or compliance with these Bylaws, Rules and Regulations, Rules and Regulations of the Department or other requirements, the President of the Medical Staff and/or CMO may, after consultation with the Department Head, deny or terminate any or all of such individual's temporary privileges. The denial or termination of temporary privileges shall not be reviewable according to the procedures set forth in Article Seven of the Medical Staff Bylaws unless required to be reported pursuant to Business and Professions Code section 805. In the event of any such termination, the practitioner's patients then in the Hospital shall be assigned to another practitioner by the Department Head/Service Chief. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner. An applicant whose temporary appointment and temporary privileges were terminated for administrative purposes, e.g., failure to pay fees, shall remain eligible to apply for Medical Staff membership and clinical privileges.

## 5.8 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 an emergency situation, a practitioner, to the degree permitted by his/her/their license and regardless of Department Head/Service Chief, Medical Staff status, or clinical privileges, shall be permitted to do, and shall be assisted by LPCHS personnel in doing everything possible to save a patient from danger. When an emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are either not requested, or denied, the patient shall be assigned to an appropriate member of the Medical Staff by the President of the Medical Staff and/or CMO.

B. EMERGENCY MANAGEMENT PLAN (DISASTER PRIVILEGES)

Emergency (Disaster) 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.

## 5.9 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

A. ADMISSIONS

1. Limited License Practitioners (Dentist (DDS), non-MD oral surgeon (DMD), clinical psychologists (Ph.D.), 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/their own patient. Otherwise, a physician member of the Medical Staff must conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry or podiatry).

B. SURGERY

Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the Head of the designated Department or his/her/their designee.

C. MEDICAL APPRAISAL

All patients admitted for care in the Hospital by a dentist, non-MD oral surgeon, psychologist or podiatrist shall receive the same basic medical appraisal (including a properly documented history & physical) as patients admitted to other services, and a physician member or a limited license practitioner with appropriate privileges shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based 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 department(s).

## 5.10 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.

## 5.11 LAPSE OF APPLICATION

If a medical staff member requesting a modification of clinical privileges or department assignment fails to timely furnish the information reasonably necessary to evaluate the request, the application shall automatically lapse, and the applicant shall not be entitled to a hearing as set forth in Article Seven.

## ARTICLE SIX
## FOCUSED REVIEW OF MEDICAL STAFF MEMBER CONDUCT

### 6.1 BASIS FOR REVIEW

The procedures provided in this Article shall be invoked, after collegial intervention efforts have not resolved the issue, whenever it appears that the activities or professional conduct of any member of the Medical Staff:

A. Jeopardizes or may jeopardize the care, treatment of provision of medical services to a patient, or the safety of a patient, 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 Bylaws, Rules and Regulations of the Medical Staff, the Rules and Regulations of the Departments of the Medical Staff, or Hospital policies, including Code of Conduct**,** or constitutes conduct that is, or is reasonably probable of being, disruptive to Hospital 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 submitted, in writing, to the President of the Medical Staff, and supported by reference to specific activities or conduct alleged. The President of the Medical Staff will apprise the Medical Executive Committee of the request for investigation. After discussion of the request for an investigation, the Medical Executive Committee may determine that an investigation commences or that no further investigation is warranted. In either event the affected member of the Medical Staff will be notified in writing that a request for investigation has been made and that an investigation will or will not commence If the Medical Executive Committee was the source of the request for investigation, it shall make an appropriate record of the reasons. Early in any investigatory process, the Medical Staff member will be afforded the opportunity to meet informally with the committee, officer, or Department Head conducting the investigation. If, in the Medical Executive Committee's view, more than sixty (60) days is needed for investigation, the Board shall advise the affected Medical Staff member and specify an appropriate time for completion of the investigation.

### 6.3 INVESTIGATION

On recommendation of the President of the Medical Staff, the Medical Executive Committee may, itself, conduct any investigation it deems necessary itself or may assign this task to an appropriately charged officer, committee, or Department Head. The investigative process shall 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) shall report to the Medical Executive Committee as soon as practical and in such form or manner

as the Medical Executive Committee shall require. The term investigation shall not include the usual activities of the Well-Being of Physicians and Physicians-in Training-Committee.

## 6.4 MEDICAL EXECUTIVE COMMITTEE ACTION

The Medical Executive Committee shall act as soon as is practical after the conclusion of any investigation. Action(s) taken by the Medical Executive Committee following the conclusion of the 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 proctoring 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.

Nothing set forth herein shall prevent the Medical Executive Committee from implementing a summary suspension or restriction of privileges at any time, in the exercise of its discretion pursuant to Section 6.6 below.

If the action is favorable to the practitioner, or constitutes an admonition, reprimand, or warning to the practitioner, or results in termination of the practitioner, it shall become effective as of the final decision of the Board of Directors. If the Medical Executive Committee fails to investigate or initiate corrective action and the Board of Directors determines that its failure to do so is contrary to the weight of the evidence then available, the 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 shall 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 Board of Directors, the 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 shall inform the Medical Executive Committee in writing of what it has done.

## 6.5 PROCEDURAL RIGHTS

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 shall entitle the Medical Staff member to the rights specified in Article Seven. In such cases, the President of the Medical Staff shall give the Medical Staff member written notice of the recommendation, the reasons for the proposed action, and of the 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.

## 6.6 SUMMARY SUSPENSION

A. CRITERIA FOR INITIATION

The President of the Medical Staff, the Medical Executive Committee, the Head of the Department of which the affected Medical Staff member is a member, or the President and CEO, or CMO, 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/their clinical privileges, the 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/their clinical privileges. A summary restriction or suspension shall be effective immediately upon imposition, provided, however, that a summary restriction or suspension imposed by the 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 shall terminate automatically.

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

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 President of the Medical Staff in consultation with the CMO 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 shall not be deemed a "hearing" as that term is used in Article Seven. The interview shall 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 shall give the Medical Staff member written notice of its recommendation and the reasons therefore with copy to the President of the Medical Staff and Medical Executive Committee which shall include the information in Section 7.3.A if the recommendation is adverse.

C. PROCEDURAL RIGHTS

Unless the Ad Hoc panel of the Medical Executive Committee terminates the suspension or restriction, it shall remain in effect during the pendency of and the completion of the review process and of the hearing if hearing is requested pursuant to Section 7.2 of and pending any appeal to the Board of Directors, unless the summary suspension or restriction is terminated by the Judicial Review Committee. The Medical Staff member shall not be entitled to the procedural rights afforded by Article Seven until such time as action has been taken under Section 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 shall result in automatic suspension or revocation of Medical Staff membership and/or clinical privileges and shall 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. Unless otherwise stated, suspension under any of these categories for longer than 90 days will result in a voluntary withdrawal of membership and privileges.

A. LICENSE

Whenever a Medical Staff member's license authorizing them 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 shall automatically apply to his/her/their Hospital Medical Staff membership and/or privileges as appropriate. Whenever a Medical Staff member's license expires, he /she/theyshall be automatically suspended from practice until there is evidence of a licensure renewal. Medical Staff members so affected shall 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 excluded from participation in the Medicare, Medicaid and other federally funded healthcare programs, he/she/they shall 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 shall automatically apply to his/her/their right to prescribe, dispense or administer medications covered by the certificate. Whenever a Medical Staff member's DEA certificate expires, the member shall be automatically suspended until there is evidence of a certificate renewal. There shall 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 shall 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 complete medical records within the time limits established by the Medical Staff Rules and Regulations and Hospital policies, a Medical Staff member's clinical privileges to admit patients and to schedule procedures (except with respect to his/her/their patients already admitted to the Hospital) shall be automatically suspended upon the expiration of seven (7) days after he/she/they are given written notice and shall 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 becomes effective pursuant to this Section shall be deemed to be a voluntary resignation from the Medical Staff.

F. FAILURE TO PAY DUES

For failure to pay dues, if any, as required under Section 10.1.A.1.m., a Medical Staff member's Medical Staff membership and clinical privileges, after two written warnings of delinquency, spaced 30 days apart, shall be automatically suspended and shall remain so suspended until the Medical Staff member pays the delinquent dues. A failure to pay such dues within sixty (60) days after the date of the automatic suspension shall be deemed to be a voluntary resignation from the Medical Staff.

G. FAILURE TO MAINTAIN PROFESSIONAL LIABILITY INSURANCE

For failure to maintain professional liability insurance as required under Section 3.5.A, a Medical Staff member's Medical Staff membership and clinical privileges shall be automatically suspended, after written warning of delinquency, and shall remain so suspended until the Medical Staff member provides documentation of professional liability insurance. A failure to provide such documentation within six (6) months after the date of the automatic suspension shall be deemed to be a voluntary resignation from the Medical Staff. Medical Staff members on leave of absence are not subject to automatic suspension for failure to provide evidence of professional liability insurance.

H. PROCEDURAL RIGHTS – MEDICAL RECORDS AND FAILURE TO PAY

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) shall 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 shall be finally convicted of a felony, his/her/their Medical Staff membership and privileges shall be immediately and automatically terminated.

J. INCOMPLETE PROCTORING

Failure to comply with the Medical Staff Proctoring Policy

K. NON-COMPLIANCE WITH HEALTH SCREENING

Failure to comply with the Medical Staff Credentialing and Privileging Policy, Flu Policy and Communicable Disease Policy on the requirements to maintain annual Health Screenings.

L. 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 shall be given by the President of the Medical Staff or CMO to the Medical Staff member, Department Head, as well as the Medical Executive Committee and the Board of Directors at their next meetings. Giving of such notice shall 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 shall be assigned to another Medical Staff member by the President of the Medical Staff or CMO. The wishes of the patient shall be considered, where feasible, in choosing a substitute Staff member.

## M. LATE CAREER PRACTITIONER POLICY

An automatic voluntary suspension will occur for those who do not comply with the Late Career Practitioner Policy within the allotted timeline.

## 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 shall 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, a petitioner shall be permitted a direct appeal and appearance in an executive session of the Medical Executive Committee. Only after the Medical Executive Committee has denied said appeal may the petitioner appeal directly to the LPCHS Board of Directors. Such appearance shall not be considered a "hearing" under this Article and shall be conducted in accordance with guidelines established by the LPCHS Board of Directors. A final determination by the LPCHS Board of Directors after such appeal shall 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 the Hospital or participants in the decision process; and the exclusive procedure for obtaining judicial review shall 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 shall apply under this Article:

1. "Notice" refers to a written communication delivered personally, with return receipt, to the required addressee, or sent by United States Postal Service, certified with return receipt, pursuant to Section 13.2 of these Bylaws, addressed to the required addressee at his, her or its address as it appears in the records of the Hospital.

2. "Petitioner" refers to the Medical Staff member or applicant who has requested a hearing or appearance pursuant to Section 7.3 of these Bylaws.

3. "Date of Receipt" of any notice or other communication shall be deemed to be the date such notice or communication was delivered personally to the required addressee or, if delivered by mail, such notice or communication shall be deemed

received 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 shall constitute grounds for a hearing unless otherwise specified in these Bylaws only if the action would require a report to the Medical Board of California (Business and Professions Code Section 805) or to the National Practitioner Data Bank.

A. Denial of Medical Staff membership

B. Denial of requested advancement in Medical Staff membership status

C. Denial of Medical Staff reappointment

D. Demotion to lower Medical Staff category or membership status

E. Summary suspension of Medical Staff membership and/or privileges during the pendency of corrective action and hearing and appeals procedures

F. Expulsion from Medical Staff membership

G. Denial of requested privileges (initial and additional)

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 where the reviewing physician has the authority to supervise, direct or transfer care from the physician being proctored

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 shall 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 a hearing as set forth in Section 7.2 of this Article, then the Medical Executive Committee

or officer shall give the affected Medical Staff member notice of the decision and of his/her/their right to request a hearing pursuant to Section B., below.

B. REQUEST FOR HEARING

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

C. TIME AND PLACE FOR HEARING

If the petitioner timely requested a hearing, the President of the Medical Staff shall confirm a date for a hearing. Notice shall be given to the petitioner of the time, place, and date of the hearing. The date of the commencement of the hearing shall be not less than thirty (30) days from the date of receipt of the request; provided that a hearing for a practitioner under suspension shall commence as soon as arrangements may reasonably be made.

D. NOTICE OF CHARGES

The President of the Medical Staff shall 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 President of the Medical Staff and the petitioner shall also provide each other with a list of witnesses expected at that time to testify at the hearing. The President of the Medical Staff and petitioner shall notify each other of any 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 President of the Medical Staff shall select, in consultation with the CMO, 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 shall be impartial and shall not have actively participated in the formal consideration of the matter at any previous level and shall not be engaged in direct economic competition with the petitioner.

F. FAILURE TO APPEAR

Failure of the petitioner without good cause to appear and proceed at a hearing shall be deemed to constitute voluntary acceptance of the actions involved, and waiver to any hearing rights, and it shall thereupon become the final recommendation of the Medical Executive Committee. Such final recommendation shall be subject on that basis alone to review and final decision by the 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 shall be permitted by the Hearing Officer, or the President of the Medical Staff before appointment of a Hearing Officer, on a showing of good cause.

## 7.4 HEARING PROCEDURE

A. PREHEARING PROCEDURE

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

B. THE HEARING OFFICER

The President of the Medical Staff shall appoint an unbiased hearing officer to preside at the hearing. The hearing officer shall be an attorney-at-law qualified to preside over a quasi-judicial hearing and, preferably, have experience in Medical Staff matters. The hearing officer shall 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 shall 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 shall maintain a record of the hearing by a certified shorthand reporter. The cost of attendance of the shorthand reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall 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 shall be excluded.

D. RIGHTS OF THE PARTIES

At the hearing, both sides shall have the right to representation by counsel or another 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 related 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. The foregoing shall not be deemed to deprive any party of its right to the assistance of legal counsel for the purpose of preparing for the hearing. If there is no counsel, the petitioner shall be 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 shall appoint a representative from the Medical Staff or from the Board of Directors (whichever body's decision prompted the hearing), who shall present its recommendation, action or decision, and the materials in support thereof, and examine witnesses.

F. MISCELLANEOUS RULES

Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a written statement in support of his/her/their 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 in its discretion.

G. BURDEN OF GOING FORWARD AND BURDEN OF PROOF

The Medical Executive Committee must initially come forward with evidence in support of such decision. Subject to the foregoing, the petitioner shall bear the ultimate burden of persuading the Judicial Review Committee by the substantial weight of the 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 shall be closed. The Judicial Review Committee shall 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 forty-five (45) days after closing of the hearing (provided that in the event the petitioner is currently under summary suspension, this time shall be thirty (30) days), the Judicial Review Committee shall render a written decision which shall 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 shall be delivered to the Medical Executive Committee, the President and CEO of the Hospital or CMO as his/her/their designee, and the Board of Directors, and, by delivery of certified or registered mail, to the petitioner. The decision of the Judicial Review Committee shall be considered final, subject only to the right of appeal to the Board of Directors as provided in Section 7.5.

## 7.5 APPEALS TO THE 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 Board of Directors. All requests for appeal shall be delivered to the President of the Medical Staff in writing either in person, or by certified or registered mail, return receipt requested, and it shall include a statement of the reasons for the appeal. If such appellate review is not requested within the fourteen (14) day period, both sides shall be deemed to have accepted the decision and it shall become the final action of the Medical Executive Committee. Such final recommendation shall be subject on that basis to final review and decision by the Board of Directors.

B. REASONS FOR APPEAL

The reasons for appeal from the hearing shall be: (1) substantial lack of compliance with the procedures required by these Bylaws at the hearing so as to deny petitioner a fair hearing; (2) the decision was not supported by substantial evidence based on the hearing record or such additional information as may be submitted pursuant to subparagraph E; and/or (3) the action was taken arbitrarily, unreasonably, or capriciously.

C. TIME, PLACE AND NOTICE

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

D. APPEAL BOARD

When an appellate review is requested, the Board of Directors may sit as the appeal board or it may appoint an appeal board which shall be composed of at least three (3) Board of Directors members. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. For the purposes of this Section, participating in an

initial decision to recommend adverse action shall not be deemed to constitute participation in a prior hearing on the same matter.

E. APPEAL PROCEDURE

The proceedings on appeal shall 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 shall have the right to present a written statement in support of his/her/their 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 shall 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 shall present to the Board of Directors its written recommendations as to whether the Board of Directors should affirm, modify, or reverse the Judicial Review Committee decision, or remand the matter to the Judicial Review Committee for further review and decision. If no appeal board is appointed, the procedures outlined in this Subsection shall apply to a hearing before the Board of Directors.

F. DECISION

Within forty-five (45) days after receipt of the appellate review body's decision, the Board of Directors shall render a final decision in writing. The 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 shall be conducted within a time frame set by the Board of Directors and shall 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 shall be submitted to the Board of Directors for a final decision. Notice of the decision of the Board of Directors shall be provided to the petitioner, Medical Executive Committee, and President and CEO of the Hospital, or the CMO as his/her/their designee.

Except when the matter is remanded for further review and recommendation, the final decision of the Board of Directors following the appeal procedures set forth in this Article shall be effective immediately and shall not be subject to further review. However, if the matter is remanded to the Judicial Review Committee or any other body or persons, said committee, body, or persons shall promptly conduct its review and make its recommendations to the Board of Directors in accordance with the instructions given by the Board of Directors. This further review process and the time required to report back shall in no event exceed thirty (30) days in duration except as the parties may otherwise stipulate.

G. RIGHT TO ONE HEARING

Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one Judicial Review Committee hearing and one appellate review on any matter which shall have been the subject of action by either the Medical Executive Committee or the Board of Directors or both.

H. EXCEPTIONS TO HEARING RIGHTS

1. Closed Staff or Exclusive Use Departments

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

2. Medico-Administrative Officer

The fair hearing rights of Article Seven do not apply to those persons serving the Hospital in a medico-administrative capacity. Removal from office of such persons shall instead be governed by the terms of their individual contracts and agreements with the Hospital. However, the hearing rights of the preceding sections of this Article Seven shall apply to the extent that Medical Staff membership status or clinical privileges, which are independent of the practitioner's contract, are also removed or suspended for reasons that constitute grounds for a hearing pursuant to Section 7.2, unless the contract includes a specific provision establishing alternative procedural rights applicable to such decisions.

## ARTICLE EIGHT
## ADVANCED PRACTICE PROFESSIONALS (APP)

### 8.1 QUALIFICATIONS

The Advance Practice Professionals (APP) category is defined in Section 2.5 of these Bylaws. APPs are not eligible for Medical Staff membership. APPs are eligible to apply for standardized procedures 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 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. Each Allied Health Practitioner member granted standardized procedures or protocols in the Hospital shall 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 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, shall 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. APPs with privileges to practice at SHC will be granted the appropriate privileges to care for adult patients at LPCH upon request. The Board of Directors shall 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 STANDARDIZED PROCEDURES OR PROTOCOLS

An APP must apply for standardized procedures or protocols as outlined in the Authorization for Individuals to Provide Services as Allied Health Practitioners Policy. Applications for granting of standardized procedures or protocols shall 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 which 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, Medical Executive Committee, and Board of Directors.

Each APP shall be assigned to the Department and Clinical Service appropriate to his or her occupational or professional training, and shall 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 shall 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 shall be subject to ongoing quality assurance, professional practice evaluation, and peer review as provided in 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 President of the Medical Staff, CMO, or the President and CEO. The APP shall have 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, shall 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 shall 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 shall be made. A written report of the findings and recommendations shall be made by the reviewing individual or entity and forwarded to the MEC which shall 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 to 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 shall make a final written decision on the matter. The action of the MEC shall be final, subject only to review and final decision by the Governing Body.

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 shall end automatically upon failure of the APP to meet any appointment standard. If the APP Supervising Physician is no longer willing or able to provide any required supervision, the APP's privileges, standardized procedures or protocols shall be automatically suspended. The APPs shall have 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 30 days will result in the automatic termination of APP status at LPCHS. None of the actions provided for under this Section 8.5.C. shall entitle the APP to hearing rights under Article Seven of the Medical Staff Bylaws.

## 8.6 PREROGATIVES

The prerogatives that may be extended to an APP shall be defined in the Rules and Regulations of the relevant Department and may include:

A. Provision of specified safe patient care, treatment, and services under the supervision or direction of an Active Medical Staff member and consistent with the standardized procedures or protocols granted to the APP and within the scope of the APP's licensure or certification;

B. Service on Medical Staff, Department, Clinical Service and Hospital Committees; and

C. Attendance at meetings of the Department and Clinical Service to which the APP is assigned, as permitted by the Department Rules and Regulations, and attendance at education programs relevant to the APP's field of practice.

D. Such other prerogatives as are permitted by law and approved by the MEC.

## 8.7 RESPONSIBILITIES

Each APP shall:

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/her/their area of professional competence for the care and supervision of each patient in the Hospital for whom he/she 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 President of the Medical 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

F. Abide by the Bylaws, Rules and Regulations of the Medical Staff, the Policies, Rules and Regulations of the Department in which he/she 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 DEPARTMENTS AND CLINICAL SERVICES

A. The Medical Staff shall be organized into Clinical Departments and Clinical Services.

B. Criteria to Qualify as a Department

The following criteria shall be used to assess whether Department status is proper:

1. The area of practice represents a major, general, distinct field of medical practice at this Hospital.

2. The level of clinical activity at this Hospital is substantial enough to warrant imposing the responsibility for Department functions.

3. The practitioners to be assigned to the Department agree to and, in fact, carry out the meeting, review, and other activities required of Departments.

The current Departments are as follows:

Pediatric Medicine
Surgery
Anesthesiology & Pain Management
Pathology
Psychiatry
Radiology
Obstetrics & Gynecology

C. Criteria to Qualify as a Clinical Service:

The following criteria shall be used to decide whether Service status is proper:

1. The area of practice is an established, professionally recognized, discrete specialty/subspecialty field within the general field of the Department. It also must be a significant area of practice at the Hospital so that specialists devote a substantial portion of their time to the specialty and the numbers and/or activity level require a Chief to coordinate services, assume quality control and promote day-to-day problem resolution.

2. The level of clinical activity is substantial enough to warrant imposing the responsibility to accomplish Service functions.

3. The practitioners to be assigned to the Service agree to and, in fact, carry out the meeting, review and other activities required of Services.

The current Clinical Services of the Department of Pediatric Medicine are

Adolescent Medicine
Cardiology
Critical Care
Dermatology
Developmental and Behavioral Pediatrics
Endocrinology & Diabetes
Gastroenterology, Nutrition & Hepatology
General Pediatrics
Genetics
Hematology/Oncology/ Stem Cell Transplant and Regenerative Medicine
Hospital Medicine
Immunology/Allergy
Infectious Disease
Neonatology
Nephrology
Neurology
Palliative Care
Pulmonary Medicine
Radiation Oncology
Rheumatology

The current Clinical Services of the Department of Surgery are:

Cardiothoracic Surgery
Dentistry
General Pediatric Surgery
Neurosurgery
Ophthalmology
Orthopedic Surgery
Otolaryngology - Head & Neck Surgery
Plastic Surgery
Transplant Surgery
Urology

The current Clinical Services of the Department of Anesthesiology & Pain Management are:

Pediatric Anesthesiology
Obstetric Anesthesiology
Pain Management

The current Clinical Services of the Department of Obstetrics & Gynecology are:

Obstetrics
Gynecology
Reproductive Endocrinology and Infertility (REI)

The current Clinical Services of the Department of Radiology are:

Diagnostic Radiology
Interventional Radiology
Nuclear Medicine

Departments and Clinical Services may be created, eliminated, subdivided or combined in accordance with changes in the departments and divisions of the Stanford University School of Medicine, or in accordance with programmatic need, and the concurrence of the Medical Executive Committee and Board of Directors.

D. Each Department and Clinical Service is a separate organizational component of the Medical Staff, and every Staff member must have a primary affiliation with the Department and Clinical Service which most closely reflects his/her/their professional training, experience, and current practice. A practitioner may be granted clinical privileges in one or more other Departments or Clinical Services and his/her/their exercise of clinical privileges within the jurisdiction of any Department or Clinical Service is always subject to the Rules and Regulations of that Department or Clinical Service and the authority of the Department Head and Service Chief.

E. Each Department 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 Department. To carry out this responsibility, each Department shall participate in the:

1. Establishment of guidelines for the delineation of specific clinical privileges within the Department.

2. Development of Department Rules and Regulations.

3. Development of recommendations regarding the need for pertinent continuing education programs that reflect the type and nature of services offered by LPCHS and the findings of performance improvement activities.

4. Oversight of members' adherence to a) Medical Staff Bylaws, Rules and Regulations, Rules and Regulations of the Department and Hospital policies; b) sound principles of clinical practice; and c) regulations designed to promote patient safety.
5. Continuously assess and improve the quality of care, treatment and services and maintain quality improvement programs as appropriate.

## 9.2 CLINICAL DEPARTMENT HEADS AND SERVICE CHIEFS

A. HEAD OF THE DEPARTMENT OF PEDIATRIC MEDICINE

The Head of the Department of Pediatric Medicine of the Hospital shall be the person who serves from time-to-time as the Chair of the Department of Pediatrics of the Stanford University School of Medicine and shall be responsible for the clinical work of the Department of Pediatric Medicine. The Chair of the Department of Pediatrics of the Stanford School of Medicine shall be the person who serves from time-to-time as the Physician in Chief of LPCHS.

This Department Head shall be a member of the Active Medical Staff and shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the Department. He/she will be certified by an appropriate specialty board, or affirmatively establish comparable competence through the credentialing process.

B. HEADS OF DEPARTMENTS OTHER THAN PEDIATRIC MEDICINE

The Head of each Department of the Hospital, other than the Department of Pediatric Medicine, shall be appointed by the President and CEO upon the recommendation of the Dean of the of Stanford University School of Medicine after consultation with the relevant Stanford University School of Medicine's Department Chairs, and Hospital's CMO. The Head of each Department is responsible for the clinical work of that Department.

Each Department Head shall be a member of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the Department. Department Heads will be board certified by an appropriate specialty board or affirmatively establish comparable competence through the credentialing process.

C. RESPONSIBILITIES OF CLINICAL DEPARTMENT HEADS

Each Department Head shall be accountable to the CMO and shall:

1. Act as presiding officer at Department meetings

2. Be a member of the Medical Executive Committee and give guidance on the medical policies of the Medical Staff and Hospital and make specific recommendations and suggestions regarding the Department

3. Determine and manage the clinically related and administrative activities within his/her/their department

4. Assess and recommend to the relevant LPCHS authority space issues, resource needs, off-site sources for needed safe patient care, treatment and services not provided by the Department or the organization

5. Continuously assess and improve the quality of care, treatment and services and maintain quality improvement programs as appropriate

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 Department

7. Recommend a sufficient number of qualified and competent persons to provide care, treatment or services

8. Determine the qualifications and competence of Department or Service personnel who are not licensed independent practitioners and who provide patient care, treatment, or services

9. Develop and implement Department 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

10. Transmit to the appropriate authorities as required in these Bylaws, the Department's recommendations concerning appointment, reappointment, delineation of clinical privileges, and disciplinary action with respect to members of the Department

11. Maintain continuing surveillance of the professional performance of all members with clinical privileges within the Department with appropriate documentation thereof. Such processes will meet regulatory requirements such as those for Ongoing Professional Practice Evaluation (OPPE)

12. Assist in developing and enforcing Medical Staff and Hospital policies and procedures that guide and support the provision of care, treatment and services and Medical Staff Bylaws, Rules and Regulations of the Medical Staff and Rules and Regulations of the Department

13. Integrate the Department into the primary functions of the organization

14. Coordinate and integrate interdepartmental and intradepartmental services

15. Implement within the Department actions taken by the Medical Executive Committee

16. Perform such other duties commensurate with his/her/their office as may from time-to-time be assigned by the President of the Medical Staff, CMO, the Medical Executive Committee, or the Board of Directors

18. Establish such committees, task forces, or other mechanisms as are necessary and desirable to perform properly the functions assigned to it

D. CHIEFS OF CLINICAL SERVICES

The Chief of each Clinical Service shall be appointed by the appropriate Department Chair of the Stanford University School of Medicine after consultation with the Dean of

the Stanford University School of Medicine, the CMO, and subject to consultation with the CEO.

Each Chief of Service shall be accountable to the Head of the respective Department and to the CMO and shall:

1. Act as presiding officer at Clinical Service meetings

2. Develop and implement, in conjunction with the Department Head, Clinical Service programs for orientation of new members, credentials review and privileges delineation, continuing medical education, utilization review, concurrent evaluation of practice, and retrospective evaluation of practice

3. Transmit to the Department Head the Clinical Service's recommendations concerning appointment, reappointment, delineation of clinical privileges, and disciplinary action with respect to members of the Clinical Service

4. Maintain continuing review of the professional performance of all members with clinical privileges within the Clinical Service with appropriate documentation thereof. Such processes will meet regulatory requirements such as those for Ongoing Professional Practice Evaluation (OPPE)

5. Continuously assess and improve the quality of care, treatment, and services, and maintain quality improvement programs as appropriate

6. Perform such other duties commensurate with his/her/their office as may from time-to-time be assigned by the Department Head, President of the Medical Staff, CMO, Medical Executive Committee, or Board of Directors

## 9.3 CHIEF MEDICAL OFFICER (CMO)

The CMO is appointed by the President and CEO of LPCHS following consultation with the Dean of the School of Medicine. The CMO shall have direct accountability to the President and CEO. The CMO is also responsible, in conjunction with the President of the Medical Staff and the Medical Executive Committee, for Medical Staff issues at LPCHS. The CMO will sit as a non-voting member of the MEC. The CMO must be a member of the active Medical Staff of LPCHS.

## 9.4 ASSOCIATE CHIEF MEDICAL OFFICER (ACMO)

The ACMO(s) are appointed by the CMO and will be responsible for partnering with the CMO, the President of the Medical Staff, and Medical Executive Committee for Medical Staff issues at LPCHS. He/she shall assume such responsibilities for the Medical Staff affairs as may be assigned by the CMO, the President of the Medical Staff, or the MEC. The ACMO(s) must be a member of the active Medical Staff of LPCHS.

## ARTICLE TEN
## ELECTED OFFICERS OF THE MEDICAL STAFF

### 10.1 TITLES OF OFFICERS

There shall be a President and Vice-President of the Medical Staff. The President and Vice-President must be members of the Active Medical Staff at the time of nomination and election and must remain in good standing during the term of office.

### 10.2 TERM OF ELECTED OFFICE

The President and Vice-President of the Medical Staff shall each serve a two (2) year term, commencing on the first day of the Medical Staff year after the election of the Vice-President. After completing his/her/their term of office, the Vice-President shall assume the office of President of the Medical Staff unless he/she has been removed pursuant to Section 9.6 of this Article.

### 10.3 NOMINATIONS

A. A Nominating Committee may be appointed pursuant to 10.2.C. which shall be responsible for recommending to the Medical Executive Committee qualified nominees to serve as elected officers of the Medical Staff and as elected members of the Medical Executive Committee. In selecting its nominees, the Committee shall consider the responsibilities involved and the candidates' interest, availability, organizational skills, communication skills, and reputation for objectivity and fairness. The Immediate Past President of the Medical Staff shall serve as chair of the Nominating Committee or he/she may select an alternate in the event he/she is not available to attend a meeting. The Nominating Committee shall consider alternating nominees such that at least 3 Community Physicians are represented on the Medical Executive Committee (MEC). If neither any faculty nor community physicians are nominated during the respective cycles, the committee will accept any active medical staff member in good standing as a candidate. The Committee may choose to review the list of nominations via email in lieu of a physical meeting.

B. The Medical Executive Committee, after receiving nominations from the Nominating Committee, shall submit to the Active Medical Staff a list of qualified nominees for the office of Vice-President of the Medical Staff and Member-at-Large.

C. Nominations can be made electronically or verbally. In either case the additional nominees shall be accepted if there is evidence that the individual so nominated is qualified and would be willing and able to serve as an elected Medical Staff officer.

### 10.4 ELECTION

The Vice-President of the Medical Staff shall be elected by a majority vote of the Active Medical Staff members voting by electronic or mail ballot. If there is a regular Medical Staff meeting

prior to the election and if only one name is presented to the Medical Staff as a candidate for this office, and if there are no further nominations from the floor, the Vice-President may be elected by a voice vote at that meeting. The President of the Medical Staff will cast no vote except in case of a tie at which time he/she will be asked to cast a tie-breaking vote.

## 10.5 RESPONSIBILITIES OF ELECTED MEDICAL STAFF OFFICERS

A. PRESIDENT OF THE MEDICAL STAFF

The President shall serve as the chief elected officer of the Medical Staff. As such, the President shall:

1. Preside at, and be responsible for the agenda of, all meetings of the MEC and regular and special meetings of the Medical Staff

2. Serve as a voting member of the Medical Executive Committee, Credentials Committee, and the Care Improvement Committee

3. Participate in any Hospital deliberations affecting the discharge of Medical Staff responsibilities

4. Serve as ex-officio member of all other Medical Staff Committees, without vote, unless otherwise indicated by these Bylaws

5. Appoint, in conjunction with the CMO, committee members for all standing and special Medical Staff committees and designate the Chair of each Committee except where otherwise indicated in these Bylaws

6. Perform such other functions as may be assigned to the President by these Bylaws, the Medical Staff, the Medical Executive Committee, or the Board of Directors

7. Periodically report to the Board of Directors, the CMO, the President of the Hospital, and/or outside licensing and accreditation agencies to represent the views and policies of the Medical Staff

8. Be the spokesperson for the Medical Staff and external professional and public relations matters

B. VICE-PRESIDENT OF THE MEDICAL STAFF

An elected officer of the Medical Staff who, upon completion of the two (2) year term of office, shall succeed to the office of President of the Medical Staff, and who shall:

1. Communicate and represent the opinions, needs, and grievances of the Medical Staff to the Medical Executive Committee, the President and CEO of the Hospital, or his/her/their designee, and the Board of Directors

2. Serve as a voting member of the Medical Executive Committee, Care Improvement Committee (CIC), and Credentials Committee

3. Serve as Chair of the Policy Committee and the Bylaws Committee

4. Serve as President-Elect

5. Serve as Medical Staff Treasurer and Chair of the Medical Staff Finance Committee. Present yearly financial reports to Medical Executive Committee

6. Serve as the liaison to the Santa Clara County Medical Association (SCCMA). Attend meetings, if necessary and bring back reports and updates to the Medical Executive Committee

7. Serve as ex-officio member of all other Medical Staff Committees, without vote, unless so designated by the Bylaws of the Medical Staff

## 10.6 REMOVAL OF THE PRESIDENT OR VICE-PRESIDENT

The Medical Staff may remove any Medical Staff Leader for failure to fulfill his/her/their responsibilities, malfeasance while in office, physical or mental infirmity to a degree that renders him/her incapable of fulfilling the duties of the office, serious acts of moral turpitude, or conduct detrimental to the interests of the Hospital and/or Medical Staff. The President or Vice-President of the Medical Staff may be removed from office when:

A. A petition, setting forth the deficiencies in performance of duties as President or Vice-President and calling for a vote on removal signed by at least thirty (30) members of the Active Medical Staff, is presented to the CMO or ACMO.

B. Two-thirds (2/3) of the Active Medical Staff responding byballot vote for the officer's removal.

## 10.7 VACANCIES IN OFFICE

A. If the President of the Medical Staff is temporarily unable to fulfill the responsibilities of the office, the Vice-President shall assume these responsibilities until the President is able to resume those duties.

B. If for any reason the President of the Medical Staff is unable to complete the elected term of office, the Vice-President of the Medical Staff shall assume the office of President and a new Medical Staff election shall be held immediately for Vice-President in accordance with Article Nine, Section 10.3 and 10.4 of these Bylaws.

C. If for any reason the Vice-President of the Medical Staff is unable to complete the elected term of office, a new Medical Staff election shall be held immediately in accordance with Section 10.3 and 10.4 of this Article.

## ARTICLE ELEVEN
## MEDICAL EXECUTIVE COMMITTEE, COMMITTEES, AND MEETINGS OF THE MEDICAL STAFF

### 11.1 MEDICAL EXECUTIVE COMMITTEE

A. RESPONSIBILITIES

The Medical Executive Committee is a Committee of the Medical Staff, serves as the Staff's Executive Committee and is empowered to act for the Medical Staff in the intervals between Medical Staff meetings.

1. In addition to such other responsibilities as are set forth in these Bylaws, the Medical Executive Committee shall:

   a. Receive and act upon reports and recommendations from the Medical Staff Committees, Hospital Departments, Clinical Departments and Clinical Services, and ad hoc committees and subcommittees, such as the Nominating Committee.

   b. Receive and act upon reports from the Medical Staff Finance Committee.

   c. 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; utilization/case management; clinical laboratory; and Ambulatory Care Center

   d. Subject to the authority of the Medical Staff, determine all professional medical policies of the Hospital

   e. With the Department Heads, set Departmental 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

   f. Recommend to the Board of Directors all matters relating to Medical Staff structure; recommend mechanisms used to review credentials and to delineate individual clinical privileges for appointments and reappointments; recommend individuals for Medical Staff membership and clinical privileges and for Department and Clinical Service assignments; recommend mechanisms by which Medical Staff membership may be terminated; and recommend mechanisms for fair-hearing procedures

   g. 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.

h. Be responsible for creating the appropriate Medical Staff committee structure to carry out the necessary duties

i. Be accountable to the Board of Directors for the quality of medical care and for the organization of quality assessment activities of the Medical Staff including the mechanism used to conduct, evaluate, and revise such activities, and reporting the 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

j. Recommend to the Board of Directors regarding the structure of the Medical Staff; and advise on sources of clinical services to be provided by consultation, contractual arrangements, or other agreements.

k. 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 action or review measures when warranted

l. Assist in obtaining and maintenance of accreditation

m. Inform the Medical Staff regarding the status of accreditation and licensure of the Hospital

n. Develop and maintain methods for the protection and care of patients and others in the event of internal or external disaster

o. 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.

p. Resolve disputes regarding expenditures from the Medical Staff Dues Account.

q. Determine a processing fee, if any, to be charged to any applicant for Medical Staff membership

r. Recommend the mechanism for corrective action and fair hearing procedures

s. Establish the mechanisms for dispute resolution between medical staff members involving the care of a patient

t. Recommend to the Board of Directors minimum requirements for malpractice insurance coverage for members of the Medical Staff

u. Receive periodic reports from the Bylaws Committee.

2. Report of Medical Executive Committee

The Medical Staff will be apprised of the activities and decisions of the Medical Executive Committee at the regular Medical Staff meetings or via regular email communication and/or through the Medical Staff Weekly. In the event a majority of the Active Medical Staff members present at a meeting at which there is a quorum, object to a specific determination and call for a vote, the Medical Executive Committee's action shall thereafter be submitted to the entire Active Medical Staff for a vote of ratification or repeal.

B. COMPOSITION

1. The voting membership of the Medical Executive Committee shall consist of the:

a. President of the Medical Staff who shall serve as the Chair
b. Vice-President of the Medical Staff
c. Chiefs of clinical services including, Surgeon-in-Chief, Anesthesiologist-in-Chief, Radiologist-in-Chief, and Neurologist-in-Chief and Physician-in-Chief
d. An equal number of members from the Departments of Pediatrics, Surgery, Radiology, Anesthesia and Obstetrics.
e. Pediatric Residency Director
f. Immediate Past-President of the Medical Staff
g. and six (6) elected members of the Medical Staff (Members at Large)

The non-voting ex-officio membership of the Medical Executive Committee shall include the:
a. President and CEO
b. Chief Operating Officer
c. Chief Quality Officer
d. Chief Medical Officer
e. Associate Chief Medical Officer
f. Directors of Risk Management & Compliance
g. Director of Palliative Care
h. Director of Pain Management
i. Medical Directors (or designees) of PICU, NICU, CVICU, and Ambulatory Care Center
j. VP of Patient Care/Chief Nursing Officer

All physician members of the Medical Executive Committee must be board certified (or equivalent). Voting members of the MEC may choose to send a representative in their absence. However, the representative would not have voting rights.

2. The procedure for selecting members to serve on the Medical Executive Committee shall be as follows:

a. The Department of Pediatric Medicine shall develop the mechanism for selection of its members to serve on the Medical Executive Committee.

b. Elected Medical Staff

(1) Nominations

(a) The Medical Executive Committee, after receiving recommendations from a Nominating Committee appointed by the President of the Medical Staff in conjunction with the CMO, shall submit to the Medical Staff a list of qualified nominees for the elected positions on the Medical Executive Committee.

(b) If there is a regular Staff meeting prior to the election, additional nominations may be made from the floor by members.

(2) Election

The elected members shall be those individuals receiving the highest number of votes of the Active Medical Staff members voting by electronic or mail ballot.

a. Elected members serve one three-year term. They can be re-elected for a maximum number of 3 terms or 9 years total. These terms do not need to be contiguous.

3. Removal from Office

The Medical Staff may remove any elected member for failure to fulfill his/her/their responsibilities, malfeasance while serving as an elected member, physical or mental infirmity to a degree that renders him/her incapable of fulfilling the duties of his/her/their elected membership, serious acts of moral turpitude, or conduct detrimental to the interests of the Hospital and/or Medical Staff. The elected members may be removed from office when:

a. A petition calling for a vote on removal signed by at least thirty (30) members of the Active Medical Staff is presented to the President of the Medical Staff.

b. Two-thirds (2/3) of the Active Medical Staff responding by mail ballot vote for an elected member's removal.

4. If an elected member of the Medical Executive Committee is unable to complete the elected term of office, the CMO and the President of the Medical Staff shall jointly appoint a replacement to fill out the unexpired term.

C. QUORUM

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

D. 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.

E. MEETINGS

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

## 11.2 STANDING COMMITTEES OF THE MEDICAL STAFF

A. APPOINTMENT TO STANDING COMMITTEES

1. Except as otherwise expressly stated, appointment of members to Standing Committees of the Medical Staff of each such committee shall be made by the CMO and the President of the Medical Staff, in consultation with the Chair of the Committee. Appointment of the Chair for each Committee shall be made by the President of the Medical Staff in consultation with the CMO. Committee members may be removed by a two-thirds (2/3) vote of the Medical Executive Committee. Vacancies shall be filled in the same manner as initial appointments.

2. The CMO, the President and Vice President of the Medical Staff, shall be a non-voting, ex-officio member of all committees unless otherwise indicated.

3. Standing Committees shall include a broad representation of the Medical Staff.

4. Each Standing Committee may, with the approval of the President of the Medical Staff, form task forces or ad hoc committees as appropriate to carry out the charge of the Standing Committee. All such groups shall be considered committees of this Medical Staff.

B. DUTIES GENERALLY

1. Reports: Except for the Medical Executive Committee, activities of all Standing Committees shall be reported to the Medical Executive Committee on a regular basis.

2. Minutes: Each committee shall 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, shall be submitted to the President of the Medical Staff and will be kept on file in Medical Staff Services or Quality Management.

Minutes of Medical Staff Committees are the property of the Medical Staff and the Hospital. The minutes are protected under California Evidence Code 1157

and distribution is limited to Medical Staff Services Department, and Chairs and members of the committee. No copies of the minutes or other material related to confidential agenda items shall be made on a routine basis. Any review of this material is to be made from the original file in Medical Staff Services. This review privilege is extended to members of the appropriate committee, the Medical Executive Committee, the Board of Directors, the CEO or designee, the director of quality management, and legal counsel. Other persons desiring review of committee minutes must make a written request stating reason, and that request will be reviewed by the committee chair who will grant or deny access.

Minutes will be copied for distribution at the meeting and collected at the end of the meeting. Minutes are not to be taken out of the meeting room by anyone other than the minutes taker. When business is conducted through virtual meetings, minutes will be available through secure online platform for viewing and not to be distributed.

3. Frequency of Meetings: Unless otherwise stated, meetings of all Standing Committees shall be held at least semi-annually, but more often whenever required by the Chair or President of the Medical Staff.

4. Medical Staff Committees shall include, but not be limited to, the Medical Staff Meeting as a committee of the whole, meetings of Clinical Departments and Services, meetings of Committees established under this Article, and meetings of special or ad hoc committees created by the Medical Executive Committee, by the Clinical Departments, or by the Committees described below. The Committees described in this Article shall be the Standing Committees of the Medical Staff.

C. SPECIAL COMMITTEES

Special Committees shall be established by the President of the Medical Staff in consultation with the CMO, as needed and members shall retain their appointments until discharged by the President of the Medical Staff. Special Committees shall confine their work to the purpose for which they were appointed and shall report to the appropriate body. They shall not have power of action unless such is specifically granted by the motion, which created the committee.

D. QUORUM

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

E. MANNER OF ACTION

Except as otherwise specified in these Bylaws, the action of a majority of the Medical Staff members present and voting at a committee meeting at which a quorum is present shall 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.

F. HOUSE STAFF

When appropriate, the CMO shall appoint members of the Housestaff to serve on the Medical Staff committees.

G. VOTING PRIVILEGES

Active Medical Staff assigned to standing committees may vote on all matters presented at the committee meetings. All other committee members may actively participate in the committee on which they hold membership, but may not vote on matters before the committee, unless otherwise stated in the committee charge. The Chair of the committee votes in case of a tie.

H. STANDING COMMITTEES

Standing Committees shall include the following:

1. BYLAWS COMMITTEE

Purpose

This committee shall review the Medical Staff Bylaws and Rules and Regulations periodically and recommend revisions based on regulatory requirements, changes recommended by medical staff committees, or to reflect LPCHS's current practice with respect to Medical Staff organization and functions.

Responsibilities

a. Perform regular review of the Medical Staff Bylaws and Rules and Regulations
b. Review proposed revisions to the clinical departments Rules and Regulations.
c. Prepare correspondence to the Medical Staff regarding proposed revisions for review and vote.

Composition

This committee shall include the Vice President of the Medical Staff who will act as Chair, the President of the Medical Staff, Immediate Past President, CMO and ad hoc members of the medical staff.

2. POLICY COMMITTEE

Purpose

This committee shall review the LPCHS polices on a monthly basis and recommend revisions based on regulatory requirements, changes recommended by medical staff committees, or to reflect LPCHS's current practice with respect to Medical Staff organization and functions.

Responsibilities

a. Perform regular review of the policies applicable to Clinical Policies and Procedures involving medical staff practice, Clinical Lab, Radiology and Pharmacy (Nursing Procedures and Clinical Policies not involving medical staff practice are not reviewed by the committee or MEC).
b. Review proposed revisions to the policies and correspond with the Policy Program to ensure comments, questions and suggestions are adequately addressed prior to presentation at the Medical Executive Committee.
c. Prepare correspondence to the Medical Executive Committee for approval/rejection of new policies and/or policies.

Composition

This committee shall include the Vice President of the Medical Staff who will act as Chair, the President of the Medical Staff, Immediate Past President, and medical staff representation from diverse clinical specialties for a total of at least 5 members.

Meetings

The committee shall review policies on a monthly basis, or whenever called by the President of the Medical Staff or Committee Chair.

3. CARE IMPROVEMENT COMMITTEE

This committee provides a forum for the medical staff to monitor and evaluate the quality and appropriateness of care provided by all individuals with clinical privileges. The committee is responsible for overseeing the peer review process for the medical staff. This committee shall be accountable to the Medical Executive Committee. The scope includes the care provided by health care professionals in the hospital and clinics. The committee also serves as the forum for the identification of important system-based problems in patient care and opportunities to improve care. As a result of identifying these problems and areas of opportunity, actions are taken, evaluated and reported to the Medical Executive Committee.

Responsibilities:

a. Receive referrals of concerns about departures from standard medical practice from Department or Service Level Professional Practice Evaluation Committees (PPEC) and the CMO and ACMO, Chief Quality Officer, and conduct a full and fair evaluation of those issues

b. Draw conclusions about issues referred to the committee and recommend actions to correct identified problems. These may include systematic and/or individual corrective actions, e.g., no action; professional practice standard changes and/or revisions of letters of admonition, reprimand, or warning; probation; education; counseling.

c. Report the Committee's findings and recommendations, through the CIC Medical and Surgical Co-Directors with support from the Chief Quality Officer to the Medical Executive Committee at least yearly.

Composition

The Committee is chaired by a Medical and Surgical Co-Chair of CIC. The CIC Co-chairs are selected by the Chief Quality Officer and Chief Medical Officer in consultation with the Chair of Pediatrics and Surgeon-in-Chief and with approval from the President of the Medical Staff. The membership will be comprised of the President of the Medical Staff, Vice-President and/or Immediate Past President of the Medical Staff, Chief Quality Officer, CNO or designee, the PPEC co-chairs and various physician and non-physician members.

4. PROFESSIONAL PRACTICE EVALUATION (PPEOC)

This committee serves as a focus of expertise and resource for monitoring and improving professional performance of our medical staff and oversees the work of professional practice evaluation.

Responsibilities

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

b. Identify resources and oversee interventions for medical staff members demonstrating opportunity for improvement in professional performance.

c. Oversee Ongoing Professional Practice Evaluation.

d. Assist in any actions from the CIC.

Composition

The committee is chaired by the CMO and President of the Medical staff. Membership will be comprised of the Medical and Surgical co-directors of the CIC, President, and Vice President of the Medical staff, CMO, assigned CMO(s), and CQO.

Meetings

The PPEOC shall meet monthly, at least 10 times per year. Additional meetings may be called as required by the chairs.

1. CREDENTIALS COMMITTEE

This Committee reviews applications for appointment, reappointment and privileges in accordance with Article Four of these Bylaws, and the Credentialing Policies and Procedures.

Responsibilities

a. Develop, review, and revise credentialing forms

b. Review the credentials of applicants and make recommendations for membership and privileges in compliance with these Bylaws and Credentialing Policies and Procedures.

c. Report to the Medical Executive Committee on individual applicants for Medical Staff membership or privileges including specific consideration of the recommendations from the Heads of Departments in which such applicant requests privileges, appointments and reappointments, and assignment of members to various Departments or Clinical Services as provided by these Bylaws

d. Interview a member or applicant and/or the Head of the involved Department, when appropriate, concerning appointment, reappointment, or change in privileges, and attempt to resolve any differences which may arise. A written report of the Committee's actions and recommendations shall be given to the Medical Executive Committee.

Composition

This Committee includes a Chair and at least five (5) members of the Medical Staff who shall be chosen to ensure representation from the major clinical areas, as well as the President of the Medical Staff, and Vice President and/or the Immediate Past Chair of the Medical Staff.

6. ETHICS COMMITTEE

This multidisciplinary and collegial Committee is available for consultation and education on bioethical and clinical issues.

Responsibilities:

a. Providing timely consultative services, on request, to facilitate the discussion and, where possible, the resolution of specific bioethical and clinical issues by the principals involved.

b. Making recommendations that would address any chronic or recurring bioethical and clinical care issues of a systemic nature (organizational ethics)

c. Providing bioethical and clinical care educational opportunities to the members of the Committee, the Hospital, and the wider community

d. When necessary, review and recommendation of hospital policies that pertain to bioethical and clinical care issues.

Composition

Membership shall be composed of representatives of the Medical and Nursing Staffs, Hospital Administration, a hospital ethicist, Social Services, Chaplaincy, the legal profession, and the lay community. The committee shall have co-chairs, one of whom is a member of the Medical Staff. The co-chairs shall be empowered to appoint temporary ad hoc members whose expertise may be necessary for a particular issue.

7. HEALTH INFORMATION MANAGEMENT COMMITTEE

The purpose of the HIM Committee is to provide physician-based oversight to the acquisition, implementation, and use of Electronic Health Record System (EHRS), provide guidelines and develop policies and procedures related to EHRS and health information management practices. The Committee is accountable to the Medical Executive Committee and serves as a forum to identify important health information management and technology issues and develop plans and actions to address these concerns.

Responsibilities:

a. Sets Policy and Procedures for legal medical record, medical record documentation, and all medical record related practice.

b. Recommends actions to improve the quality of medical documentation and evaluates the results of actions taken.

c. Provides guidance regarding the strategic direction for the electronic health record transformation, electronic personal health record (PHR), and patient portal.

d. Monitors the on-going review of medical records for compliance with all state, federal, and other national standards.

e. Monitors delinquency rate and develops recommendations for achieving timeliness in chart completion.

f. Ensures the implantation of information security policies and control procedures.

g. Monitors how the LPCHS medical community documents patient care and takes actions to improve the effectiveness and usefulness of clinical documentation.

h. Approves and monitors the guidelines of Integrated Documentation Committee (IDC); provide physician support to medical record forms.

i. Provides oversight and support for Master Patient Index (MPI) committee.

Composition:

The Health Information Management Committee includes representatives from Medical Staff, hospital administration, clinic administration, Health Information Management Services, Information Services, Quality Management and nursing administration.

8. INTERDISCIPLINARY PRACTICE COMMITTEE (IDPC*) (sub-committee of Credentials Committee)*

The Interdisciplinary Practice Committee (IDPC) exists to provide medical staff oversight to non-medical staff members as well as fulfill State of California requirements related to performance of standardized procedures by advance practice nurses and privileging of health care professionals who are not members of the medical staff organization of Lucile Packard Children's Hospital Stanford Medical Staff (LPCHS) but who are required to be privileged by the Joint Commission. The committee is responsible for recommending appointments and reappointments of Advance Practice Professionals, delineation of staff privileges and practice protocols. The membership shall be consistent with the requirements set forth by Title 22 Section s70706.

Responsibilities:

a. Review and recommend approval of credentialing, privileges and standard procedures and protocols to the Credentials Committee who will report to the Medical Executive Committee.
b. Develop, review and revise credentialing and privileging forms for all employed and non-employed Allied Health Professionals.
c. Interview a member, supervising physician or service chief when appropriate concerning appointment, reappointment or change in privileges and attempt to resolve any differences which may arise.

Composition:

The membership of this committee shall include, as a minimum, the Director of Nursing (or Designee), Director of Advance Practice Professionals (or designee) and an equal number of physicians appointed by the Medical Executive Committee of the Medical 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 shall also be included in the committee.

9. EXECUTIVE VALUE COMMITTEE (EVC)

The LPCH Quality and Safety Governance structure is led by EVC. EVC provides leadership, coordination, and oversight for Lucile Packard Children's Hospital Stanford (LPCHS) quality planning and initiatives. The EVC directs multidisciplinary project selection, prioritization and change recommendations. It oversees a number of sub-committees including the Quality and Safety Oversight Committee and the Effectiveness and Efficiency Committee.

Responsibilities:

a. Monitoring the Board-defined key performance indicators in Quality, Safety, and Service. Results are reported up to the Quality, Safety and Service Committee (QSS) of the LPCHS Board of Directors.

b. Monitoring of actual or potential patient care problems and processes

c. Monitoring effectiveness of improvement teams

d. Addressing utilization, length of stay, resource consumption and admission and discharge processes as needed

e. Track Action Plans created from Root Cause Analysis (RCA)s performed as well as track Serious Safety Events

f Coordination of quality management activities for the Medical Staff

g. Evaluation of Performance Improvement Plan for LPCHS

h. Evaluation of the Patient Safety Plan for LPCHS.

Composition:

The EVC is comprised of physician and administrative leaders. The physician leaders represent the key medical, surgical and obstetrical services for LPCHS. The administrative leaders represent Hospital Operations and Patient Care Services, Ambulatory Care Services, Risk Management and Strategic Planning and Business Development. The Chief Quality Officer, Executive Director of the

Center for Pediatric and Maternal Value, and the Chief Nursing Officer oversee EVC.

EVC will report to the Medical Executive Committee and the Board of Directors of Lucile Packard Children's Hospital Stanford as appropriate.

10. PHARMACY AND THERAPEUTICS COMMITTEE

This Committee formulates and reviews policies regarding the selection, intra-hospital distribution, storage, and safe use and administration of drugs within the enterprise in order to ensure optimum clinical results and a minimum potential for hazard. The Medical Staff performs the pharmacy and therapeutics function in cooperation with the Departments of Pharmacy, Nursing, Administration, and other departments or clinical services as required.

Responsibilities:

a. Interface with Stanford Medicine Children's Health quality improvement process to enhance patient safety and efficacious medication utilization.

b. Provide Medical Staff oversight for the medication management process, including selection, procurement, storage, ordering, preparing, dispensing, administration, and monitoring.

c. Manage the Drug Formulary system, including the evaluation of medications requested for addition or deletion. Criteria will include, but are not limited to, clinical data (including pediatric and/or obstetric-specific data), indications for use, effectiveness, risks (including potential for medication error), and cost.

d. Review appropriateness of empiric, prophylactic, and therapeutic use of drugs through the analysis of individual or aggregate patterns of drug practices.

e. Development and approval of policies and procedures relating to the selection, distribution, handling, use, and administration of drugs and diagnostic testing materials.

f. Evaluate the medication management system or risk points and identifying areas to improve safety.

g. Establish standards concerning the dispensing and storage of investigational or experimental drugs.

h. Approve drugs to be stocked on the nursing unit floors and by other services under override category.

i. Communication of Committee activities to the Medical, Nursing, Pharmacy, and other appropriate staff.

j. Provide clinical oversight for issues related to food and nutrition. This will include review of clinical policies and procedures, diet manual, food and drug interactions, and related education of the patient and family. The Director of Clinical Nutrition Services shall report on these issues at least annually.

Composition:

This Committee consists of a Chair and at least three (3) representatives of the Medical Staff; a member of the nursing staff; the Director of Pharmacy Services and at least one (1) additional pharmacist; a dietitian; and representation from Hospital Administration.

Meetings:

The Committee meets a minimum of six (6) times per year and can meet electronically. The Chair of the committee can facilitate approval with a quorum of at least 2 physicians pending a full committee review.

11. TISSUE COMMITTEE

Responsibilities

The duties of the tissue committee shall include review of surgical cases in which a specimen (tissue or non-tissue) is removed, as well as cases in which no specimen is removed. In the latter case, however, a screening mechanism based upon pre-established criteria may be established. The review shall include the indications for surgery. All cases in which there is a major discrepancy between the pre-operative and post-operative (including pathologic) diagnosis may also be reviewed. The LPCHS Tissue Committee will refer cases to the appropriate departmental peer review. The committee will report to the MEC at least annually.

Composition

The Tissue Committee shall consist of at least 4 members of the LPCHS medical staff: 1. the Service Chief of Pediatric Pathology, or their designee, 2. the Service Chief of Pediatric General Surgery, or their designee, 3. the Service Chief of Pediatric Radiology, or their designee and 4. the Service Chief of Pediatric Hematology/Oncology, or their designee. The Chair of the Committee will be the Service Chief of Pediatric Pathology.

12. UTILIZATION REVIEW COMMITTEE (URC)

Utilization Review Committee has the authority and responsibility to provide review for patients (including Medicare and Medicaid patients) with respect to medical necessity of admissions to the institution, duration of stays, and professional services furnished including drugs and biologicals. This committee

shall be accountable to the Medical Executive Committee. URC also reports its activities at the Effectiveness and Efficiency Committee for coordination purposes.

The URC implements procedures for reviewing stages of hospital admissions, including but not limited to, medical necessity for admission, over/under utilization of ancillary services, delays in services, quality of care indicators, adequacy of medical record documentation, lengths of stay and timeliness of discharge. The URC may review third party payor denials and will review all significant lengths of stay, referred patient admission by any party at Lucile Packard Children's Hospital Stanford (LPCHS) and will work closely with finance, social services, case management, patient placement and the medical staff of LPCHS.

The URC will develop the Utilization Management Plan, which will be reviewed annually. The URC will report findings including problems, areas of opportunities, recommendations and actions taken to the appropriate department, medical staff, and other hospital entities. These same findings will also be fully evaluated and reported to the Medical Executive Committee.

Responsibilities:

a. Review of admissions before, at, or after hospital admission.
b. Reviews may be conducted on a sample basis.
c. Under prospective payment, review cases reasonably assumed to be outliers as determined by high costs and utilization of institutional resources.
d. Under prospective payment, review cases reasonably assumed to be outliers as determined by extended length of stay.
e. Under prospective payment for professional services, review cases deemed to be an outlier based on extraordinarily high costs.
f. Report to the MEC quarterly.

Composition:

The Utilization Review Committee will consist of a Co-Chairs representing the hospital and physicians. Representatives from the following medical, surgical and support services will include: General Pediatrics, Cardiology, Pediatric Critical Care, Cardiovascular Intensive Care, Neonatology, General Pediatric Surgery, Pediatrics Transplant, Pediatric Nursing, Case Management, Quality Management, Performance Improvement, Health Information Systems, Social Services, Respiratory Care, Finance, and Patient Access Services including Director Access and Care Coordination and Administrative Director Cancer Center & Complex Care.

13. WELL-BEING OF PHYSICIANS AND PHYSICIANS-IN-TRAINING COMMITTEE

The purpose of the Stanford Hospital & Clinics and Lucile Packard Children's Hospital Stanford Medical Staff Well-Being of Physicians and Physicians-in-Training Committee is to support the well-being of our physicians, in so doing to protect patient welfare, improve patient care, and improve Medical Staff functioning. The Committee works to achieve this purpose through facilitation of, treatment for, prevention of, and intervention in alcohol-related, drug related, and behavioral problems of members of the Medical Staff. The Committee aims to foster a culture of mutual concern, safety, professionalism, and confidentiality.

The committee interfaces with and oversees projects of the WellMD Center, which helps to lead and coordinate the Stanford Medicine wide efforts to improve the wellness and professional satisfaction of all Stanford physicians. This includes the Peer Support program, which is a component of the quality improvement function of the Medical Staff. The administration of the peer-support program is delegated to the Stanford Medicine WellMD and WellPhD Center.

Responsibilities

a. Receive reports related to health, well-being, or impairment of Medical Staff members. With respect to matters involving individual Medical Staff members, the Committee may, upon its own initiative, upon request of the involved clinician, or upon request of a Medical Staff or Department committee or officer, provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential; however, if the Committee receives information that demonstrates that the health or impairment of a Medical Staff member may pose a risk of harm to Hospital patients (or prospective patients, visitors, employees or colleagues), that information shall be referred to the CMO, ACMO, President of the Medical Staff and/or Medical Executive Committee for review, who will determine whether corrective action is necessary to protect patients. If immediate action is not necessary, the matter will be referred to the committee for review.

b. Compile a resource list of organizations and individuals who can provide professional assistance to the impaired provider.

c. Develop a protocol to guide Department Heads in responding to specific instances of impairment.

d. Serve as a statistical resource for such information as incidence, mode of discovery, therapy, and long-term follow-up of cases of impairment.

e. Sponsor and/or publicize educational programs, when appropriate, which deal with issues of impairment.

f. Establish and monitor the efforts of a Physician Support Panel with responsibility for dealing directly and confidentially with impaired physicians and physicians in training.

g. Keep any records regarding individual practitioners strictly confidential and maintained independently from the general records of the Committee.

Composition

Voting membership of this Committee includes at least five (5) members of the Stanford Health Care/Lucile Packard Children's Hospital Stanford Medical Staffs, including at least one psychiatrist with experience in drug dependence, and shall also have representatives from Hospital Administration and legal services as non-voting members.

14. COMMITTEE FOR PROFESSIONAL SATISFACTION AND SUPPORT (SCPSS)

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.

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. Coordinate relevant activities and resources across the medical center, while disseminating best practices.
e. Report to the MEC

Composition:

Membership of the Committee, 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.

## 15. PROFESSIONALISM LEADERSHIP COUNCIL

### 1. Purpose

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. Promotion of professionalism relies upon the free exchange of information regarding the professional behavior of trainees as well as providers of the active medical staff between the Medical Staff and the School of Medicine. To this end, a Professionalism Leadership Council (PLC) is established.

### 2. Responsibilities

a. Reviewing the professionalism reporting databases (e.g. ICARES) used to identify patterns and trends of unprofessional behavior.

b. Developing and recommending interventions to enforce professional conduct.

c. Overseeing interventions for medical staff members demonstrating unprofessional behavior.

d. Providing guidance to the Chiefs of the Clinical Services in the management of those providers who manifest unprofessional behavior.

e. Provide recommendations to the Credentials Committees of the SHC and LPCH Medical Staff regarding the credentialing of providers who manifest unprofessional behavior.

### 3. Composition

The Committee will be comprised of the following representatives from the SHC and LPCH Medical Staffs, the Stanford University School of Medicine, and their legal counsel: Vice-Chief, Chief, and Immediate Past Chief of the SHC Medical Staff; the Vice President, President, and Past President of the LPCH Medical Staff; the Senior Associate Dean for Faculty Affairs; the Director of Faculty Relations; legal counsel representing the SHC and LPCH Medical Staffs as well as the Stanford University School of Medicine; the Chairs of the SHC and LPCH Credentials Committee; and the Chairs of the SHC and LPCH Committees for Professionalism.

### 4. Meeting Frequency

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

## 11.3 MEETINGS OF THE MEDICAL STAFF

A. SPECIAL MEETINGS: Special meetings of the Medical Staff may be called at any time by the Medical Executive Committee, President of the Medical Staff. The President of the Medical Staff, or CMO 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 thirty (30) members of the Active Medical Staff. No business shall be transacted at any special meeting except that stated in the meeting notice. The President of the Medical Staff or his/her/their designee will serve as Chair.

B. NOTICE: Notice of the date, time and place of the Medical Staff meetings shall be sent to each member at the member's last known business address, or electronically**,** at least two (2) weeks prior to the scheduled date of the meeting.

C. QUORUM: The presence of thirty (30) members of the Active Medical Staff at any regular or special meeting shall constitute a quorum.

D. VOTING: Only members of the Active Medical Staff shall be eligible to vote at meetings of the Medical Staff.

## 11.4 DEPARTMENT MEETINGS

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

## 11.5 MINUTES

Minutes may be kept for meetings of the Medical Staff.

## 11.6 ATTENDANCE REQUIREMENTS

A. To foster quality professional interaction and awareness of items of general interest to the Medical Staff as well as applicable standards and policies, all Staff Members are encouraged to attend Medical Staff meetings and Committee, Department and Service meetings. Meeting attendance is a professional obligation of each Staff Member.

B. Medical Executive Committee and Medical Staff Committees: Members of the Medical Executive Committee and Medical Staff Committees must attend at least half of all the meetings held. Failure to attend at least half of the meetings or absence from three consecutive meetings may result in removal from the committee.

## 11.7 DUES AND FEES

A. DUES

1. The Medical Executive Committee shall 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 shall be separately accounted for in a medical Staff Dues Account to be used, as appropriate, for the purposes of the Medical Staff, including retention of, and representation by, independent legal counsel at the Medical Staff's expense.

3. Expenditures from the Medical Staff Dues Account shall be limited to the annual budget approved by the Medical Executive Committee. Any dispute regarding expenditures from the Medical Staff Dues Account shall be resolved by the Medical Executive Committee.

4. Non-budgeted expenditures may require the approval of the Finance Committee.

B. PROCESSING FEES

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

## ARTICLE TWELVE
## CONFIDENTIALITY AND IMMUNITIES

### 12.1 CONFIDENTIALITY OF INFORMATION

A. CONFIDENTIALITY OF INFORMATION: GENERAL

Medical Staff, Department, Clinical Service, and Medical Staff Committee minutes, files, and records, including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential. Dissemination of such information and records shall 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 the Hospital and Medical Staff to solicit and provide information bearing upon a physician's, dentist's, podiatrist's, or clinical psychologist's ability and qualifications; or by express approval of the Medical Executive Committee. The information shall be part of the Medical Staff files and shall not become part of any patient's file or of general Hospital records.

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 the Hospital must be based on free and candid discussions. Any breach of confidentiality of the records, discussions or deliberations of Medical Staff, Departments, Clinical Services, or Committees, is considered outside appropriate standards of conduct for this Medical Staff, disruptive to the operations of the Hospital, and detrimental to quality patient care, treatment and services. Further, all patient care, treatment and services records and related activities shall be kept confidential and not be disclosed inappropriately by any member of the Medical Staff. Any breach of confidentiality is grounds for immediate removal from committee service and shall be a basis for corrective action.

### 12.2 ACTIVITIES AND INFORMATION COVERED

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

### 12.3 IMMUNITY FROM LIABILITY FOR ACTIONS TAKEN AND INFORMATION PROVIDED

Each representative of the Medical Staff and/or Hospital acting pursuant to these Bylaws shall 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/their 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 this Hospital.

## 12.4 INDEMNITY AND DEFENSE

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

## ARTICLE THIRTEEN
## ORGANIZED HEALTH CARE ARRANGEMENT WITH LPCHS

LPCHS, together with all members of the Medical Staff, Housestaff, Fellows, Allied Health Practitioners, and non-physician health care providers that provide clinical services at LPCHS (collectively, for the purposes of this Article Fourteen only, "LPCHS Staff"), constitutes an Organized Health Care Arrangement ("OHCA") under the HIPAA Privacy Regulations. Accordingly, LPCHS and LPCHS Staff will issue a joint notice of privacy practices, as permitted under the HIPAA Privacy Regulations, and each member of the LPCHS 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. LPCHS and LPCHS 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 FOURTEEN
## GENERAL PROVISIONS

### 14.1 ACCEPTANCE OF PRINCIPLES

All members of whatever 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 shall be distributed by mail, electronically, or on the Internet, in a timely fashion to each member on his/her/their initial appointment, and a copy of each amendment thereto promptly after adoption. Any violation of these Bylaws shall subject the applicant or member to such disciplinary action as the Medical Executive Committee or Board of Directors shall direct.

### 14.2 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, shall be in writing and shall be delivered personally or Certified by United States Postal Service, return receipt required for both methods. In the case of notice to Hospital, Board of Directors, Medical Staff or Officers, or Committee thereof, the notice shall be addressed as follows:

Lucile Packard Children's Hospital Stanford
Medical Staff Services and Credentialing
Stanford, California 94304

In the case of a notice by the Hospital or Medical Executive Committee to an applicant, Medical Staff member, or other party, the notice shall be addressed to the business address as it appears in the records of the Hospital. If personally delivered, such notice shall be effective upon delivery to the person or to such address, and if mailed as provided for above, such notice shall 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.

### 14.3 PROFESSIONAL LIABILITY INSURANCE

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

### 14.4 DISPOSITION AND/OR FINAL JUDGMENT

Each member of the Medical Staff shall report to Medical Staff Services, the filing or service of any professional liability suits 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.

## ARTICLE FIFTEEN
## AMENDMENT OF BYLAWS AND RULES AND REGULATIONS OF THE MEDICAL STAFF

### 15.1 BYLAWS

The Bylaws shall be reviewed periodically and amended to reflect LPCHS's current practices with respect to the Medical Staff organization and functions. Suggested changes in the Bylaws of the Medical Staff shall be submitted to the Medical Executive Committee. The Bylaws may be amended by the affirmative vote of a majority of the Medical Executive Committee present at a meeting at which there is a quorum and the affirmative vote of a majority of the Active Medical Staff responding in an electronic or mail ballot and shall become effective when approved by the Board of Directors, which approval shall not be withheld unreasonably. Neither the Board of Directors, Medical Staff Services Departments nor the Medical Executive Committee shall unilaterally amend the Bylaws.

### 15.2 PROCESS FOR BYLAWS AMENDMENT

A. BY THE MEDICAL EXECUTIVE COMMITTEE

Proposed amendments to the Medical Staff Bylaws shall be submitted to the Medical Executive Committee when developed by the Bylaws Committee as provided in Section 11.2.H. of these Bylaws. The Medical Executive Committee may also develop proposed amendments to the Medical Staff Bylaws. Amendments developed by the Medical Executive Committee itself or through recommendations of the Bylaws Committee shall be submitted for vote to the Medical Staff as provided for in Section 15.1.

B. BY THE MEDICAL STAFF

The Medical Staff may develop and recommend amendments to the Medical Staff Bylaws. An amendment proposed by the Medical Staff must be done by a petition stating the exact language of the proposed amendment and signed by at least 25 percent of the Medical Staff members entitled to vote on Bylaws amendments. The petition shall be submitted to the Medical Executive Committee which shall then arrange for a vote on the amendment as provided in Section 15.1. The Medical Executive Committee and the signers of the petition proposing an amendment each have the right to circulate comments on the proposed amendment to the voting Medical Staff in advance of the vote and to the Board of Directors in advance of the Board's consideration of the amendment if it is adopted by the Medical Staff.

### 15.3 TECHNICAL CORRECTIONS

The Medical Executive Committee shall have the power to approve technical corrections, such as reorganization or renumbering of the Bylaws, or to correct punctuation, spelling or other errors of grammar, expression or inaccurate cross-references. No substantive amendments are permitted pursuant to this Section. Corrections may be affected by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such corrections shall be communicated in writing to the Medical Staff and to the Governing Body. Such corrections are effective upon adoption by the Medical Executive Committee; provided

however, they may be rescinded by vote of the Medical Staff or the Governing Body within 120 days of the date of adoption by the Medical Executive Committee.

## 15.4 RULES AND REGULATIONS AND POLICIES

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

B. The organized Medical Staff, by this Section 15.4.B., delegates to the Medical Executive Committee the authority to adopt, subject to Board of Director approval, Medical Staff Rules and Regulations and Policies.

C. Medical Staff Rules and Regulations and Policies may be adopted or amended by either:

1. The affirmative vote of a majority of the Medical Executive Committee members present at a meeting at which a quorum is present, in addition to the approval of the Board of Directors; or

2. The affirmative vote, conducted by means of an electronic or mail ballot, of a majority of the Active Medical Staff responding, in addition to the approval of the Board of Directors. An electronic or mail ballot of the Active Medical Staff shall be conducted for this purpose upon request of a majority of the Active Medical Staff members present at the Medical Staff meeting at which there is a quorum.

D. The process for adoption or amendment of Rules and Regulations or Policies is as follows:

1. When the Medical Executive Committee proposes to adopt a Rule and Regulation or amendment thereto, it first communicates the text of that Rule and Regulation to the Medical Staff at least thirty (30) days prior to voting on adoption.

2. When the Medical Executive Committee adopts a Policy or amendment thereto, it communicates the text of the Policy to the Medical Staff in a timely fashion after adoption.

3. The Medical Staff, by a petition signed by no less than 10% of the Active Medical Staff, may propose the adoption, or amendment, of a Rule or Regulation or Policy. Any such proposal must be submitted to the Medical Executive Committee and must contain the specific language proposed for adoption. Upon receipt, the Medical Executive Committee shall consider the proposal. If the Medical Executive Committee agrees with the proposal, it shall be adopted as provided in Section 15.4.C.1. If the Medical Executive Committee does not approve the proposal, it shall notify the Medical Staff. The Medical Executive Committee and the Medical Staff each has the option of invoking or waiving the conflict management process of Section 15.6 within thirty (30) days. If the

conflict management process is not invoked within thirty (30) days, the right to the process shall be deemed waived.

4. Nothing in this Section 15.4.D. is intended, nor will it be construed, to prevent direct communication by the Medical Staff to the Board of Directors on any Rule and Regulation or Policy, however adopted. The Board of Directors shall establish the method for such communication(s).

5. After documentation of an urgent need to adopt a Rule and Regulation or amendment thereto, to comply with law or regulation, the Medical Staff delegates to the Medical Executive Committee the authority to provisionally adopt, and the Board of Directors to provisionally approve, a Rule and Regulation or amendment thereto. In such circumstances, the Medical Executive Committee will immediately communicate the text of the Rule and Regulation to the Medical Staff for review and comment. The Medical Staff shall have 15 days to review the provisionally adopted Rule and Regulation or amendment. If objection to the Rule and Regulation or amendment is submitted to the Medical Executive Committee in a writing(s) signed by 10 percent of the Active Medical Staff, the dispute shall be resolved in accordance with Section 15.6. In the absence of such written objection, the provisionally adopted Rule and Regulation or amendment stands as finally adopted.

## 15.5 PROVISION OF TEXT

When significant changes are made to the Medical Staff Bylaws, Rules and Regulations, or policies, the Medical Staff members and other individuals who have delineated clinical privileges are provided with revised texts of the written materials.

## 15.6 CONFLICT RESOLUTION

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 or Policies, amendments to such documents, or other issues. Such conflicts may be identified by the Medical Executive Committee, or by a petition signed by at least 10 percentof the Active Medical Staff. When such conflicts are identified, the CMO or President of the Medical Staff shall call a Special Meeting of the Medical Staff as provided in Section 11.3 of the Medical Staff Bylaws. The sole issue for any such Special Meeting shall be the issue in conflict which shall be resolved as provided in Section 11.3 of these Bylaws.

## 15.7 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff Services Departments positions or other offices, leadership positions, Medical Staff or Hospital committees, or the Medical Executive Committee shall, 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 foreseeably 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 shall evaluate the significance of such disclosures and discuss any significant conflicts with the nominee. If a nominee with a significant conflict remains on the ballot, the nature of his or her conflict shall be disclosed in writing and circulated with the ballot.

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 SIXTEEN

### 16.1 ADOPTION

The Bylaws, Rules and Regulations when adopted by the Medical Executive Committee and a majority of the Active Medical Staff responding in an electronic or mail ballot, shall replace all previous Bylaws of the Medical Staff and shall become effective within thirty (30) days of approval by the Board of Directors, with subsequent notification to all Medical Staff.

### 16.2 EFFECT AND OBLIGATIONS OF MEDICAL STAFF DOCUMENTS

The Medical Staff Bylaws, Rules and Regulations, and Policies and the LPCHS Hospital Bylaws and Policies are compatible with each other and compliant with law and regulation. The Medical Staff complies with the Medical Staff Bylaws, Rules and Regulations and Policies. The Medical Staff enforces the Medical Staff Bylaws, Rules and Regulations and Policies 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 Bylaws, Rules and Regulations, and Policies which it has approved.