

El Camino Ambulatory Surgery Center, LLC
2480 Grant Road
Mountain View, CA 94040

EL CAMINO AMBULATORY SURGERY CENTER
MEDICAL STAFF BYLAWS

Whereas, El Camino Ambulatory Surgery Center, LLC, organized under the laws of the state of California, owns and operates the El Camino Ambulatory Surgery Center (“Center”), an ambulatory surgery center, designed to provide quality care for eligible patients who are scheduled to undergo procedures which meet the criteria for ambulatory care; and

Whereas, it is recognized there is a need to provide quality care and management.

Therefore, the Physicians practicing in the Center shall organize their activities in order to carry out the functions delegated to the Medical Staff by the Governing Body in conformity with these Bylaws.

DEFINITIONS

For the purposes of these Bylaws, the following definitions shall apply:

1. **Medical Staff** – The Physicians who have been granted Medical Staff membership and Clinical Privileges to care for patients at the Center.
2. **Physician** – An individual with a M.D., D.D.S., D.M.D., D.P.M., or D.O. degree who is licensed to practice medicine, surgery or osteopathy in the state of California.
3. **Admitting Physician** – A Physician who has been granted Medical Staff membership at the Center whose Clinical Privileges support initiating the admission of a patient to the Center.
4. **Center** – El Camino Ambulatory Surgery Center.
5. **Quality Assessment and Performance Improvement Committee (“QAPIC”)** – Appointed by the Governing Body, this Committee monitors, evaluates, supervises and establishes controls designed to achieve and maintain high standards of professional practice and the delivery of high quality medical services at the Center.
6. **Governing Body** – The Managing Member, E3 ECSC LLC, appoints Larry Aufmuth, Steven F. Kanter, MD, Jay Pruzansky, DPM, and Carole Wilson as Governing Body members. The Chief Executive Officer and Medical Director are ex-officio, non-voting members.
7. **Clinical Privileges** – The permission granted to Medical Staff members to provide patient care and includes the use of the Center’s resources that are necessary to effectively exercise those patient care Clinical Privileges.

ARTICLE I NAME

The name of the organization shall be The El Camino Ambulatory Surgery Center Medical Staff (the “Medical Staff”).

ARTICLE II PURPOSE

2. The purposes of this organization are:

- a. To ensure all patients treated in this Center, regardless of gender, race, age, creed, disability or national origin, shall receive quality medical care;
- b. To serve as the primary means for accountability to the Governing Body for the quality and appropriateness of the professional performance and ethical conduct of the Medical Staff members and to strive toward assuring that the patient care in the Center is consistently maintained at the level of quality and efficiency with the state of the healing arts and the resources locally available;
- c. To recommend and maintain Rules and Regulations for the governance of the Medical Staff;
- d. To provide a means where the Medical Staff with the management of the Center can discuss issues concerning the Medical Staff and the Center;
- e. To provide quality care through adherence to the policies and standards of the Joint Commission; and
- f. To promote the public’s confidence in and utilization of comprehensive outpatient services performed by the Medical Staff at the Center.

ARTICLE III MEDICAL STAFF MEMBERSHIP

3.1 Nature of Medical Staff membership.

Membership on the Medical Staff of the Center is a privilege extended to qualified, ethical and competent Physicians who meet the standards and requirements set forth by these Bylaws. No person otherwise qualified as provided in these Bylaws shall be denied appointment or reappointment to the Medical Staff or particular Clinical Privileges, solely on the basis of gender, race, age, creed, disability or national origin.

3.2 Qualifications of Medical Staff membership.

3.2.1 Physicians licensed to practice in the State of California and who apply for Medical Staff membership shall possess:

- a. Current, valid physician license to practice in the State of California;
- b. Current, valid DEA certificate (except for staff with only surgical assisting Clinical Privileges);

- c. Training and experience relevant to the Clinical Privileges requested, including submission of surgical case logs from a hospital, ambulatory surgery center or similar entity that demonstrate experience in the procedures requested at Center;
- d. Current demonstrated professional competence, verified in writing by individuals personally acquainted with the applicant's professional and clinical performance as determined by the Governing Body;
- e. Physical and mental health necessary to exercise the Clinical Privileges requested;
- f. Attestation of tuberculosis testing.
- g. Professional liability insurance in an amount, and with an insurer, deemed satisfactory by the Governing Body;
- h. Physicians who do not maintain Medical Staff membership and/or appropriate Clinical Privileges at an area hospital must provide evidence of a physician sponsor who will accept responsibility for patient transfers to an area hospital when needed; and
- i. A record free of felony convictions, and suspensions or terminations from the Medicare or Medicaid program.

3.2.2 Acceptance of Medical Staff membership shall constitute the agreement of a Medical Staff member that he/she will strictly abide by the Code of Ethics of the American Medical Association, American Dental Association, American Podiatry Association, or American Osteopathic Association, whichever is applicable, and this Medical Staff's Bylaws and Rules and Regulations and applicable policies of the Medical Staff and the Center; work cooperatively with others so as not to adversely affect patient care; participate in and properly discharge Medical Staff's responsibilities; and exercise good judgment in the care and treatment of patients.

3.2.3 Physicians, dentists and podiatrists applying for Medical Staff membership on the Medical Staff must have the following particular qualifications.

- a. **Physicians:** An applicant for Physician Medical Staff membership in the Medical Staff must hold an M.D. or D.O. degree issued by a medical or osteopathic school approved at the time of issuance of such degree by the Medical Board of California and must also hold a valid and unsuspended certificate to practice medicine issued by the Medical Board of California or the Board of Osteopathic Examiners of the State of California.
- b. **Dentist:** An applicant for dental Medical Staff membership in the Medical Staff, must hold a D.D.S. or equivalent degree issued by a dental school approved at the time of the issuance of such degree by the Board of Dental Examiners of California and must also hold a valid and unsuspended certificate to practice dentistry issued by the Board of Dental Examiners of California.
- c. **Podiatrist:** An applicant for podiatric Medical Staff membership on the Medical Staff must hold a D.P.M. degree conferred by a school approved at the time of issuance of such degree by the Medical Board of California's Board of Podiatric Medicine and must hold a valid and unsuspended certificate to practice podiatry issued by the Medical Board of California's Board of Podiatric Medicine.

3.2.4 Physicians transferring patients from the Center shall agree to cooperate with the receiving facility's medical staff peer review process on the transferred patient.

3.2.5 The foregoing qualifications shall not be exclusive of other qualifications and conditions deemed by the Medical Staff to be relevant in considering an applicant's qualifications for Medical Staff membership and Clinical Privileges in the Center.

3.3 Basic Responsibilities of Medical Staff membership.

The ongoing responsibilities of each Medical Staff member include:

- a. Providing patients with the quality of care meeting the professional standards of the Center's Medical Staff;
- b. Abiding by the Medical Staff's Rules and Regulations and applicable policies;
- c. Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the Medical Staff member by virtue of Medical Staff membership, including committee assignments;
- d. Preparing and completing in a timely fashion all medical records for all the patients to whom the Medical Staff member provides care in the Center as outlined in the Rules and Regulations;
- e. Abiding by the lawful ethical principles of the California Medical Association or the Medical Staff member's respective professional association;
- f. Aiding in any Medical Staff approved educational programs for medical students, interns, Medical Staff members, nurses and other personnel;
- g. Working cooperatively with Medical Staff members, nurses, Center's administration, and others so as to not adversely affect patient care;
- h. Making appropriate arrangements for coverage for his or her patients;
- i. Refusing to engage in improper inducements for patient referral;
- j. Participating in continuing education programs, in accordance with the Medical Board of California requirements;
- k. Discharging such other staff obligations as may be lawfully established from time to time by the Medical Staff or Quality Assessment and Performance Improvement Committee; and
- l. Providing information to and/or testifying on behalf of the Medical Staff or an accused practitioner regarding any matter under an investigation.

3.4 Clinical Privileges

3.4.1 Each Medical Staff member practicing at the Center by virtue of Medical Staff membership shall be entitled to exercise those specific Clinical Privileges granted to him/her by the Governing Body.

3.4.2 Documentation of Clinical Privileges granted at an area hospital, ambulatory surgery center, or similar entity, without evidence of restriction or adverse action, shall be considered relevant, but shall not be the sole factor in granting Clinical Privileges.

3.4.3 Application for additional Clinical Privileges shall be made in writing, and shall contain supporting documentation of the Physician's relevant education, training, and experience, and if requested, documentation of said Clinical Privileges at a local hospital.

ARTICLE IV

PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT TO THE MEDICAL STAFF

Except as otherwise specified herein, no person (including persons engaged by the Center in administratively responsible positions) shall exercise Clinical Privileges in the Center unless and until that person applies for and receives appointment to the Medical Staff or is granted Temporary Clinical Privileges set forth in these Bylaws. By applying to the Medical Staff for appointment or reappointment, the applicant acknowledges responsibility to first review these Bylaws and agrees that throughout the period of Medical Staff membership that the applicant will comply with the responsibilities of Medical Staff membership and with the Bylaws and Rules and Regulations, and applicable policies, of the Medical Staff as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the appointee only such Clinical Privileges as have been granted in accordance with these Bylaws. The duration of the appointment to the Medical Staff shall be for two years. All Medical Staff members shall be reviewed and evaluated for reappointment every two years hence.

4.1 Application for Appointment.

4.1.1 Application for appointment to the Medical Staff shall be made in writing and signed by the applicant on a printed form endorsed by the Quality Assessment and Performance Improvement Committee. The application shall contain detailed information which shall include, but not be limited to information concerning:

- a. Verification of the identity of the individual seeking privileges by viewing a valid picture identification issued by a state or federal agency;
- b. Primary source verification of the applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA certification, (except those with only surgical assisting Clinical Privileges); sources include but are not limited to the National Practitioner Data Bank (NPDB), AMA, the California Medical Board, etc.
- c. Peer references familiar with the applicant's professional competence and ethical character;
- d. Request for Clinical Privileges and submission of surgical case logs from a hospital, ambulatory surgery center or similar entity that demonstrate experience in the procedures requested at Center;
- e. Past or pending professional disciplinary action (state level, federal level or Drug Enforcement Agency) including voluntary or involuntary relinquishment or any licenses, certificates or privileges;
- f. Past or pending disciplinary actions or investigations of any peer review body or organization, including voluntary and involuntary relinquishment of Medical Staff membership, Clinical Privileges or employment;
- g. Physical and mental health status;
- h. Attestation of tuberculosis testing;

- i. Final judgments or settlements made against the applicant's professional liability insurance company, and any cases pending;
- j. Professional liability coverage;
- k. Past or pending criminal litigation;
- l. Past or pending investigations, suspensions or terminations by the Medicare and/or Medicaid programs; and
- m. Such other information as the Quality Assessment and Performance Improvement Committee deem necessary.

Each application for initial appointment to the Medical Staff shall be in writing and submitted on the prescribed form with all provisions completed (or accompanied by an explanation of which answers are unavailable), and signed by the applicant. When an applicant requests an application form, that person shall be given a copy of these Bylaws, the Medical Staff Rules and Regulations and other applicable policies relating to clinical practices at the Center.

4.1.2 By applying for appointment to the Medical Staff, each applicant:

- a. Signifies willingness to appear for interviews as needed in regard to the application;
- b. Authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications, and performance, and authorizes such individuals and organizations to candidly provide all such information;
- c. Consents to an inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out the Clinical Privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;
- d. Releases from any liability, to the fullest extent permitted by law, all persons from their acts performed in connection with investigating and evaluating the applicant;
- e. Release from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;
- f. Consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required or allowed by law, any information regarding the applicant's professional or ethical standing that the Center or Medical Staff may have, and releases the Medical Staff and the Center from liability for so doing, to the fullest extent permitted by law;
- g. Pledges to provide continuous quality care for patients; and
- h. Pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing continuous care for patients, seeking consultation whenever necessary, refraining from providing ghost surgical or medical services, and refraining from delegating patient care and responsibility to non-qualified or inadequately supervised practitioners.

4.1.3 The applicant has the burden of producing adequate information for proper evaluation of current professional competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications. The applicant's failure to sustain this burden shall be grounds for denial of application. Significant omissions or misstatements on the application form or during the application process are also grounds for denial of the application, or for

termination of Medical Staff membership if discovered after favorable action has been taken on the application.

4.2 Procedures for Appointment.

4.2.1 Upon receiving the application, a Center's employee, selected by the Governing Body, will research and verify all necessary references, licensure, and other information concerning the applicant's qualifications for the requested Clinical Privileges.

4.2.2 The completed application shall be transmitted to the Medical Director. Temporary Clinical Privileges may be granted in accordance with section 4.3.

4.2.3 The completed application, along with the recommendation from the Medical Director, shall be submitted to the Quality Assessment and Performance Improvement Committee. The Quality Assessment and Performance Improvement Committee shall evaluate the character, qualifications, professional standing, and suitability of the applicant, and, after this evaluation is completed, shall make a recommendation to the Governing Body regarding appointment to the appropriate category of the Medical Staff. When determining qualifications, the Quality Assessment and Performance Improvement Committee shall recommend Clinical Privileges for specific procedures, commensurate with the Physician's documented education, training and experience as provided in these Bylaws.

4.2.4 All applicants, as well as Medical Staff members, consent to the release of pertinent information for any purpose set forth in these Bylaws, and release from liability and agree to hold harmless any person or entity furnishing or releasing such information for application for Medical Staff status as more fully detailed in Article XII of these Bylaws.

4.2.5 The recommendation of the Quality Assessment and Performance Improvement Committee shall be transmitted to the Governing Body for review. The Governing Body shall have ultimate authority in all decisions concerning Medical Staff appointments. Notification of the Governing Body decision is provided to the applicant in writing with a copy of the approved, deferred or denied privileges within 30 days.

4.2.6 In the event the Governing Body should decide to deny Medical Staff membership or the granting of some or all of the Clinical Privileges for which an applicant has applied, the applicant shall be notified in writing of the Governing Body's decision, in accordance with Article VII. An applicant who has received final adverse decision regarding appointment or Clinical Privileges shall not be eligible to reapply to the Medical Staff for a period of two years. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

4.2.7 The Medical Staff shall be divided into the following categories: Provisional Staff, Active Staff, Courtesy Staff as delineated in sections 4.4, 4.5, and 4.6.

4.3 Temporary Clinical Privileges.

The Medical Director is empowered, where good cause exists and upon the basis of the information contained within the completed application, to grant Temporary Clinical Privileges to the applicant. Prior to granting Temporary Clinical Privileges, an application for Clinical Privileges must be on file with primary source verification of a current medical license, valid DEA certificate (except for applicants only applying for surgical assisting clinical privileges), information from the NPDB, professional training and competence and evidence of acceptable professional liability insurance and malpractice history. If there is a failure on the part of the applicant to provide accurate information or an inability to verify the accuracy of the information, his or her Temporary Clinical Privileges will be automatically terminated. Temporary Clinical Privileges will remain in effect until the next Quality Assessment and Performance Improvement Committee meeting, unless the Medical Director withdraws those Temporary Clinical Privileges. Unless the Medical Director gives prior authorization, Temporary Clinical Privileges shall not continue for more than sixty (60) days, with the possibility of extending up to another sixty (60) days.

4.4 Provisional Staff.

A Physician's initial appointment shall be to the Provisional Staff. The Provisional Staff shall consist of those Physicians who shall be considered for advancement to either the Courtesy or the Active Staff after twelve (12) months, based on a period of monitoring and evaluation. The Provisional Staff appointee must complete 18 cases within a rolling 6-month period during the initial twelve (12) months' evaluation and monitoring period in order to move to Active status, otherwise, if the eighteen-case (18-case) requirement has not been met, the Provisional Staff appointee will move to Courtesy Staff. Provisional Staff appointees shall be monitored through the Medical Staff peer review process and the Quality Assessment and Performance Improvement Program. Results of this monitoring shall be considered at the time of consideration for Active or Courtesy Staff. The initial Provisional Staff category may be waived for a new applicant, who was a Medical Staff member in good standing, completed proctoring requirements, leaves and reapplies within one year. (See proctoring requirements under section 5.3)

4.4.1 The Provisional Staff appointee may move to Active Staff, as determined by the Governing Body, within the first six (6) months of monitoring and evaluation by completing a minimum of eighteen (18) cases.

4.5 Active Staff.

All Medical Staff members, except those covered under sections 4.4, 4.6 and 4.7, shall be Active Staff members. Active Staff membership may follow Provisional Staff membership. Active Staff members have full rights and responsibilities of Medical Staff membership, unless limited according to procedures herein, for a period not to exceed two (2) years. A minimum of eighteen (18) cases must be done during any rolling six-month period to maintain Active Staff membership, unless exempted by the Governing Body. If the Medical Staff member fails to perform his/her eighteen (18) cases in any rolling six-month period, the Medical Staff member shall be deemed to have voluntarily converted from Active Staff to Courtesy Staff effective as of the month-end in which the eighteen-case (18-case) requirement in a rolling six-month (6-month) period was not met. Conversion from Active Staff to

Courtesy Staff shall not extend nor shorten the period for which the Medical Staff member was credentialed. Alternatively and at the sole discretion of the Governing Body, to maintain Active Staff membership a Medical Staff Member can contribute to one or more of the goals of the Center:

- Maintain a strong presence in the local physician community the Center serves;
- Enhance the reputation of the Center by working to continue to improve the physician and patient service provided by Center;
- Assist in making the Center a success by actively marketing the Center to prospective new physicians;
- Serve on the Center's Quality Assessment and Performance Improvement Committee if requested;
- Advise on staffing, equipment, supplies, and other clinical processes of the Center; or
- Contribute in an instrumental way to the success of the Center.

If Active Staff membership terminates under this section 4.5, the procedure set forth in Article VII shall not apply.

4.6 Courtesy Staff.

Courtesy Staff status requires evidence of a current, valid, unrestricted California Physician and Surgeon license, DEA certificate and professional liability insurance deemed satisfactory by the Governing Body. This status requires a formal process of credentialing verification but carries no voting rights. Courtesy Staff members have full rights and responsibilities of Medical Staff membership, unless limited according to procedures herein, for a period not to exceed two (2) years. Courtesy Staff members shall participate in a minimum of ten (10) cases within the two-year reappointment cycle in order to maintain Medical Staff membership and Clinical Privileges and for the purpose of peer review and reappointment criteria. In the event that the case minimum is not completed, the applicant must state in writing that he/she is currently on the Active Staff at an acute care hospital or ASC that is on the current list of ASCs or acute care hospitals approved by the Governing Body and submit case logs to demonstrate his/her continued clinical practice. If a Courtesy Staff member meets or exceeds the Active Staff membership threshold for cases performed in a rolling six-month period at the end of his/her two-year appointment or earlier, at the discretion of the Governing Body, then the Center will place him/her on the Active Staff at the time of his/her two-year reappointment if he/she successfully reapplies for Medical Staff membership and Clinical Privileges, or earlier at the discretion of the Governing Body.

4.7 Temporary Surgical-Assisting Clinical Privileges for a Non-Applicant/Non-Medical Staff member:

Temporary Surgical-Assisting Clinical Privileges for surgical-assisting only for a non-applicant/non Medical Staff member shall consist of Physicians selected by the Admitting Physician for surgical assistance to improve patient care when an equally skilled Medical Staff member is unavailable to surgically assist. A Physician who is a non-applicant/non-Medical Staff member may not assist more than four (4) times in a 12-month period. In the event that a Physician wishes to continue to surgically assist beyond four (4) times in a 12-month period, he/she must apply for Medical Staff membership. Once an application has been completed, the Governing Body will determine approval after reviewing the recommendations of the Medical Director and Quality Assessment and Performance

Improvement Committee. A Physician, who wishes to assist four (4) or less times in a year, must fill out a Surgical Assisting Privileges for Non-Applicant form prior to the scheduled case and submit all requested documentation, which consists of his/her current medical license, evidence of acceptable professional liability and any other required documentation.

4.8 Medical Staff Credentials Files.

The following applies to the records of the Medical Staff and their committees that are responsible for the evaluation and improvement of patient care:

- a. The records of the Medical Staff and their committees responsible for the evaluation and improvement of the quality of patient care rendered in the Center shall be maintained as confidential;
- b. Access to such records shall be limited to duly appointed representatives of the Center and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality is maintained;
- c. Information which is disclosed to the Governing Body of the Center by their appointed representatives in order that the Governing Body may discharge its lawful obligations and responsibilities shall be maintained by the Governing Body as confidential;
- d. Information contained in the credentials file of any Medical Staff member or any Physician with Temporary Clinical Privileges or Temporary Surgical-Assisting Clinical Privileges may be disclosed with the Medical Staff member's or non-Medical Staff member's consent, or to any medical staff or other peer review organization, professional licensing boards, or as required by law;
- e. Any other disclosures must be approved by the Quality Assessment and Performance Improvement Committee; and
- f. A Medical Staff member shall be granted access to his/her own credentials file, subject to the following provisions:
 1. The Medical Staff member shall make timely notice of such to the Medical Director or his/her designee;
 2. The Medical Staff member may review, and receive a copy of only those documents provided by or addressed personally to the Medical Staff member;
 3. The review by the Medical Staff member shall take place in the Medical Director's office, during normal work hours, with an officer or designee of the Medical Staff present.

4.9 Procedures for Reappointment or Modification of Medical Staff Category or Clinical Privileges.

The Quality Assessment and Performance Improvement Committee shall review and evaluate each Medical Staff member's request for reappointment (reapplication) to the Medical Staff and his/her request for Clinical Privileges at least every two (2) years in the following manner:

4.9.1 Application for reappointment to the Medical Staff shall be made in writing, signed by the applicant on a printed form endorsed by the Quality Assessment and Performance Improvement Committee. In addition, any request for a change in Medical Staff category or Clinical Privileges shall be made in writing on a printed form endorsed by the Quality

Assessment and Performance Improvement Committee. Specific consideration shall be given to each Medical Staff member with respect to:

- a. Current, valid license to practice medicine in the state of California verified by primary source;
- b. Current, valid DEA certificate (except for applicants requesting only surgical assisting clinical privileges) verified by primary source;
- c. Training and experience relevant to Clinical Privileges requested. Physicians that perform less than a total of ten (10) cases at the Center will be required to submit case logs from a hospital, ambulatory surgery center or similar entity to demonstrate current experience in the procedures requested
- d. Current demonstrated professional competence, verified by peer review, determined by the Quality Assessment and Performance Improvement Committee;
- e. Physical and mental health to exercise the Clinical Privileges requested;
- f. Maintaining professional liability insurance in an amount, and with an insurer, deemed satisfactory by the Governing Body;
- g. Physicians who do not maintain Medical Staff membership and/or appropriate Clinical Privileges at an area hospital must provide evidence of a physician sponsor who will accept responsibility for patient transfers to an area hospital when needed;
- h. A record free of felony convictions related to or impacting on patient care, and suspensions or terminations from the Medicare/Medicaid program;
- i. Cooperation with the Center's personnel;
- j. General attitude toward patients, the Center, and the public;
- k. Utilization patterns;
- l. Compliance with Medical Staff Bylaws and Rules and Regulations and applicable policies; and
- m. Updated information with respect to the items referred to in section 4.1.1.d., f. and i. of these Bylaws.

4.9.2 The completed application shall be submitted to the Medical Director for review. The effect of the application shall be the same as that provided in section 4.1.2.

4.9.3 The completed application, along with the recommendation of the Medical Director shall be submitted to the Quality Assessment and Performance Improvement Committee. The Quality Assessment and Performance Improvement Committee shall evaluate the character, qualifications, professional standing and suitability of the applicant, and shall make a recommendation regarding appointment after this evaluation is completed.

4.9.4 The recommendation of the Quality Assessment and Performance Improvement Committee shall be transmitted to the Governing Body and be reviewed at its next regularly scheduled Governing Body meeting. The Governing Body shall have ultimate authority in all decisions concerning reappointments.

4.9.5 If the Governing Body decides to deny Medical Staff membership or the granting of some or all of the Clinical Privileges for which a Physician has applied/requested or reapplied/re-requested, the Physician shall be notified according to Article VII. The fair hearing process the Physician may use is delineated in Article VII of these Bylaws.

4.9.6 Failure without good cause to timely file a completed application for reappointment will result in automatic termination of the Medical Staff member's Clinical Privileges at the end of the current Medical Staff appointment, unless otherwise extended by the Medical Director with the approval of the Governing Body. Failure to submit an application for reappointment within sixty (60) days past the date it was due, will be deemed a voluntary resignation from the Medical Staff.

4.10 Leave of Absence.

4.10.1 At the discretion of the Quality Assessment and Performance Improvement Committee, a Medical Staff member may obtain a voluntary leave of absence from the Medical Staff upon submitting a written or documented verbal request to the Quality Assessment and Performance Improvement Committee stating the approximate period of leave desired, which may not exceed twelve (12) months. During the period of leave, the Medical Staff member shall not exercise Clinical Privileges at the Center, and Medical Staff membership rights and responsibilities shall be inactive.

4.10.2 At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff member may request reinstatement of Clinical Privileges by submitting a written notice to that effect to the Quality Assessment and Performance Improvement Committee. The Medical Staff member shall submit a summary of relevant activities during the leave, if the Quality Assessment and Performance Improvement Committee so requests. The Quality Assessment and Performance Improvement Committee shall make a recommendation concerning the reinstatement of the Medical Staff member's Medical Staff membership and Clinical Privileges to the Governing Body.

4.10.3 Failure, without good cause, to request reinstatement of Clinical Privileges prior to thirty (30) days of the end of a leave of absence shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Medical Staff membership. A request for Medical Staff membership subsequently received from a Medical Staff member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

ARTICLE V CLINICAL PRIVILEGES

5.1 Exercise of Clinical Privileges.

Except as otherwise provided in these Bylaws, a Medical Staff member who practices Clinical Privileges at the Center shall be entitled to exercise only those Clinical Privileges specifically granted. Said Clinical Privileges performed at the Center, must be within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to the Rules and Regulations of the Center and their Medical Staff, and authority of the appropriate committee(s) and the Medical Staff. Clinical Privileges may be granted, continued, modified, or terminated by the Governing Body of the Center upon recommendation of the Quality Assessment and Performance Improvement Committee and only for reasons directly related to quality of patient care and

other provisions of the Medical Staff Bylaws and Rules and Regulations and applicable policies.

5.2 Delineation of Clinical Privileges in General.

5.2.1 Each application for appointment or reappointment to the Medical Staff must contain a request for the specific Clinical Privileges desired by the applicant. A request by a Medical Staff member for a modification of Clinical Privileges may be made at any time, and documentation of training and/or experience supportive of the request may be required.

5.2.2 Request for Clinical Privileges shall be evaluated on the basis of the applicant's or Medical Staff member's education, training, experience, demonstrated professional competence and judgment, clinical performance, and the documented results of patient care and other quality review and monitoring which the Medical Staff deem appropriate. Clinical Privileges determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where an applicant or Medical Staff member exercises Clinical Privileges.

5.3 Proctoring.

5.3.1. New Medical Staff members must be proctored for a minimum of three (3) cases. If observed proctoring cannot be reasonably carried out within the confines of the Center, evidence of proctoring from a local organization or hospital may be accepted as long as the proctor also carries Medical Staff membership and Clinical Privileges at the Center. Performance of three (3) cases as established by the Quality Assessment and Performance Improvement Committee shall be observed and/or chart reviewed by the appropriate proctor(s), as determined by the Quality Assessment and Performance Improvement Committee during the period of proctoring specified by the Quality Assessment and Performance Improvement Committee, to determine suitability to continue to perform Clinical Privileges within the Center. The Medical Staff member shall remain subject to such proctoring until the Quality Assessment and Performance Improvement Committee furnishes documentation describing the types and number of cases observed, an evaluation of the applicant's performance, and a statement that the applicant appears to meet all of the qualifications for unsupervised practice of the requested Clinical Privilege(s) at the Center.

New Medical Staff members will be required to complete proctoring within a one-year time period.

5.3.2 If a new Medical Staff member fails to complete the requirements described in Section 5.3.1 within the time frame allowed, his/her Medical Staff membership and Clinical Privileges shall automatically terminate, and the Medical Staff member shall be entitled to the hearing rights afforded by Article VII only if the failure to obtain approval was based on a medical disciplinary cause or reason.

5.3.3 The failure to complete proctoring requirements for any specific Clinical Privilege shall not, in itself, preclude the advancement (e.g., from Provisional Staff to either Active Staff or Courtesy Staff) in a Medical Staff category of any Medical Staff member. If such advancement of Medical Staff membership is granted, absent a completion of proctoring

requirements, continued proctorship on any Clinical Privilege that requires further proctoring, shall continue for the specified time period.

5.3.4 Upon recommendation by the Medical Director or the QAPIC, the Governing Body may waive proctoring requirements with justification of the decision documented by the Medical Director in the applicant's Medical Staff credentials file.

5.6 Utilization of Allied Health Professional Staff ("AHP")

In the event that a Medical Staff member utilizes an AHP to assist on a case, that Medical Staff member agrees to: supervise and be physically present for core, complex and "other" complex procedures as outlined in the Delineation of Privileges List, to monitor the AHP's actions as necessary, to be personally responsible for any and all acts of the AHP while working at the behest of and/or assisting the Medical Staff member at the Center; indemnify and hold the Center harmless from any and all claims or liability resulting from that AHP's actions; and to sign the attestation form documenting this agreement. Medical Staff members are to acquire attestation forms from the Medical Director or his/her designee. The Medical Staff member's submission of a signed attestation warrants that the Medical Staff member limits his/her supervision of AHP personnel to four nurse practitioners, or three nurse midwives, or two physician's assistants, or four of the above individuals in any combination which does not exceed the limits stated for each category.

ARTICLE VI CORRECTIVE ACTION AND LOSS OF CLINICAL PRIVILEGES

6.1 Initiation.

Whenever the activities or professional conduct of any Physician with Medical Staff membership and/or Clinical Privileges or Temporary Clinical Privileges or Temporary Assistant-Clinical Privileges are not consistent with these standards of the Medical Staff or are disruptive to the operations of the Center, or are detrimental to patient care, or are unethical or below applicable professional standards, corrective action against such Physician may be requested by any Medical Staff member, Governing Body member or the Medical Director. All requests shall be made in writing to the Quality Assessment and Performance Improvement Committee and shall be supported by reference to the specific activity or conduct that constitutes such grounds for the request.

6.2 Grounds.

Grounds for requesting corrective action include, but are not limited to:

- a. Activities or professional conduct inconsistent with the standards of the Medical Staff;
- b. Activities disruptive to the Center;
- c. Unexpected outcomes involving patient injury;
- d. Substandard practices whether or not they have caused patient injury;
- e. Unethical practices;

- f. Conduct in violation of the Bylaws, Rules and Regulations, or other Center's policies;
- g. Failure to keep adequate records which impact the quality of care rendered;
- h. Signs of physical or mental impairment that could adversely affect patient care;
- i. Sexual harassment;
- j. Loss or limitation of Clinical Privileges at any hospital of which the Physician is a Medical Staff member; or
- k. Confirmed adverse information pertaining to Physician competence and/or performance from outside sources such as, but not limited to, The NPDB and/or other health care facilities.

6.3 Investigation.

Upon receiving a request, the Quality Assessment and Performance Improvement Committee shall investigate the matter. The Quality Assessment and Performance Improvement Committee may appoint an Ad Hoc Investigation Committee to manage the investigation. It shall be the function of the Quality Assessment and Performance Improvement Committee (or the Ad Hoc Committee) to conduct a fact-finding investigation within sixty (60) days after the receipt of the request to determine the facts and circumstances surrounding each incident that is the basis for the request for corrective action. The Quality Assessment and Performance Improvement Committee shall review the results of the investigation, make a written report of its findings, and take action on the request within the following sixty (60) day period. The Quality Assessment and Performance Improvement Committee consistent with obtaining a complete investigation may grant reasonable extensions of the investigation time frames.

6.4 Interview.

Prior to the making of its written report, the Physician against whom corrective action has been requested, shall have the opportunity for an interview with the Quality Assessment and Performance Improvement Committee, if the Physician so desires. At such interview, the Physician will be informed of the general nature of the charges made against the Physician and will be invited to discuss, explain or refute them. This interview shall be preliminary in nature, shall not constitute a hearing and none of the procedural rules provided in these Bylaws pertaining to a hearing shall apply. The Quality Assessment and Performance Improvement Committee shall make a record of such interview. Failure of the Physician to attend a scheduled interview shall constitute a waiver of the right to this interview.

6.5 Actions.

6.5.1 As soon as practicable after the conclusion of the investigation the Quality Assessment and Performance Improvement Committee shall take action, which may include, without limitation:

- a. Determining no corrective action need be taken, and if the Quality Assessment and Performance Improvement Committee determines there was no credible evidence for the complaint, removing any adverse information from the Medical Staff member's file;
- b. Deferring action for a reasonable time where circumstances warrant;

- c. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude the issuance of written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected Medical Staff member may make a written response that shall be placed in the Medical Staff member's file;
- d. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of Clinical Privileges, including without limitation, requirements for co-admissions, mandatory consultation, or monitoring;
- e. Recommending reduction, modification, suspension, or revocation of Clinical Privileges;
- f. Recommending reductions of Medical Staff membership status or limitations of Clinical Privileges directly related to the Medical Staff member's delivery of patient care;
- g. Recommending suspension, revocation or probation of Medical Staff membership; or
- h. Taking other actions deemed appropriate under the circumstances.

6.5.2 Any recommendation by the Quality Assessment and Performance Improvement Committee for denial, alteration, or limitation of Clinical Privileges or Medical Staff membership, if the action would result in a report to the Medical Board of California, is subject to hearing rights as provided for in Article VII, except as mentioned in this Article VI or Article VII.

6.6 Summary Suspension.

6.6.1 Any or all of the Clinical Privileges of a Medical Staff member may be immediately suspended or restricted where the failure to take such action may result in an imminent danger to the health of any individual. The Medical Director, two or more Physician Quality Assessment and Performance Improvement Committee members who are not in direct economic competition with the suspended Medical Staff member, or the Chief Executive Officer may initiate summary suspension of Clinical Privilege(s). Such summary suspension shall become effective immediately upon imposition and will be confirmed by written notice that generally describes the reason for action.

6.6.2 Imposition of a summary suspension shall constitute a request for corrective action under section 6.1, and the Medical Director with the Quality Assessment and Performance Improvement Committee shall thereafter initiate an investigation of the reasons for the suspension as soon as possible.

6.6.3 The affected Medical Staff member may request an interview with the Quality Assessment and Performance Improvement Committee, which shall be convened as soon as reasonably possible under the circumstances; such interview shall be informal and not constitute a hearing under these Bylaws. The Quality Assessment and Performance Improvement Committee may thereafter continue, modify, or terminate the summary action. Unless the Quality Assessment and Performance Improvement Committee terminates the

summary suspension, it shall remain in effect and continued until the completion of the corrective action process, including any hearing and appellate review.

6.6.4 Upon the conclusion of the investigation the Quality Assessment and Performance Improvement Committee may recommend modification, continuance, or termination of the summary suspension. If, as a result of such investigation, the Quality Assessment and Performance Improvement Committee finds the suspension should stand as is or needs to be modified, the suspension remains in effect and the Physician is entitled to the procedural rights of a fair hearing as outlined in Article VII.

6.7 Automatic Suspension.

6.7.1 Any of the following actions is grounds for automatic suspension or restriction consistent with the action taken and without hearing rights:

- a. Suspension, limitation or restriction of a Medical Staff member's license;
- b. Suspension, limitation or probation of DEA certificate;
- c. Failure to maintain the amount of professional liability insurance deemed appropriate by the Center;
- d. Failure to provide proof of current license, DEA certificate (except those with only surgical assisting Clinical Privileges) or professional liability insurance;
- e. Suspension from the Medicare or Medicaid program;
- f. Actions taken by the Medical Examiners Board or Osteopathic Board of Examiners in California restricting a Medical Staff member's license or placing him/her on probation, will be the subject of an immediate review by the Quality Assessment and Performance Improvement Committee and/or Governing Body as to the reason(s) for the disciplinary measures; or
- g. Failure to complete medical records within a reasonable time as prescribed in the Rules and Regulations or by the Quality Assessment and Performance Improvement Committee. A limited suspension in the form of a withdrawal of admitting and other related Clinical Privileges until medical records are completed, shall be imposed by the Medical Director, after written notice of delinquency for failure to complete medical records. The suspension shall continue until lifted by the Medical Director after he/she confirms that the records have been satisfactorily completed. Accumulation of more than sixty (60) days of medical record suspension within any twelve-month period shall be deemed a voluntary resignation from Medical Staff membership. In such circumstances, the hearing rights of Article VII will not apply unless a decision is made that the action must be reported to the Medical Board of California (Section 805 report). The Medical Staff member may reapply when any delinquent records are completed. Such reapplication shall be treated as an initial application.

6.7.2 Imposition of an automatic suspension shall constitute a request for corrective action under section 6.1, and the Medical Director with the Quality Assessment and Performance Improvement Committee shall thereafter initiate an investigation of the reasons for the suspension as soon as possible.

6.7.3 Appropriate actions will be taken pending the outcome of the investigation. Reinstatement of the Physician to former Medical Staff status and Clinical Privileges is

directly dependent on reversal of the event that triggered the suspension. However, the facts that led to a state medical board or DEA sanction may be the basis for corrective action by the Quality Assessment and Performance Improvement Committee.

6.8 Termination.

6.8.1 Any of the following is grounds for automatic termination without hearing rights:

- a. Revocation of Physician's professional license;
- b. Revocation of DEA certificate;
- c. Suspension or termination by the Medicare or Medicaid program;
- d. Conviction of a felony related to or impacting patient care (as determined by the Quality Assessment and Performance Improvement Committee);
- e. Loss of hospital privileges such that Physician has no hospital privileges in the local area (unless accepted under 4.9.1 g.)

6.8.2 Should there be a reversal of section 6.8.1, and the Physician desires reinstatement of Medical Staff membership and Clinical Privileges, the Physician must reapply in writing for Center's Clinical Privileges. Such reapplication shall be processed in the same manner as initial appointments to the Medical Staff.

ARTICLE VII PROCEDURAL FAIRNESS

7.1 Right to Hearing.

7.1.1 When any Physician receives notice from the Quality Assessment and Performance Improvement Committee of a recommendation that will adversely affect his/her status as a Medical Staff member, or his/her Clinical Privileges, as stated in section 7.1.2 below, the Physician shall be entitled to a hearing before an Ad Hoc Hearing Committee appointed by the Quality Assessment and Performance Improvement Committee.

7.1.2 The following actions/recommendations are grounds for a hearing if, and only if, they require reporting to the Medical Board of California.

- a. Denial of staff appointment, reappointment or advancement in Medical Staff membership status;
- b. Suspension of Medical Staff membership (except as set forth in section 6.7.1);
- c. Revocation of Medical Staff membership (except as set forth in section 6.7.1 or 6.8.1);
- d. Denial of advancement in Medical Staff membership;
- e. Denial of requested Clinical Privileges;
- f. Involuntary reduction of current Clinical Privileges;
- g. Suspension of Clinical Privileges; or
- h. Termination of Clinical Privileges.

7.1.3 All hearings shall be in accordance with the procedural safeguards set forth in this article.

7.2 Request for Hearing.

7.2.1 The Medical Director shall be responsible for giving prompt written notice by Certified Mail (Return Receipt Requested) of an adverse recommendation to any affected Physician who is entitled to a hearing. This should include, and not be limited to, the following:

- a. The general reasons for the proposed action;
- b. Whether the recommendation or action, if adopted, shall be reported to the Medical Board of California pursuant to California Business and Professions Code Section 805 or to the NPDB pursuant to federal law;
- c. A statement that the Physician has the right to request a hearing on the proposed action within thirty (30) days of the receipt of the notice; and
- d. A summary of the Physician's rights with respect to the conduct of the hearing.

7.2.2 Within thirty (30) days after receipt of such notice, the affected Physician may request a hearing, by delivering a written request, either in person or by Certified mail (Return Receipt Requested), to the Medical Director. The failure of a Physician to request a hearing, to which the Physician is entitled to by these Bylaws within the time and in the manner herein provided, shall be deemed a waiver to the right to such a hearing. Once a hearing right has been waived, the adverse recommendation or decision shall become the final recommendation or decision of the Quality Assessment and Performance Improvement Committee.

7.2.3 Within a period of not less than thirty (30) days after receipt of a request for a hearing from a Physician entitled to same, the Medical Director shall schedule and arrange for a hearing and shall notify the affected Physician of the time, place and hearing date so scheduled by Certified Mail (Return Receipt Requested). Another date may mutually be agreed upon. The hearing shall commence no later than sixty (60) days from the date of the receipt of request for hearing. In the case of a summary suspension, the hearing will be held as soon as reasonably possible.

7.2.4 The notice of hearing shall include all reasons for the final proposed action taken or recommended, including the acts or omissions with which the Physician is charged and a list of specific or representative charts being questioned (if any).

7.3 Composition of Hearing Committee.

7.3.1 An Ad Hoc Hearing Committee composed of no less than three (3) Medical Staff members, not more than seven (7) Medical Staff members, except as noted in section 7.3.3, shall conduct the hearing. The Governing Body will appoint such committee. Where feasible, the committee shall include an individual practicing the same specialty as the affected Physician.

7.3.2 The Committee shall be composed of unbiased individuals who shall gain no direct financial benefit from the outcome and who have not actively participated in consideration of the adverse recommendation or action, including acting as an accuser, investigator, fact finder, or initial decision maker in the same matter. There shall be a reasonable opportunity to voir dire the committee's members and to challenge the impartiality of any committee

member. The Presiding Officer, who shall be the Hearing Officer if one has been selected, shall rule challenges to the impartiality of any committee member.

7.3.3 In the event that it is not feasible to appoint a Hearing Committee from the Medical Staff or if additional specialized medical expertise is needed, the Governing Body may appoint Physicians who are not Medical Staff members to the Hearing Committee.

7.4 Conduct of Hearing.

7.4.1 The hearing provided for in these Bylaws is for the purpose of resolving matters bearing on professional competency and conduct. The Ad Hoc Hearing Committee shall consider the record (testimony and exhibits) produced at the hearing.

7.4.2 The affected Physician for whom the hearing has been scheduled shall be required to be physically present throughout the hearing. A Physician who fails without good cause to appear and proceed at such hearing shall be deemed to have waived the right to a hearing and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become the final recommendation or decision of the Quality Assessment and Performance Improvement Committee.

7.4.3 An attorney may represent the affected Physician at the hearing, provided he/she gives written notice to the Medical Director at least thirty (30) days prior to the hearing. If the affected Physician is not represented by an attorney, the Physician shall be entitled to be accompanied at the hearing by a Medical Staff member in good standing, or by a member of his/her professional society, which person shall not also be an attorney. If an attorney does not represent the affected Physician at the hearing, the Quality Assessment and Performance Improvement Committee shall not be so represented.

7.4.4 A Presiding Officer, who shall either be a member of the Ad Hoc Hearing Committee or a Hearing Officer, shall preside over the hearing, determine the order of procedures during the hearing, ensure that all participants in the hearing have a reasonable opportunity to present oral and documentary evidence, rule on any issues or questions that might arise, maintain decorum, and ensure that all parties present their positions promptly and without unnecessary delay. If the Governing Body selects a Hearing Officer, the Hearing Officer should be an attorney at law capable of presiding over a quasi-judicial hearing who does not regularly represent the Center in legal matters. The Hearing Officer shall be unbiased, shall gain no direct financial benefit from the outcome of the hearing, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote. There shall be a reasonable opportunity to voir dire the Hearing Officer and to challenge the Hearing Officer's impartiality. The Hearing Officer shall rule on challenges to the Hearing Officer's impartiality.

7.4.5 The hearing need not be conducted according to the rules of civil procedure relating to the examination of witnesses or presentation of evidence. Any relevant evidence, including hearsay, on which the responsible persons customarily rely in the conduct of serious affairs, shall be considered, regardless of the existence of any rule that might make the evidence inadmissible in a court of law. The Hearing Committee may interrogate witnesses or call additional witnesses if it deems such action appropriate.

7.4.6 The Medical Staff appointed representative and the affected Physician shall have the following rights:

- a. To be provided with all the information made available to the Ad Hoc Hearing Committee;
- b. To call, examine and cross-examine witnesses;
- c. To introduce and rebut evidence determined by the Presiding Officer to be relevant; and
- d. To submit a written statement at the close of the hearing.

7.4.7 An accurate, complete record of the hearing must be kept (e.g., court reporter, taping with transcription). The Ad Hoc Hearing Committee shall establish the mechanism. All involved parties shall receive a copy of the hearing record upon written request. A reasonable fee may be charged for copies of the record.

7.4.8 The affected Physician shall have the right to inspect and copy, at the Physician's expense, any documentary information relevant to the charges, which the Medical Staff has in their possession or under their control, as soon as practicable after the receipt of the Physician's request for a hearing. The Medical Staff shall have the right to inspect and copy, at their expense, any documentary information relevant to the charges which the affected Physician has in his or her possession or control as soon as practicable after receipt of the Medical Staff's request. The failure of either party to provide access to this information at least thirty (30) days before the hearing shall constitute a good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable practitioners, other than the Physician under review. The affected Physician and the Medical Staff shall have the right to receive all evidence that will be made available to the hearing panel. The Presiding Officer and Hearing Officer shall consider and rule upon any request for access to information and may impose any safeguards for the protection of the peer review process as justice requires.

7.4.9 When ruling upon requests for access to information and determining the relevancy thereof, the Presiding Officer or Hearing Officer shall, among other factors, consider the following:

- a. Whether the information sought may be introduced to support or defend the charges;
- b. The exculpatory or inculpatory nature of the information sought;
- c. The burden imposed on the party in possession of the information sought, if access is granted; and
- d. Any previous requests for access to information submitted or resisted by the parties to the same proceeding.

7.4.10 At the request of either side, the parties shall exchange lists of witnesses expected to testify and copies of all documents expected to be introduced at the hearing. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance.

7.4.11 The burden of presenting evidence and proof during the hearing shall be as follows:

- a. The Medical Staff shall have the initial duty to present evidence that supports the charge or recommended action;

- b. Initial applicants shall bear the burden of persuading the Ad Hoc Hearing Committee by a preponderance of the evidence of their qualifications by producing information, which allows for adequate evaluation and resolution of reasonable doubts concerning their current qualifications. Initial applicants shall not be permitted to introduce information not produced upon request of the Medical Staff during the application process unless the initial applicant established that the information could not have been produced previously in the exercise of reasonable diligence; and
- c. Except as provided above for initial applicants, the Medical Staff shall bear the burden of persuading the Ad Hoc Committee by a preponderance of the evidence that the action or recommendation is reasonable and warranted.

7.4.12 The Ad Hoc Committee may recess the hearing and reconvene the same for the convenience of the participant or for the purpose of obtaining new or additional evidence or consultation.

7.4.13 Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Ad Hoc Hearing Committee shall thereupon, at a time convenient to itself, promptly conduct its deliberations.

7.4.14 No Hearing Committee member may vote by proxy.

7.5 Final Decision.

Upon conclusion of the presentation of evidence, the hearing shall be closed, and the Ad Hoc Hearing Committee, outside the presence of any other person, except the Hearing Officer, shall conduct its deliberations. The Majority recommendation of the Ad Hoc Hearing Committee will be the final decision on the matter, subject to approval by the Governing Body. Upon reaching its decision, the Ad Hoc Hearing Committee shall prepare a written decision, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. The Ad Hoc Committee shall send notice of the decision to the Physician within fifteen (15) days of completion of the hearing by Certified Mail (Return Receipt Requested). The parties shall also receive a written explanation of the procedure for appealing the decision.

ARTICLE VIII APPELLATE REVIEW PROCEDURE

8.1 Nature of Proceeding.

The proceedings by the Governing Body shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Committee and that Committee's report. The Governing Body shall also consider material as may be presented and accepted under sections 8.3 and 8.4 of this Article. The Governing Body may consider:

- a. Whether the decision being appealed was supported by substantial evidence and/or

- b. Whether the hearing conformed to the procedural requirements of these Bylaws or applicable law.

A written request for an appellate review shall be filed with the Governing Body within thirty (30) days of a party's receipt of the hearing decision. Failure to request an appellate review in such manner shall be deemed an acceptance of the hearing decision, which will then be subject to final decision by the Governing Body.

8.2 Presiding Officer.

The chairperson of the Governing Body, or such other member of the Governing Body as the chairperson shall appoint, shall be the Presiding Officer. The Presiding Officer shall determine the order of the procedure during the review, make all required rulings and maintain decorum.

8.3 Procedure.

Both parties have the right to appear and make an oral statement before the Governing Body and to be represented by an attorney or such other representative as they may designate, according to such procedure as the Governing Body may prescribe in its discretion. Any party or representative appearing shall be required to answer questions put to him by members of the Governing Body.

8.4 Consideration of New or Additional Matters.

Additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review only at the discretion of the Governing Body, following an explanation by the party requesting the consideration of such matter or evidence as to why it was not presented earlier.

8.5 Presence of Governing Body members and Vote.

A majority of the Governing Body must be present throughout the review and deliberations. If a Governing Body member is absent from any part of the proceedings, he/she shall not be permitted to participate in the deliberations or the decision.

8.6 Recesses and Adjournment.

The Governing Body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned.

8.7 Action Taken.

The Governing Body may affirm, modify, or reverse the decision of the Ad Hoc Hearing Committee.

8.8 Conclusion.

The appellate review shall not be deemed to be concluded until all of the procedural steps have been completed or waived. The Governing Body's decision is final and shall not be subject to further hearing or appellate review. The Governing Body shall send notice to the affected Physician, including a written decision, by Certified Mail (Return Receipt Requested). The decision shall be in writing, shall specify the reasons for the action taken, and shall be forwarded to the Medical Director, the Quality Assessment and Performance Improvement Committee, and the affected Physician.

8.9 Individual Evaluations vs. Requests to Review Rules and Requirements.

The sole purpose of the formal hearings and appeals provided in this Article is to evaluate individual Physicians on the basis of bylaws, rules, regulations, policies and standards of the Medical Staff and the Center. The hearing committees provided for in this Article have no authority to modify, limit or overrule any established bylaw, rule, regulation, exclusive contract, policy or standard of the Medical Staff or the Center and shall not entertain challenges to such rules and requirements. Any Physician wishing to challenge an established rule or requirement must notify the Quality Assessment and Performance Improvement Committee and the Governing Body of the rule or requirement he or she wishes to challenge and of the basis of the challenge. The Governing Body shall then consult with the Quality Assessment and Performance Improvement Committee regarding the request. No Physician shall initiate judicial challenge to any bylaw, rule, policy or exclusive contract until the Governing Body, following consultation with the Quality Assessment and Performance Improvement Committee, has reviewed the issue and reached a decision regarding the validity of the item being challenged. Any such challenge must be brought as a writ of traditional mandamus under California Code of Civil Procedure Section 1085.

ARTICLE IX ALLIED HEALTH PROFESSIONAL APPOINTMENTS

9.1 Definition.

Allied health professionals shall be defined as non-Physician healthcare workers. They may be employed by a Medical Staff member or practice as independent practitioners, if permitted by state law and subject to any supervision requirements imposed by state law or these Medical Staff. Allied health professionals shall include, but may not be limited to, the following individuals:

- a. Non-Physician surgical assistants;
- b. Private Physician's scrub nurses or technicians; and
- c. Physician Assistants.

9.2 Procedure for Appointment.

9.2.1 Application for appointment to the Allied Health Professional Staff shall be made in writing, and signed by the applicant on a printed form endorsed by the Quality Assessment and Performance Improvement Committee. The application shall contain detailed information concerning the applicant's professional qualifications and include a statement indicating that

the applicant has read the applicable sections of the Bylaws, Rules and Regulations, and Policy and Procedure manuals of the Center, and agrees to abide by the terms.

9.2.2 The applying Allied Health Professional shall identify at least one Medical Staff member with appropriate clinical privileges who has agreed to provide any necessary supervision for the Allied Health Practitioner's practice at the Center. The application shall be signed by the employing Medical Staff member and/or supervising Physician when applicable, shall sign the application, indicating the Medical Staff member's agreement to be fully responsible for the Allied Health Professional's actions in dealing with patients treated at the Center.

9.2.3 When requested by the Medical Staff, the employing/affiliated Medical Staff member and/or supervising Physician shall provide a statement in the application indemnifying the Center against the actions or omissions of the Allied Health Professional Staff member requesting appointment. The applicant shall provide evidence of professional liability insurance coverage.

9.2.4 The application shall outline a description of duties the applicant desires to perform at the Center, the scope of practice, and the level of supervision to be provided by the Medical Staff member.

9.2.5 The applicant shall submit a current professional license or other legal credentials authorizing their practice, when applicable.

9.2.6 The Medical Director shall review the completed application and recommend to the Governing Body to either grant or deny Clinical Privileges.

9.2.7 The completed application along with the recommendation from the Medical Director shall be submitted to the Quality Assessment and Performance Improvement Committee. The Quality Assessment and Performance Improvement Committee shall make its recommendation to the Governing Body based upon the applicant's current license (if applicable), education, training, experience, the references of the applicant, and needs of the Medical Staff/Center.

9.2.8 The recommendation of the Quality Assessment and Performance Improvement Committee shall be transmitted to the Governing Body for review. The Governing Body shall have ultimate authority in all decisions concerning Allied Health Professional appointments.

9.2.9 Temporary Surgical-Assisting Clinical Privileges for a Non-Applicant

Temporary Surgical-Assisting Clinical Privileges for surgical-assisting only for a non-applicant shall consist of an Allied Health Professional (AHP) selected by the Admitting Physician for surgical assistance to improve patient care when an equally skilled Medical Staff or AHPS member is unavailable to surgically assist. An AHP who is a non-applicant/non-AHPS member may not assist more than four (4) times in a 12-month period. In the event that an AHP wishes to continue to surgically assist beyond four (4) times in a 12-month period, he/she must apply for AHPS membership. Once an application has been completed, the Governing Body will determine approval after reviewing the recommendations

of the Medical Director and Quality Assessment and Performance Improvement Committee. An AHP, who wishes to assist four (4) or less times in a year, must fill out a Surgical Assisting Privileges for Non-Applicants form prior to the scheduled case and submit all requested documentation, which consists of his/her current AHP license, evidence of acceptable professional liability and any other required documentation.

9.3 Procedures for Reappointment.

Allied Health Professionals shall be reappointed in writing according to the same procedure as listed in 9.2, including peer review, every two (2) years.

9.4 Removal from Staff.

9.4.1 An Allied Health Professional who ceases employment/affiliation with the supervising Medical Staff member(s), thereby having no such supervision in place, will have his/her ability to practice automatically suspended, effective on the date that the relationship with the supervising Medical Staff member(s) ends. The employing/affiliated Medical Staff supervisor is responsible for notifying the Medical Director within two working days of severing the employment/affiliation relationship of the Allied Health Professional. Failure of the Allied Health Professional to secure supervision from a Medical Staff member with appropriate clinical privileges within thirty (30) days of losing all such supervision will be deemed a resignation of the Allied Health Professional's staff status. No procedural rights shall apply to the suspension and/or resignation covered by this Section 9.4.1.

9.4.2 If a supervising Medical Staff member loses his/her Medical Staff membership at the Center, resulting in an Allied Health Professional not having the required supervision, the Allied Health Professional's ability to practice will be automatically suspended effective on the date the Medical Staff member loses his/her membership. Failure of the Allied Health Professional to secure supervision from a Medical Staff member with appropriate clinical privileges within thirty (30) days of the Medical Staff member's loss of membership will be deemed a resignation of the Allied Health Professional's staff status. No procedural rights shall apply to the suspension and/or resignation covered by this Section 9.4.

9.4.3 The Governing Body may terminate Allied Health Professionals from the Allied Health Professional Staff for activities or professional conduct inconsistent with the standards of the Center after review by the QAPIC.

9.4.4 Independent practitioners and other Allied Health Professionals are entitled to an interview with the Quality Assessment and Performance Improvement Committee regarding their termination of Clinical Privileges, if the termination of Clinical Privileges is for reasons other than a change in employment status. The Quality Assessment and Performance Improvement Committee will render a written decision regarding the termination after any such interview. The Governing Body makes final decisions concerning recommendations.

ARTICLE X RESIDENTS

10.1 Definition.

Residents shall be defined as Physicians-in-training from an accredited program.

10.2 Scope of Practice.

Residents are only allowed to surgically assist and must work under the direct supervision of a Medical Staff member at all times.

10.3 Verification.

A list of residents shall be obtained from the residency program, along with verification of medical licenses and professional liability insurance, applicable to their work at the Center.

ARTICLE XI GOVERNANCE AND COMMITTEES

11.1 Quality Assessment and Performance Improvement Committee.

11.1.1 The Quality Assessment and Performance Improvement Committee shall be a standing committee and shall consist of representatives selected by the Governing Body from each major specialty of the Medical Staff in addition to the Medical Director who shall be the chairperson. The Chief Executive Officer of the Center may serve as an ex-officio member of the Quality Assessment and Performance Improvement Committee but shall not participate in any proceedings or activities of the Quality Assessment and Performance Improvement Committee when it is acting as a peer review and medical review committee. The Quality Assessment and Performance Improvement Committee has been empowered by the Governing Body for the establishment, maintenance, and improvement of professional and quality ongoing monitoring and review of the factors that relate to quality patient care. The chairperson shall report to the Governing Body.

11.1.2 The duties of the Quality Assessment and Performance Improvement Committee shall be:

- a. To represent and act on behalf of the Medical Staff subject to such limitations as may be imposed by these Bylaws;
- b. To receive committee reports and make recommendations to the Governing Body;
- c. To implement the Bylaws and Rules and Regulations and appropriate policies of the Medical Staff;
- d. To provide a liaison between the Medical Staff and the Center;
- e. To recommend action to the Medical Director;
- f. To make recommendations on the management of the Center;
- g. To fulfill the Medical Staff accountability for the quality of care provided to patients at the Center;
- h. To review the credentials of all applicants to the Medical and Allied Health Professional Staff, make recommendations on appointments, reappointments and delineation of Clinical Privileges;
- i. To review periodically or at least every two (2) years, information available regarding the performance and current clinical competence of Physicians and other practitioners with Clinical Privileges and make recommendations for changes in Clinical Privileges;

- j. To take all reasonable steps to ensure professional and ethical conduct and competent clinical performance on the part of Medical Staff members;
- k. To serve as a hearing committee when requested;
- l. To report any changes in patient care rules and regulations and participate in organizational performance and improvement activities;
- m. To review and take action, or make recommendations, upon matters related to risk management, medical records, nursing, infection control, medical education and workplace safety;
- n. To designate committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the Medical Director;
- o. To assist in the obtaining and maintenance of accreditation;
- p. To develop and maintain methods for the protection and care of patients and others in the event of internal and external disaster;
- q. To conduct utilization review and tissue review;
- r. To review and approve of the Center's Medical Staff members, as an authorized representative for National Practitioner Data Bank purposes;
- s. To make such other recommendations as deemed necessary; and
- t. To report to the Governing Body.

11.1.3 The Quality Assessment and Performance Improvement Committee shall meet quarterly and shall keep a permanent record of its proceedings.

11.2 Medical Director.

The Governing Body shall select the Medical Director, who shall serve at the pleasure of the Governing Body. The Medical Director shall be the Chief Medical Executive Officer of the Center, shall chair the Quality Assessment and Performance Improvement Committee, and shall perform such other duties as defined, from time-to-time, by the Governing Body. The Governing Body may select Co-Medical Directors, Assistant Medical Directors and/or Medical Directors in specialty practice areas and shall define the respective duties of all such persons.

11.3 Medical Staff's Meetings.

11.3.1 A meeting shall be called when the Quality Assessment and Performance Improvement Committee or the Governing Body deems it necessary. The Medical Director shall arrange the time and place of such meeting. Written notice stating the place, date and hour of the meeting of the Medical Staff shall be delivered either personally or by mail to each Medical Staff member.

11.3.2 The agenda at Medical Staff meetings shall be:

- a. Reading of the notice calling the meeting.
- b. Transaction of business for which the meeting was called
- c. Adjournment.

11.3.3 A copy of minutes will be circulated to the Medical Staff.

11.3.4 A majority vote of Active Staff members present is required to carry out any motion or vote brought before the Medical Staff membership.

ARTICLE XII IMMUNITY FROM LIABILITY

12.1 Conditions.

12.1.1 Any act, communication, report, recommendation, or disclosure with respect to any such Physician, performed or made in good faith and without malice at any request of an authorized representative of the Medical Staff or any other health care facility for the purpose of achieving and maintaining quality patient care in this or any other health care facility shall be privileged to the fullest extent permitted by law.

12.1.2 Such confidentiality shall extend to Medical Staff members, the Quality Assessment and Performance Improvement Committee, to other practitioners who supply information, and to third parties who receive, release, or act upon the same. For the purpose of this Article, the term, third parties, means both individuals and organizations from which an authorized representative of the Medical Staff or the Center has requested information.

12.1.3 There shall be, to the fullest extent permitted by the law, absolute immunity from civil liability arising from any act, communication, report, recommendation or disclosure, even when the information involved would otherwise be deemed privileged.

12.1.4 Such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in good faith in connection with the Center's activities, related, but not limited to:

- a. Applications for appointment or Clinical Privileges;
- b. Periodic reappraisals for reappointment of Clinical Privileges;
- c. Corrective action including summary suspension;
- d. Hearings and reviews;
- e. Medical care evaluations;
- f. Infection control;
- g. Committee activities related to quality patient care and inter-professional conduct; and/or
- h. National Practitioner Data Bank queries and reports, peer review organizations, The Medical Board of California and similar reports.

12.1.5 The acts, communications, reports, recommendations and disclosures referred to in this Article XII relate to a Physician's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or other matters which may directly or indirectly have an impact on patient care.

12.1.6 In furtherance of the foregoing, each applicant and/or Medical Staff member shall, upon request of the Center's Medical Director, execute a written release in accordance with the tenor and import of this Article in favor of the individuals and organization specified in section 12.1.2 and whether or not such written release is requested or executed, each applicant and/or Medical Staff member agrees to such release.

ARTICLE XIII GENERAL PROVISIONS

13.1 Rules and Regulations.

The Governing Body shall adopt such Rules and Regulations as may be necessary to implement these Bylaws. The Rules and Regulations shall relate to the proper conduct of Medical Staff organizational activities and shall embody the level of practice required of Medical Staff's appointee. Rules and Regulations may not conflict with or contravene the Bylaws. In all cases where there are discrepancies or divergent interpretations, the Bylaws shall prevail.

13.2 Professional Liability Insurance.

Each Physician and other individuals granted Clinical Privileges in the Center shall continuously maintain in force professional liability insurance in not less than the minimum amounts as may be determined by the Governing Body, with full coverage for all Clinical Privileges or services provided in the Center. The Governing Body shall determine the amount of professional liability insurance deemed satisfactory. Upon request, each Physician or Allied Health Professional shall provide satisfactory evidence of such coverage to the Quality Assessment and Performance Improvement Committee, including full information as the exceptions or exclusions from coverage, and shall immediately notify the Medical Director of any change in such coverage. Each such policy shall provide that it will not be cancelled except on thirty (30) days prior notice to the Center.

13.3 No Contract Intended.

13.3.1 Notwithstanding anything herein to the contrary, it is understood that these Bylaws and the Rules and Regulations do not create, nor shall they be construed as creating, in fact, by implication or otherwise, a contract of any nature between or among the Center or the Governing Body or the Medical Staff and any Medical Staff member or any person granted Clinical Privileges. Any Clinical Privileges are simply Clinical Privileges that permit conditional use of the Center, subject to the terms of these Bylaws and the Rules and Regulations and applicable policies.

13.3.2 Notwithstanding the foregoing, the provisions containing undertakings in the nature of an agreement or indemnity or a release shall be considered contractual in nature and not a mere recital and shall be binding upon Physicians and those granted Clinical Privileges in the Center.

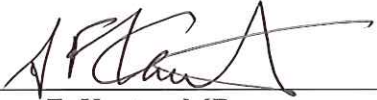
13.4 No Agency. Physicians and Practitioners shall not, by virtue of these Bylaws, Medical Staff membership, or Clinical Privileges, be authorized to act on behalf of or bind the Center, and shall not hold themselves as our agents, apparent agents, or ostensible agents of the Center, except where specifically and expressly authorized in a separate written contract with the Center.

ARTICLE XIV
ADOPTION AND AMENDMENTS

These Bylaws shall become effective when approved by the Governing Body. They shall be equally binding on the Governing Body and Medical Staff. Governing Body members, Active Staff members or the Quality Assessment and Performance Improvement Committee may submit proposed amendments to these Bylaws. The Governing Body must ratify an amendment before it becomes effective, which ratification shall not be withheld unreasonably.

Approved on July 17, 2014

By: The Governing Body



By: Steven F. Kanter, MD
Member

Approved List of ASCs and Acute Care Hospitals

(Section 4.6, Courtesy Staff)

El Camino Hospital

El Camino Hospital Los Gatos

Stanford Hospital

Sequoia Hospital

Good Samaritan Hospital

Bascom Surgery Center

Silicon Valley Surgery Center

Waverley Surgery Center

Campus Surgery Center

O'Connor Hospital

Regional Medical Center of San Jose

Los Gatos Surgery Center