Loma-Linda University Medical Center
Medical Staff Bylaws 2023-2024

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Section 1.01 Preamble

Loma Linda University Medical Center has as one of its primary purposes serving as a clinical base for affiliated programs for educating and training medical students, graduate physicians and dentists, nurses, and AHP paramedical personnel in a setting promoting optimal care of the patient, operating in accordance with the ethics, principles, and philosophy of the Seventh-day Adventist Church.

These Bylaws are adopted to provide for the organization of the Medical Staff of Loma Linda University Medical Center and to provide for a framework for self-government of the Medical Staff in order for it to accept and assume its responsibility in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. The relationship of the organized Medical Staff and Governing Body are guided by these Bylaws.

Definitions

1. **Administrator** means the person appointed by the Governing Body to act on its behalf in the overall management of the Medical Center, or authorized representative.
2. **Allied Health Professional** or **AHP** means an individual, other than a licensed physician, dentist or podiatrist, who holds a valid license, certificate or other legal credential, as required by California law, that authorizes the individual to provide patient care services in collaboration with a physician, dentist or podiatrist. The categories of AHPs authorized in the Medical Center are listed in the Rules and Regulations. "Allied Health Staff" means those Allied Health Professionals who are neither employees of the Medical Center nor, pursuant to the terms of these Bylaws, eligible for Medical Staff membership, but who have been granted "Practice Privileges" (as defined below) by the Medical Staff to provide patient care services in collaboration with a physician, dentist or podiatrist member of the Medical Staff.
3. **Board Certified** means Currently Board Certified by a certifying Board recognized by the American Board of Medical Specialties (ABMS), or the American Osteopathic Association, or other pathway recognized by an ABMS specialty board.
4. **Clinical Privileges** or **Privileges** means the permission granted to a Medical Staff member to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services.
5. **Emergency** means an unforeseen happening or state of affairs requiring prompt action.
6. **Fellow** A physician registered as a post graduate House Staff member in an LLU-approved fellowship program. There are ACGME-accredited Fellows and non-ACGME fellows. Non-ACGME fellows may function as members of the Medical Staff.
7. **Governing Body** means the Loma Linda University Medical Center's Board of Trustees or a duly authorized committee thereof.
8. **LLU Affiliated Site** means the various affiliated facilities with which LLUMC has a shared credentialing and peer review agreement. These facilities include: Loma Linda University Health Care (LLUHC), Loma Linda University Children's Hospital (LLUCH), Social Action Community Health System (SACHS), and Loma Linda University Medical Center –Murrieta (LLUMC-M).

9. **Medical Center** means all entities covered by the general acute care license.
10. **Medical Staff** means the formal organization of all licensed physicians, dentists, and podiatrists who may practice independently are granted recognition as members under the terms of these Bylaws.
11. **Medico-Administrative Officer** means a practitioner, employed by or otherwise serving the Medical Center on a full- or part-time basis, whose duties include certain responsibilities, which are both administrative and clinical in nature.
12. **Physician** means an MD or DO degree or the equivalent degree (i.e. foreign) as recognized by the Medical Board of California (MBC) or the Osteopathic Medical Board of California (OMBC), who is licensed by either the MBC or the OMBC.
13. **Practice Privileges** means the permission granted by the Medical Staff to **an Allied Health Professional (AHP)** who has been granted Allied Health Staff status to render specific diagnostic or therapeutic services to Medical Center patients when such services are within the individual AHP's legal scope of practice, qualifications, and competency, and when such services by an Allied Health Professional are within the rules and limits established by the Governing Body, the Medical Staff, these Bylaws, the Medical Staff Rules and Regulations, and any applicable state or federal law or regulation.
14. **Practitioner** means, unless otherwise expressly limited, any physician, dentist, or podiatrist who is applying for Medical Staff membership and/or clinical privileges or who is a Medical Staff member and/or who exercises clinical privileges in this Medical Center.
15. **Resident** means a physician or dentist in an accredited graduate medical or dental education specialty program.

Section 1.02 Article I: Name

The name of this organization shall be the Medical Staff of Loma Linda University Medical Center.

The Structure of this organization shall be:

1. Open Staff
2. Divided into Clinical Services

Article II: Purposes

The purposes of this organization are to:

1. Promote education, research, and to maintain standards which meet the educational requirements of the health-related schools and teaching programs of Loma Linda University.
2. Promote a high level of professional performance of all practitioners and AHPs authorized to practice in the Medical Center through an ongoing review and evaluation of each practitioner's and AHP's performance in the Medical Center.
3. Initiate and maintain Rules and Regulations for the Medical Staff.
4. Provide means whereby issues concerning the Medical Staff and the Medical Center may be discussed by the Medical Staff with the Governing Body and the Administrator.

Section 1.03 Article III: Membership

3.1 Nature of Medical Staff membership

Only physicians, dentists, and podiatrists are eligible to apply for Medical Staff membership. No physician, dentist, or podiatrist, including those in a medical administrative position by virtue of a contract with the Medical Center, shall care for patients in the Medical Center unless the practitioner is a member of the Medical Staff and has been granted privileges germane to the care that s/he will provide, or the practitioner has been granted temporary or emergency clinical privileges in accordance with these Bylaws. Licensed independent practitioners other than physicians, dentists, and podiatrists are not eligible for Medical Staff membership but may be eligible to apply for and be granted Practice Privileges in accordance with these Bylaws. Medical Staff membership or clinical privileges shall not be denied on the basis of race, color, creed, sex or national origin. Membership in the Medical Staff shall confer on the member only such clinical privileges as have been granted by the Governing Body in accordance with these Bylaws. Medical Staff membership and/or clinical privileges may be limited based upon: (1) the Medical Center's provision of specific facilities, supportive services and courses of treatment for an applicant and his/her patients; or (2) the patient care needs for additional staff members as reasonably determined by the Medical Staff and the Medical Center.

3.2 Qualifications for Medical Staff membership

3.2-1 General Qualifications

Practitioners shall be qualified for Medical Staff membership only if they:

a) are a physician, dentist, or podiatrist currently licensed to practice in the State of California
b) have adequate education, training, background and experience,
c) have current competence, including good judgment, and
d) have adequate health status in order to adequately demonstrate to the satisfaction of the Medical Staff that they are professionally competent and that any patient treated by them can reasonably expect to receive care of the generally recognized

professional level of quality established by the Medical Staff. Practitioners in the Administrative and Honorary Staff categories are not required to show evidence of their current licensure and health status.

e) are found to
   1) adhere strictly to the ethics of their respective professions,
   2) work cooperatively with others in the Medical Center,
   3) adhere to Medical Center policies approved by the Medical Staff Executive Committee specifically including those policies dealing with patient privacy and confidentiality,
   4) be willing to participate in and properly discharge Medical Staff responsibilities, and
   5) be willing to commit to and regularly assist the Medical Staff in fulfilling its obligations related to patient care and medical education.

f) maintain in force professional liability insurance in not less than the minimum amounts jointly determined by the Governing Body and the Medical Staff Executive Committee (MSEC). Practitioners in the Administrative and Honorary Staff categories are not required to maintain professional liability insurance.

g) are willing to maintain a standard of conduct in all settings, which will not be in conflict with the ethics, principles, and philosophy of the Seventh-day Adventist Church.

3.2-2 Specific Qualifications

a) **Physicians**: In order to qualify for membership in the Medical Staff, a Physician must:

   1) hold an M.D. or D.O. degree (or their equivalent if issued from a school outside the United States; the equivalence must be recognized by the licensing boards in the State of California)

   2) hold a valid license to practice medicine issued by the Medical Board of California or the Osteopathic Medical Board of California. Physicians who have been granted a certificate of registration by the Medical Board of California under Section 2113 or 2168 of the Business and Professions Code may be eligible to apply for Medical Staff membership defined in Section 2065 or Section 2066 of the Business and Professions Code. Practitioners in the Administrative and Honorary Staff categories are not required to maintain professional licensure.

   3) for initial appointment be certified or be progressing toward certification by (1) a board which is duly organized and recognized by an American Board of Medical Specialties member board OR (2) Medical Board of California OR (3) a board or association with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in that specialty or subspecialty.

   Applicants/re-applicants who are progressing toward board certification must have completed the educational requirements for board certification and must become board certified within 5 years of the initial granting of Medical Staff membership, unless extended for good cause by the Medical Staff Executive Committee. Current members of the Medical Staff who were not, as of July 1, 2003, board certified or

progressing toward board certification, and who cannot reasonably be expected to pursue board certification, may be considered for renewal of Medical Staff membership if they can document sufficient training, experience, and competence, and otherwise meet the requirements of Medical Staff membership.

Persons not fulfilling the above eligibility criteria including board certification may apply for special consideration and must demonstrate that their education, training, experience, demonstrated ability, judgment, and medical skills are equivalent to or greater than the level of proficiency evidenced by the eligibility criteria listed above.

b) **Dentists**: Dentists applying for membership in the Medical Staff must hold a D.D.S. or equivalent degree issued by a dental school and must hold a valid and unsuspended certificate to practice dentistry issued by the Dental Board of California.

c) **Podiatrists**: Podiatrists applying for membership in the Medical Staff must hold a D.P.M. degree conferred by a school approved by the Medical Board of California and must hold a valid and unsuspended certificate to practice podiatry issued by the Medical Board of California/Board of Podiatric Medicine.

Persons not fulfilling eligibility criteria for Board certification, but hold a current and unrestricted Physician and Surgeon or Osteopathic Physician and Surgeon license in the State of California, may apply for privileges as an Assistant as outlined in Section 4.11. Additional qualifications required by the respective Service will be outlined on that Service's privilege form.

3.2-3 Basic Responsibilities of Medical Staff Membership

The ongoing responsibilities of each member of the Medical Staff shall include:

a) Providing patients with the quality of care meeting the professional standard of the Medical Staff of the Medical Center.

b) Abiding by the Medical Staff Bylaws, Rules and Regulations, and Medical Center Policies.

c) Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments.

d) Preparing and completing in timely fashion medical records for all of the patients to whom the member provides care in the Medical Center. This includes assuring the completion of a physical examination and medical history on all patients within twenty-four (24) hours after admission or immediately before by a physician (as defined in section 1861(r) of the Act), an oral-maxillofacial surgeon, or other qualified individual in accordance with State law and Medical Staff policy. This requirement may be satisfied by a complete history and physical that has been performed within the thirty 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 twenty-four (24) hours after admission. Additionally, the history and physical must be updated including any changes in the patient's condition within

twenty-four (24) hours prior to any surgical procedure or other procedure requiring general anesthesia or moderate or deep sedation regardless of inpatient or outpatient procedure status.

e) Abiding by the lawful ethical principles of the California Medical Association and the member's professional association.

f) Aiding in any Medical Staff approved educational programs for medical students, interns, resident physicians, resident dentists, Medical Staff physicians and dentists, nurses and other personnel.

g) Making appropriate arrangements for coverage for the member's patients as determined by the Medical Staff.

h) Refusing to engage in improper inducements for patient referral.

i) Working cooperatively with members, nurses, Loma Linda University Medical Center Administration and others, so not to adversly affect patient care.

j) Participating in continuing education programs as determined by the Medical Staff.

k) Participating in such emergency service coverage or consultation panels as may be determined by the Medical Staff.

l) Discharging such other staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Staff Executive Committee.

m) Providing information to and/or testifying on behalf of the Medical Staff or an accused practitioner regarding any matter under investigation pursuant to Article VIII and those which are the subject of a hearing pursuant to Article IX.

n) Reporting to Medical Center Administration whenever asked to give a deposition in a case involving a Medical Center patient.

o) Reporting to the Medical Staff Administration within 30 days any termination, restriction/suspension, or loss of clinical privileges at other hospital(s) or health care facility/ies where s/he currently holds staff Medical Staff membership.

p) Reporting to the Medical Staff Administration within 30 days any communication from a peer review organization where questions are raised regarding the quality of care rendered to a patient in the Medical Center.

q) Reporting to the Medical Staff Administration, within 30 days, any malpractice judgment, settlement or arbitration against the member.

r) Reporting to the Medical Staff Administration within 30 days any voluntary relinquishing of privileges or Medical Staff membership or sanction by a third party payor or regulatory agency.

s) Notify Medical Staff Administration staff of any change to address, telephone, or email within 30 days of change.

t) All Medical Staff members will participate in appropriate training sessions in order to become proficient in new processes. The need for, and frequency of these sessions will be determined by the Medical Staff Executive Committee.

3.2-4 Behavioral Expectations of Medical Staff Members and Code of Conduct

a) All members of the Medical Staff are expected to comport themselves in accordance with the Loma Linda University Medical Center values.

b) Behavior contrary to these statements may result in disciplinary action by the Medical Staff.

Harassment by a Medical Staff member against any individual on any basis, including but not limited to race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation, shall not be tolerated. "Individual" includes patients, Medical Center employees, students, residents, fellows, visitors, members of the Medical Staff and AHPs.

Harassment may include, but is not limited to, verbal or physical abuse or threatened abuse of any nature, which substantially interferes with patient care, the individual's work, or creates an intimidating, hostile, or offensive environment.

"Sexual harassment" is unwelcome verbal or physical conduct of a sexual nature. It may be verbal (including offensive language) and/or physical (including such actions as assault, unwelcome touching, or interference with movement), and/or visual (such as unnecessary display of sexually related anatomy or displaying offensive printed material).

Sexual harassment also includes unwelcome advances, requests for sexually related favors, and any other verbal, visual, or physical conduct of a sexual nature when:

a) submission to or rejection of this conduct by an individual is used as a factor in decisions regarding evaluations, promotions, hiring or dismissal; or

b) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment; or

c) the conduct is directed towards an individual.

All allegations of harassment shall be immediately investigated by the Medical Staff and, if confirmed, will result in appropriate corrective action. Such corrective action may range from reprimand up to and including termination of Medical Staff privileges or Medical Staff membership.

LLUMC Medical Staff Code of Conduct:

Medical Staff members working at LLUMC will treat others with respect, courtesy, and dignity. Medical Staff members will conduct themselves in a manner that supports the mission of the hospital. Their demeanor will promote quality patient care, cooperation and teamwork.

Specifically, physicians will:

a) Respect patient autonomy, confidentiality and welfare.

b) Respond to patient, staff and colleague calls and requests in an appropriate, respectful, and timely manner.

c) Cooperate and communicate with other members of the healthcare team in a courteous and professional manner that respects colleague time, work flow and expertise.

d) Manage concerns with courtesy through appropriate medical staff or administrative channels.

Physicians must avoid disruptive behavior such as:

a) Physical, visual, verbal or sexual harassment of any kind.

1) Fighting, disorderly conduct, threatening, intimidating, attempting bodily harm or injury or interfering with other individuals.

2) Profanity or offensive language, signs or dramatics that intimidate, degrade, embarrass or humiliate other persons.

b) Inappropriate criticism, blaming or shaming of staff, learners or colleagues that intimidates, undermines confidence, demeans, or belittles.

c) Misconduct toward or abuse of others, including patients, visitors, employees, and colleagues.

d) Impertinent or inappropriate verbal communication or written documentation in medical records or other official documents that compromises the effectiveness or reputation of the hospital.

3.2-5 Effect of Other Affiliations

No practitioner shall be automatically entitled to Medical Staff membership or to exercise any particular clinical privileges merely because the practitioner 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; or had, or presently has, Medical Staff membership or privileges at this Medical Center 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, or other practice organization or in contracts with a third party which contracts with the Medical Center other than as permitted by Section 3.3.

3.3 Exclusive Contracts / Independent Contractors

A practitioner who performs services as an independent contractor must be a Medical Staff member, achieving Medical Staff membership and obtaining all necessary clinical privileges through the procedures provided in Articles VI and VII. Any such practitioner is subject to the duties, responsibilities and obligations contained in these Bylaws and any contract shall be consistent with the requirements of these Bylaws.

The Medical Staff recognizes the value of exclusive contracts and/or closed service arrangements in furthering the quality of care at Loma Linda University Medical Center. Therefore, privileges made exclusive pursuant to a contract or closed service arrangement may be terminated automatically upon termination of practitioner's contract or closed service arrangement without affording access to the procedures contained in Articles VIII and IX of these Bylaws. Requests for privileges may be denied when such a request is in conflict with an exclusive contract or closed service arrangement without affording access to the procedures contained in Articles VIII and IX of the Bylaws. Practitioners providing services under an exclusive contract or closed service arrangement must include any applicable exclusivity and automatic termination provisions in any subcontracts or arrangements such practitioners may have with any other practitioners ("subcontractors") providing

services under the exclusive contract or closed service arrangement. However, failure to include such provisions shall not affect the Medical Center's right to enforce exclusivity and/or automatic termination provisions against such subcontractors.

Any challenge to the substantive validity of an exclusive contract and/or closed service arrangement must utilize the procedures provided in Section 9.1-1 of these Bylaws prior to seeking judicial review.

3.4 Leave Of Absence

3.4-1 Leave Status

A Medical Staff member may obtain a voluntary leave by submitting a written request to the Chief of Staff stating the reason(s) for the leave and the approximate length anticipated. Alternatively, should the Chief of Staff determine that a member should be on a leave of absence, he/she may place the member on leave. All leaves must be approved by the Medical Staff Executive Committee. During the leave of absence, the member's clinical privileges are suspended.

3.4-2 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.

3.4-3 Termination of Leave

When the member desires to return to clinical practice, he/she may request reinstatement of his/her clinical privileges by submitting a written request to the Service Chief and to the Chair of the Medical Staff Credentials Committee. The member shall-provide a written summary of his/her relevant activities during the leave and provide documentation of fitness to resume clinical practice, if applicable. The member will respond to any questions from the Service Chief and the chair of Credentials Committee. Thereafter they shall provide a recommendation to the Medical Staff Executive Committee. A member may resume clinical practice/have privileges reinstated only on approval of the Medical Staff Executive Committee.

3.4-4 Termination of Medical Staff Membership

Failure to request termination of a leave/resumption of clinical practice by the end of a leave period shall be deemed a voluntary resignation of Medical Staff membership. Continuation of a leave (for greater than 60 days) while questions from the Medical Staff Executive Committee remain unresolved after a request for reinstatement shall result in automatic termination of Medical Staff membership and clinical privileges. A practitioner whose Medical Staff membership and/or clinical privileges are terminated shall not be entitled to the procedural rights under Article VIII of the Medical Staff Bylaws. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments. A denial of reinstatement by the Medical Staff Executive Committee or a reinstatement with privilege limitations shall 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).

3.4-5 Reappointment During Leave

If the member's appointment expires during a leave, it is the member's responsibility to ensure that a reappointment application and any other necessary information is submitted in a timely fashion so that the reappointment process may be completed prior to the termination of the leave.

Failure, without good cause, to request reinstatement or to provide a requested summary of activities shall be deemed to be a voluntary resignation from the Medical Staff and shall result in automatic termination of Medical Staff membership and clinical privileges. A practitioner whose Medical Staff membership is terminated shall be entitled to the procedural rights provided in Article VIII for the sole purpose of determining whether the failure was with or without good cause. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

3.5 Voluntary Termination of Medical Staff membership and Clinical Privileges

A member of the Medical Staff in good standing may, at any time, terminate his/her Medical Staff membership and clinical privileges. Such termination shall be effectuated through submission of a letter of resignation to the Medical Staff Administration requesting termination of Medical Staff membership and privileges. The termination shall be effective upon receipt of such letter of resignation by Medical Staff Administration and upon receipt by Medical Staff Administration of a notice from the Health Information Management Department that the resigning Staff member has completed all medical records. A Staff member is responsible for ensuring continuity of care for any patients for which that member is responsible at the Medical Center subsequent to such voluntary termination of Medical Staff membership. This section shall not limit the right of the Medical Staff to deem a Staff member's resignation or to otherwise limit a practitioner's Medical Staff membership or clinical privileges consistent with the provisions of these Bylaws.

Section 1.04 Article IV: Categories of Membership

4.1 Categories

The categories of the Medical Staff shall include the following: Active, Provisional, Courtesy, Consulting, Honorary, Administrative, Temporary, and Affiliate.

Exceptions

Regardless of the category of their membership in the Medical Staff, unless otherwise required by law, non-physician members:

a) May not hold office in the Medical Staff. The right of a dentist or podiatrist member as a member of a Clinical Service or Committee to hold office in and vote on matters considered by that Clinical Service or Committee shall be governed by the Medical Staff members category, the applicable Clinical Service or committee rules, and any limitations imposed pursuant to Section 3.2-2.

b) May only admit and treat patients as defined in these Bylaws and/or the Rules and Regulations of the Medical Staff.

4.2 Active Staff

4.2-1 Qualifications

The Active Staff shall consist of practitioners who:

a) Regularly admit patients to, or otherwise regularly provide professional services for patients in the Medical Center, or are regularly involved in Medical Staff functions and are located closely enough to the Medical Center to provide appropriate care to their patients. If the Active Staff member has provided professional services for less than ten (10) patients in the Medical Center during each Medical Staff year, it shall be at the Service and/or Section Chief's discretion to assess the appropriateness of continuation in the Active Staff membership category at the time of Reappointment.

b) A practitioner seeking an initial Active Medical Staff appointment must also have completed all IPPE/Proctoring requirements applicable under these Bylaws, including demonstration of his/her ability to continuously meet the standard of care expected of Active Medical Staff members. The practitioner must also have received a favorable recommendation as to his/her ability to cooperate with and contribute to the clinical education and training programs at the Medical Center, and have been a member in good standing of the Provisional Staff and must have cared for an adequate number of patients, as determined by the Service, in the Medical Center during the Provisional Period to allow the Service and Credentials Committee to perform IPPE/Proctoring to evaluate the qualifications for continued Medical Staff membership.

4.2-2 Prerogatives

The prerogatives of an Active Medical Staff member shall be to admit patients to the Medical Center consistent with approved privileges, care for patients in Clinics or other Ambulatory Care facilities owned, operated by, or otherwise affiliated with the Medical Center, and exercise clinical privileges granted pursuant to Article VII.

4.2-3 Rights to Vote and Hold Office

Each Active Medical Staff member shall be eligible to:

a) Hold office and serve on committees in the Medical Staff and in the clinical service of which s/he is a member;

b) Vote for Medical Staff Officers, on Bylaws amendments and on all matters presented at general and special meetings of the Medical Staff and of the clinical service and committees of which s/he is a member.

4.2-4 Responsibilities

Each Active Medical Staff member shall meet the standards in Section 3.2.

4.3 Provisional Staff

4.3-1 Qualifications

a) All initial appointees to the Medical Staff shall be placed in the Provisional Category for at least the duration of their IPPE/Proctoring term.

b) The initial appointment to the Provisional category shall not create for the appointee any vested right to reappointment to the same or another staff category at the completion of the IPPE/Proctoring term or any appointment period.

c) The Chief of Service, or designee, shall evaluate each Provisional member's ability to cooperate with and contribute to the clinical education and training programs of LLUMC to the extent that the member is requested to participate in these education and training programs. Failure to adequately demonstrate such ability and/or to carry out clinical education or training responsibilities assigned to the Provisional member may be grounds for recommending termination of the member's Medical Staff appointment.

d) The Medical Staff membership and clinical privileges of a practitioner who does not qualify for advancement to the Active, Administrative, Courtesy, or Consulting Staff category by the completion of their Initial Appointment period shall be terminated. Such member shall be entitled to the procedural rights set forth in Article IX.

e) In order to qualify for advancement from the Provisional category, a member must:

1) Successfully complete the IPPE/Proctoring requirements contained in these Bylaws.

2) Demonstrate (to the satisfaction of the Service Chief) his/her ability to cooperate with and contribute to the clinical education and training programs of LLUMC to the extent that the member was requested to participate.

3) Demonstrate (to the satisfaction of the Service Chief) his/her ability to work harmoniously with other members of the Medical Staff and with the employees of the Medical Center.

4.3-2 Prerogatives

The prerogatives of a Medical Staff member in the Provisional Staff category shall be to exercise such clinical privileges as have been granted to the member pursuant to Article VII in facilities owned, operated by or otherwise affiliated with the Medical Center, depending on the availability of beds and in accordance with such requirements as are applicable to the member pursuant to these Bylaws.

4.3-3 Rights to Vote and Hold Office

A Provisional member may:

a) Serve as a voting member on committees, unless provided otherwise in these Bylaws. A Provisional member may not hold office in the Medical Staff or in the Clinical Service and committees of which s/he is a member;

b) Not vote for Medical Staff Officers, on Bylaws amendments, or on any matters presented at general and special meetings of the Medical Staff and of the Clinical Service of which s/he is a member.

4.3-4 Responsibilities

Each Provisional Staff member shall meet the standards in Section 3.2.

4.4 Courtesy Staff

4.4-1 Qualifications

The Courtesy Staff shall consist of practitioners who:

a) Admit, depending on the availability of beds, or otherwise provide professional services for at least three (3) but generally not more than ten (10) patients in the Medical Center during each Medical Staff year unless otherwise specified in Rules and Regulations of the Clinical Service; If the Courtesy Staff member has provided professional services to more than ten (10) patients in the Medical Center during each Medical Staff year, it shall be at the Service and/or Section Chiefs discretion to assess the appropriateness of either continuation in the Courtesy Staff membership category or transfer to the Active Staff membership category.

b) Have been a member in good standing of the Provisional Staff and must have cared for an adequate number of patients, as determined by the Service, in the Medical Center during the Provisional Period to allow the Service and Credentials Committee to perform IPPE/Proctoring to evaluate the qualifications for continued Medical Staff membership;

c) Have completed the IPPE/Proctoring as discussed in these Bylaws.

4.4-2 Prerogatives

The prerogatives of a Courtesy Staff member shall be to:

a) Admit, depending on the availability of beds, or provide professional services for not less than three (3) or generally not more than ten (10) patients in the Medical Center during each Medical Staff year unless otherwise specified in the Clinical Service Rules and Regulations.

b) Exercise such clinical privileges as are granted to the member pursuant to Article VII.

c) Attend meetings of the Medical Staff and Clinical Service of which s/he is a member as outlined in these Bylaws.

4.4-3 Rights to Vote and Hold Office

A Courtesy Staff member may not vote or hold office in the Medical Staff or in the Clinical Service of which s/he is a member but may serve as a voting member on committees, unless provided otherwise in these Bylaws.

4.4-4 Responsibilities

Each Courtesy Staff member shall meet the standards in Section 3.2.

4.5 LLUCH Staff

4.5-1 Qualifications

The LLUCH Staff shall consist of practitioners who:

a) Meet the membership standards in Section 3.2

b) Are members of the Active Staff at LLUCH

c) Are called to LLUMC periodocally by an LLUMC attending to render care to patients admitted or treated at this facility.

4.5-2 Prerogatives

a) Treat and otherwise care for patients at this facility on request of the patient's attending physician.

b) Exercise all clinical privileges held at LLUCH, which privileges are automatically granted by a favorable determination regarding Staff membership in this category. Provisional Staff membership and proctoring may be waived for members in this category with respect to membership determination and all clinical privileges held at LLUCH.

c) Exercise such additional clinical privileges beyond the privileges delineated in 4.5-2b) above as are granted through the standard clinical privilege process of this Medical Staff.

4.5-3 Responsibilities

a) Satisfy the requirements of the Service of which he/she is a member.

b) Are not required to meet the various 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.

4.6 Consulting Staff

4.6-1 Qualifications

The Consulting Staff shall consist of practitioners who:

a) Possess clinical expertise and come to the Medical Center when so scheduled or when called to render a clinical opinion within their competence;

b) Have been a member in good standing of the Provisional Staff and must have cared for an adequate number of patients, as determined by the Service, in the Medical Center during the Provisional Period to allow the Service and Credentials Committee to perform IPPE/Proctoring to evaluate the qualifications for continued Medical Staff membership;

c) Have completed the IPPE/Proctoring as discussed in these Bylaws.

d) Must be Active at another TJC accredited hospital. Exception may be granted for good cause as approved by the Medical Staff Executive Committee.

4.6-2 Prerogatives

The prerogatives of a Consulting staff member shall be to:

a) Exercise such clinical privileges as are granted to the member pursuant to Article VII; however, s/he shall not be eligible to admit patients or to assume responsibility for continuing care of patients in the Medical Center;

b) Attend meetings of the Medical Staff and the Clinical Service of which s/he is a member.

4.6-3 Rights to Vote and Hold Office

A Consulting Staff member may not vote or hold office in the Medical Staff or in the Clinical Service of which s/he is a member or serve on standing committees, but may serve as a voting member on special committees.

4.6-4 Responsibilities

Each Consulting Staff member shall meet the standards in Section 3.2 and responsibilities set forth in Section 3.2.

4.7 Honorary Staff

4.7-1 Qualifications

The Honorary Staff shall consist of practitioners recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous long-standing service to the Medical Center, but, who are not active in the Medical Center.

4.7-2 Prerogatives

Honorary Staff members are not eligible to admit patients to the Medical Center or to exercise clinical privileges in the Medical Center, and are not subject to reappointment or reappraisal.

4.7-3 Rights To Vote and Hold Office

Honorary Staff members may attend Medical Staff and Clinical Service meetings. An Honorary Staff member may not vote or hold office in the Medical Staff or in the Clinical Service of which s/he is a member or serve on committees.

4.8 Administrative Staff

4.8-1 Qualifications

The Administrative Staff shall consist of practitioners who are members of the Medical Staff who have no clinical privileges and who must:

a) Agree to refrain from participating in any activities within the Medical Center that require Clinical Privileges.

b) Provide a significant service to the Medical Center and the Medical Staff in the form of academic activities, quality improvement activities, or administration.

c) Be recommended for appointment or reappointment to the Administrative Staff by the Chief of the Clinical Service, the Credentials Committee, and by Medical Staff Executive Committee.

Failure to continue to meet any of these qualifications will be adequate grounds to deny reappointment.

4.8-2 Prerogatives

The prerogatives of an Administrative Staff member shall be to:

a) Attend meetings of the Medical Staff and the Clinical Service to which s/he has been assigned.

4.8-3 Rights To Vote and Hold Office

A member of the Administrative Staff may serve as Chair or as a voting member on committees. A member of the Administrative Staff may not hold office in the Medical Staff or in a Clinical Service.

4.8-4 Responsibilities

Each member of the Administrative Staff shall meet the standards in Section 3.2 other than those standards which in the judgment of the Credentials Committee and Medical Staff Executive Committee do not apply because of the absence of clinical activity. If a patient of a member of the Administrative Staff requires care by the Medical Center, the Administrative Staff member shall relinquish all responsibility for the patient to a Medical Staff member with the appropriate clinical privileges.

4.8-5 Care of Patients

Should a member of the Administrative Staff wish to provide clinical care for a patient in the Medical Center, that Administrative Staff member must obtain Temporary Privileges limited to consultation on a single patient as outlined in Section 7.5. If the Administrative Staff member wishes to obtain clinical privileges in the Medical Center, that member must apply for Modification of Medical Staff membership Category as described in Section 4.

4.9 Temporary Staff

4.9-1 Qualifications

The Temporary Staff shall consist of physicians, dentists, and podiatrists who do not actively practice at the Medical Center but are important resource individuals for Medical Staff

Quality Assessment and Improvement activities. Such persons shall be qualified to perform the functions for which they are made temporary members of the Medical Staff.

4.9-2 Prerogatives

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

4.10 Affiliate Staff

Medical Staff members in the Active, Courtesy, or Consulting Category who at the time of reappointment are found to have no clinical activity during the current appointment period shall be transferred to the Affiliate Staff category:

4.10-1 Qualifications

The Affiliate Staff shall consist of practitioners who must:

a) Have been a member in good standing in the Active, Courtesy or Consulting category during the immediate preceding appointment period.

b) Have completed, in a timely manner as described elsewhere in these Bylaws, an application for reappointment.

c) Have been found to be completely qualified for reappointment (other than the volume of clinical activity) based on the standards and procedures described in Article VI.

d) Have paid the standard reappointment fee and any other outstanding fees or fines.

4.10-2 Prerogatives

a) Medical Staff members in the Affiliate category may exercise those clinical privileges granted pursuant to Article VII. They may attend meetings of the Medical Staff and of the previously assigned Clinical Service. They may not vote at these meetings.

4.10-3 Limitations

Medical Staff members in the Affiliate category may not:

a) Vote or hold office in the Medical Staff or Clinical Service

b) Be a member of any Medical Staff Committee

c) Be reappointed to the Affiliate category. If the member wishes to remain a member of the Medical Staff beyond the end of the Affiliate category appointment period, s/he must qualify for appointment in the Active, Courtesy, Consulting, Administrative, Referring or Honorary category.

4.11 Assistant

4.11-1 Qualifications

The Assistant Staff shall consist of practitioners who meet the qualifications of Section 3.2-1 only to the extent that the practitioner holds an M.D. or D.O. degree (or their equivalent if issued from a school outside the U.S.; the equivalence must be recognized by the licensing boards of the State of California) and is licensed to practice medicine in the State of California.

4.11-2 PREROGATIVES

The practitioner shall be entitled to assist at surgery and/or assist in the care and treatment of LLUMC patients subject to the ongoing supervision of the attending physician. Privileges to assist shall be processed under Article VII and applications for such privileges shall be evaluated based on training, qualifications and experience in the same manner as are other privilege applications under Article VII. The physician will not be entitled to serve as an Attending physician.

4.11-3 RIGHTS TO VOTE AND HOLD OFFICE

Practitioners in this category may serve on committees of the Medical Staff and/or of the Clinical Service of which s/he is a member subject and may vote if authorized by the appointment. Members may not vote on Medical Staff matters and may not hold office in the Medical Staff or in the Clinical Service to which s/he is appointed.

4.11-4 RESPONSIBILITIES

Each Assistant Staff Member shall meet the standards of Section 3.2 with the exception of residency training and board certification.

4.12 Referring Medical Staff

4.12-1 Qualifications

The Referring Medical Staff shall consist of those physicians who wish to refer patients to members of the Provisional, Active, Courtesy, and Affiliate Medical Staff for inpatient care, but who do not treat patients in the Hospital.

4.12-2 Prerogatives

Members of the Referring Medical Staff may write orders to admit for inpatient and observation care with an appropriately privileged member of the medical staff who agrees to accept the patient.

4.12-2 Limitations

Medical Staff Members in the Referring category may not:

a) Perform surgical or invasive procedures or otherwise treat patients in the hospital;

b) Have delineated clinical privileges;

c) Be a member of any Medical Staff Committee;

d) Vote on Medical Staff matters, or hold office in the Medical Staff or in any Clinical Service.

4.13 Modification of Medical Staff membership

4.13-1 Modification

Any Medical Staff member other than a member in the Provisional Category may request a change in category at any time. To request a change, the member must:

Apply in writing for transfer to another staff category.

Apply for clinical privileges. The Medical Staff will evaluate the requested clinical privileges using the same procedure that is followed in evaluating a request for clinical privileges that accompanies a reapplication.

Assist the Medical Staff in resolving any quality of care issues that may have existed during any appointment period during which the member had been granted clinical privileges.

4.13-2 Modification Of Medical Staff membership Category At The time of Reappointment

The Credentials Committee may recommend a change in staff category at the time of reappointment based on the information and materials available to the Credentials Committee at that time.

4.13-3 Modification Of Medical Staff membership Category By The Medical Staff Executive Committee

On its own, upon recommendation of the Credentials Committee, or pursuant to a request by a member, or upon direction of the Governing Body as set forth in Section 7.4-2, the Medical Staff Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of the Bylaws.

Section 1.05 Article V: Allied Health Professionals

5.1 Qualifications

Allied Health Professionals (AHPs) are not eligible for Medical Staff membership. An AHP who is neither an employee of the Medical Center nor eligible for Medical Staff membership may be granted practice privileges. AHPs who are Limited License Independent Practitioners (AHP-LLIP) who have been granted practice privileges may only exercise those privileges while they are under the general supervision of a member of the Medical Staff. AHPs who are Dependent Practitioners (AHP-DP) who have been granted practice privileges may exercise those privileges only under the direction and specified supervision of a member of the Medical Staff.

An AHP is eligible for practice privileges in the Medical Center only if:

a) S/he seeks to provide those practice privileges in a category of AHPs previously authorized by the Medical Staff and Governing Body as eligible to apply for practice privileges;

S/he holds a license, certificate, or other legal credential determined by the Interdisciplinary Practice Committee (IDP), the Medical Staff, and the Governing Body as the minimum credential required for granting of the requested practice privileges; **For Nurse Practitioners, national certification by a recognized certification board must be completed prior to the credentialing decision.**

b) S/he documents his or her experience, background, training, current competence, judgment, and ability with sufficient adequacy to demonstrate that any patient treated by the AHP will receive care of the generally recognized professional level of quality established by the Medical Staff;

c) It is determined on the basis of documented references, that s/he will adhere strictly to the lawful ethics of his or her profession, work cooperatively with others in the hospital setting so as not to adversely affect patient care, and be willing to commit to and regularly assist the medical staff in fulfilling its obligations related to patient care, within the area of the AHP's professional competence and credentials;

d) S/he agrees to comply with all Medical Staff and Clinical Service bylaws, rules and regulations, policies, and protocols to the extent these are applicable to the AHP;

e) The qualifications of the AHP have been reviewed by the IDP Committee, and the IDP Committee has recommended the granting of specified practice privileges;

f) Where applicable, s/he meets the same qualifications specified in Section 3.2 for Medical Staff members;

g) The training, experience and privileges of the Medical Staff member(s) who will direct and supervise the AHP are appropriate to the practice privileges requested;

h) The Medical Staff member(s) who will direct and supervise the AHP and the AHP both provide evidence satisfactory to the Medical Staff that the member(s) and the supervised AHP maintain professional liability insurance consistent with the requirements of Section 15.3;

i) In the case of an AHP-LLIP, the Medical Staff member requesting the service of the AHP-LLIP shall be responsible for providing the general supervision of the AHP-LLIP.

j) In the case of an AHP-DP, the Medical Staff member(s) who will direct and supervise the AHP has been granted the privilege of directing and supervising AHPs applying for practice privileges.

k) The practice privileges will be explicit in the level of supervision required for the AHP;

l) The Credentials Committee must have recommended the practice privilege(s) on a privilege-by-privilege basis;

m) Any violation of the supervision requirements will result in discipline by the Medical Staff of the AHP and the supervising physician.

5.2 Delineation of Categories of AHPs Eligible to Apply for Practice Privileges

The categories of AHPs eligible for practice privileges shall be listed in the Medical Staff Rules and Regulations. Changes in these categories shall be processed in the same manner as any change in the Medical Staff Rules and Regulations. For each AHP category approved by the MSEC and the Governing Body, the specific practice privileges shall be defined and published.

5.3 Procedure for Granting Practice Privileges

An AHP seeking practice privileges must apply and qualify for those practice privileges by procedures paralleling the procedures described for the granting of clinical privileges in Article VII. Each AHP shall be assigned by the Credentials Committee to a Clinical Service. Unless otherwise specified in the Rules and Regulations, each AHP shall be subject to terms and conditions paralleling those specified in Article III and Article VII as they may logically be applied to AHPs.

5.4 Prerogatives

The prerogatives which may be extended to an AHP shall be defined in the Medical Staff Rules and Regulations. Such prerogatives may include:

a) For the AHP-LLIP providing specified patient care services by the request of and under the general supervision of a member of the Medical Staff;

b) For the AHP-DP providing specified patient care services under the supervision and direction of a member of the Medical Staff who has been granted the privilege to supervise the AHP;

c) Serving on Medical Staff, Clinical Service, and Medical Center committees;

d) Attending meetings of the Medical Staff and Clinical Service to which s/he is assigned, as permitted by the Clinical Service Rules and Regulations, and attending Medical Center education programs in his/her field of practice.

5.5 Responsibilities

Each AHP shall:

a) Meet those responsibilities required by the Medical Staff Rules and Regulations, and if not so specified, meet those responsibilities specified in Section 3.2 as are generally applicable to the more limited practice of the AHP;

b) Ensure that all supervision requirements applicable to his/her practice privileges are continuously met;

c) Retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the Medical Center for whom the AHP provides services;

d) Participate as appropriate in quality review, evaluation, and monitoring activities required of AHPs, in supervising initial appointees of his/her same occupation or profession or of a lesser included occupation or profession, and in discharging such other functions as may be required from time to time by the Medical Staff or the Clinical Service to which the AHP is assigned;

e) Attend meetings of the Medical Staff, the Clinical Service to which the AHP is assigned, and the Committees of which s/he is a member, in accordance with attendance requirements and conditions parallel to those set forth for members of the Active and Provisional Medical Staffs in Section 13.7 of these Bylaws.

5.6 Automatic Suspension/Termination

a) The AHP's practice privileges shall be automatically *suspended* when there no longer is a member of the Medical Staff acceptable to the Credentials Committee available to supervise the AHP or if the AHP's certificate or license is suspended;

b) The AHP's practice privileges shall be automatically *terminated* when the AHP's certificate or license expires or is revoked.

c) The AHP shall not be entitled to the procedural rights afforded by Section 9.6-2 when action to suspend or terminate practice privileges is taken under Section 5.6(a) or 5.6(b);

d) Applicable AHP hearing rights are set forth in Section 9.6-2 of these Bylaws.

Section 1.06 Article VI: Procedures for Appointment and Review

Every appointment to the Medical Staff shall be made by the Governing Body after a recommendation and report has been made in accordance with these Bylaws. Appointment to the Medical Staff shall confer on the member only such clinical privileges as have been granted by the Governing Body in accordance with these Bylaws.

6.1 General Procedure

The Medical Staff, through its designated Clinical Services, committees, and officers, shall consider each application for appointment or reappointment to the Medical Staff, for clinical privileges, for each request for modification of Medical Staff membership status or clinical privileges, and shall investigate and validate the contents of each application before adopting and transmitting its recommendations to the Governing Body.

The Medical Staff shall perform the same function in connection with any individual who has applied only for temporary privileges or who otherwise seeks to exercise privileges or to provide specified services in any Medical Center Clinical Service.

6.2 Duration of Appointment

All initial appointments to the Medical Staff shall be for a term not to exceed two (2) years. Under no circumstance shall the interval between appointment and reappointment exceed two (2) years. Under no circumstances shall the interval between reappointments exceed two (2) years. The Credentials Committee may recommend to the MSEC a period of appointment or reappointment of less than two (2) years specifically for cause, which may or may not be reportable.

6.3 Application for Appointment

Each individual who applies for appointment/reappointment to the Medical Staff must demonstrate ability to provide a standard of service that is consistent with the special requirements and standards necessary for to maintain and enhance its reputation and meet its educational and patient care responsibilities in its function as a tertiary care teaching institution. The criteria used in determining whether an applicant meets this standard at a minimum shall include:

a) Evidence that the applicant meets the General and Specific Qualifications for Medical Staff membership found in Article III of these Bylaws.

b) Written certification by the applicant that he/she will under all circumstances cooperate with the educational programs of the Medical Center and when asked by their Service Chief will agree to participate in the educational activities of the Medical Center.

6.3-1 Application Content

All applications for appointment to the Medical Staff shall be signed by the applicant and shall be submitted in a form prescribed by the Medical Staff. The application shall require the applicant to provide:

a) Detailed information concerning the applicant's professional qualifications, competency, and current California licensure and current DEA Certificate unless exemption is granted upon written attestation of the physician that the physician will

not prescribe controlled substances in the Medical Center. Concurrence from the Service Chief and Credentials Committee Chair is required. The applicant must submit a written request for waiver. In the case of temporary privileges, the Credentials Committee Chair may serve as the agent of the committee to determine if a DEA is required;

b) For initial appointment the names of at least three (3) persons who hold the same professional level of education/training as does the applicant must be provided including, one (1) which must be the Director of the postgraduate training program(s) if the program was completed within the last two (2) years. When appropriate, a letter from the Chief of the Department or Service(s) of previous and/or current primary hospital must be obtained. Whenever possible, at least two (2) Active Staff members who can provide adequate references based on their current knowledge, gained through observation of or working with the applicant, of the applicant's qualifications, competency, and ethical character, should be obtained. Additional letters of recommendation may be required at the discretion of the Medical Staff.

c) For reappointment at least (1) professional recommendation is required at the time of recredentialing.

d) Information as to whether any action, including any investigation, has ever been undertaken, whether still pending or completed, which involves denial, revocation, suspension, reduction, limitation, non-renewal, voluntary or involuntary relinquishment by resignation or expiration (including relinquishment that was requested or bargained for) of the applicant's Medical Staff membership status and/or clinical privileges at any other Medical Center or institution; membership or fellowship in any professional organization; license to practice any profession in any jurisdiction; Drug Enforcement Administration (DEA) or other controlled substances registration; specialty board certification; and/or professional school faculty position or membership;

e) Documentation pertaining to the applicant's professional liability insurance coverage and information as to any professional liability claims, complaints, or causes of action that have been lodged against him/her and the status or outcome of such matters;

f) Information as to any pending or final administrative agency or court cases in which the applicant is alleged to have violated or was found guilty of violating any criminal law (excluding minor traffic violations);

g) Information pertaining to the condition of the applicant's health;

h) Acknowledgement that s/he has received the Medical Staff Bylaws, Rules and Regulations, and Policies and agrees to abide by them.

i) The applicant shall provide valid picture ID issued by a state or federal agency (e.g. driver's license or passport) verifying that the practitioner requesting approval is the same practitioner identified in the credentialing documents. This identification will be copied, attested to authenticity, and filed in the credential file with the application documents.

6.3-2 Application Fee

Subject to the Governing Body's approval, the Medical Staff Executive Committee shall establish a Medical Staff application fee at a level reasonably expected to cover the expenses associated with processing applications and IPPE/Proctoring and otherwise monitoring the activities of Provisional members. Each applicant for Medical Staff membership shall be required to submit the application fee with the application form. No part of the application fee shall be refunded.

6.3-3 Effect of Application

By applying for appointment to the Medical Staff, each applicant thereby signifies his/her willingness to appear for interviews in regard to his/her application; authorizes the Medical Staff or its designee to consult with and receive information from Medical Staffs of other hospitals with which the applicant has been associated; and with others who may have information bearing on the applicant's competence, character and ethical qualifications; consents to the Medical Center's inspection of all records and documents that may be material to a full evaluation of the application for Medical Staff membership and the clinical privileges s/he requested; certifies that s/he will report any changes in the information submitted on the application form which may subsequently occur, to the Credentials Committee and the Administrator; and releases from any liability, to the fullest extent permitted by law, all individuals and organizations providing information to the Medical Center concerning the applicant and all representatives of the Medical Center and its Medical Staff for their acts performed in connection with evaluating his/her application and credentials.

By applying for appointment to the Medical Staff, the applicant signifies his/her understanding and acknowledgment that the Medical Center is a clinical education and training institution, and therefore, patients who are admitted to the Medical Center for treatment must be available for health care education and training purposes, and that each member's ability, training and academic qualifications necessary to cooperate with and to contribute to the Medical Center's health care education and training programs are conditions of Medical Staff membership, as required.

A copy of the Medical Staff Bylaws and Rules and Regulations is provided to each applicant and the applicant agrees to be bound by the provisions set forth. It is the responsibility of the applicant to familiarize themselves with the Bylaws and Rules and Regulations.

6.4 Processing the Application

6.4-1 Applicant's Burden

The applicant shall have the burden of producing accurate and adequate information for a proper evaluation of his/her experience, background, training, demonstrated ability, health status, and all other qualifications specified in the Medical Staff Bylaws,Rules and Regulations, and Policies for resolving any doubts about these matters. The provision of information containing significant misrepresentations or omissions and/or failure to sustain the burden of producing adequate information shall be grounds for denial of the application. It is the applicant's responsibility to keep Medical Staff Administration informed of his/her current address and telephone number. Failure to notify Medical Staff Administration of a change will be deemed a voluntary, automatic withdrawal.

6.4-2 Verification of Information

The applicant shall deliver a completed application to Medical Staff Administration, who shall forward it to the Chief of each Service to which the applicant is applying, and thereafter assist the Chief(s) of Service in verifying the appropriate information. Medical Staff Administration shall verify the information provided by contacting all primary sources, and shall make inquiries of the National Practitioner Data Bank and the Medical Board of California with respect to a practitioner's status in the records of these institutions. Medical Staff Administration shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information. A completed application is one which has been fully completed and signed by the applicant and, for which all requested information has been collected and verified.

An applicant whose application is not completed within six 6 months after it was signed shall be automatically removed from consideration for Medical Staff membership. Such an application may thereafter be reconsidered only if all information therein which may change over time, including but not limited to hospital reports and personal references, has been resubmitted.

6.4-3 Action by Service Chief(s)

Upon receipt, the Chief(s) of each Service in which the applicant seeks privileges shall review the application and supporting documentation, may conduct a personal interview with the applicant, and transmit to the Credentials Committee a written report and recommendations, which are prepared in accordance with Section 6.3.

6.4-4 Credentials Committee Action

The Credentials Committee shall review the application, the supporting documentation, the report(s) and recommendation(s) submitted by the Chief(s) of Service, and such other relevant information as may be available. The Credentials Committee shall transmit to the Medical Staff Executive Committee its report and recommendations, which are prepared in accordance with Article VI of these bylaws, or it may request further information.

6.4-5 Executive Committee Action

After receipt of the Credentials Committee report and recommendations, the Medical Staff Executive Committee shall consider the Credentials Committee and Chief(s) of Service's reports and such other relevant information as may be available in accordance with Article VI. The Committee shall then forward to the Governing Body its written report and recommendations, which are prepared in accordance with Section 6.4-6. The Committee may also request further information prior to taking action.

6.4-6 Appointment Reports and Basis for Appointment Recommendation

The Chief(s) of Service, Credentials Committee, and Medical Staff Executive Committee reports and recommendations shall be submitted in the form prescribed by the Medical Staff Executive Committee. Each appointment is recommended, and, if so, the Medical Staff membership category, Clinical Service affiliation, and clinical privileges to be granted and any special conditions to be attached to the appointment. The reasons for each recommendation shall be stated and supported by reference to the completed application and all other documentation, which was considered, all of which shall be transmitted with the report.

Each recommendation concerning an applicant for Medical Staff membership and clinical privileges shall be based upon, and shall state the following: whether the applicant meets the qualifications specified in Article III, that they can carry out the responsibilities specified in Article III and, that they meet all of the standards and requirements set forth in all sections of these Bylaws and Rules and Regulations.

6.4-7 Effect of Executive Committee Action

Favorable Recommendation: When the Medical Staff Executive Committee's recommendation is favorable to the applicant, it shall be forwarded promptly to the Governing Body, together with the reports and recommendations of the Chief(s) of Service, the Credentials Committee, and the Medical Staff Executive Committee.

Adverse Recommendation: When the Medical Staff Executive Committee's recommendation is adverse to the applicant, the applicant shall be given written notice of the adverse recommendation and of the right to request a hearing in the manner specified in Article IX and the applicant shall be entitled to the procedural rights as provided in Article IX. Any such adverse recommendation shall also be sent to the Governing Body following the Judicial Review process.

6.4-8 Action By the Governing Body

a) **On Favorable Medical Staff Executive Committee Recommendation**: The Governing Body shall, in whole or in part, adopt or reject a Medical Staff Executive Committee recommendation or refer the recommendation back to the Medical Staff Executive Committee for further consideration, stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. If the recommendation of the Governing Body is one of those set forth in Section 9.2, the Administrator shall give the applicant written notice of the tentative adverse recommendation and of the applicant's right to request a hearing before any final action is taken. If the Governing Body's recommendation is not one of those set forth in Section 9.2, it shall become effective as the final decision of the Governing Body.

b) **Where Recommendation is Adverse**: In the case of an adverse Medical Staff Executive Committee recommendation, or an adverse Governing Body recommendation, pursuant to Section 6.4, the Governing Body shall take final action in the matter only after the applicant has exhausted or has waived his/her procedural rights as provided in Article IX. Action thus taken shall be the conclusive decision of the Governing Body, except that the Governing Body may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Governing Body shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the Governing Body shall make a final decision.

6.4-9 Notice of Final Decision

a) Notice of the Governing Body's final decision shall be given through the Administrator to the Medical Staff Executive Committee, the Credentials Committee, the Chief(s) of each Service concerned, and the applicant.

b) A decision and notice to appoint shall include: (1) the Medical Staff category to which the applicant is appointed; (2) the Clinical Service to which s/he is assigned; (3) the clinical privileges s/he may exercise; and (4) any special conditions attached to the appointment.

6.4-10 Reapplication After Adverse Decision, Denying Application, Adverse Corrective Action Decision, or Resignation in Lieu of Medical Disciplinary Action

An applicant, former Medical Staff member, or current Medical Staff member, who has received a final adverse decision regarding Medical Staff membership or clinical privileges, or who has resigned from the Medical Staff or withdrawn his/her application for Medical Staff membership or clinical privileges prior to a final decision, shall not be eligible to reapply for Medical Staff membership and/or clinical privileges for a period of at least thirty-six (36) months from the date the adverse decision became final, the date the application was withdrawn, or the date the former Medical Staff member's resignation became effective, whichever is applicable.

After the thirty-six (36) month period, the affected individual may submit a new application for Medical Staff membership and/or clinical privileges, which shall be processed as an initial application. As part of its decision on the new application, the Medical Staff Executive Committee shall decide, based on the submission of satisfactory evidence, whether the previous problem has been resolved.

This section shall not apply to an individual who has resigned from the Medical Staff or given up clinical privileges while in good standing or to an individual who has withdrawn an application without the presence of an adverse recommendation. Such individuals shall be allowed to reapply or renew their applications in the same manner as any other applicant or Medical Staff member seeking initial or additional privileges.

6.4-11 Time Periods For Processing

Applications shall be considered in a timely and good faith manner by all individuals and groups required to act thereon by these Bylaws. Medical Staff Administration shall transmit the application to the concerned Chief(s) of Service and the Credentials Committee within thirty-five (35) days after all information collection and verification tasks are completed and all relevant materials have been received. In the event the relevant materials are not received within sixty (60) days after the application is received, the applicant shall be notified, and the application shall remain pending until either the materials are received by Medical Staff Administration or the expiration of six 6 months from the date the application was received. The applicable Chief(s) of Service shall act on an application within forty five 45 days after receiving it from Medical Staff Administration. The Credentials Committee shall then make its recommendation within forty five 45 days after the Chief(s) of Service has acted. The Medical Staff Executive Committee shall review the application and make its recommendation to the Governing Body within forty five 45 days after receiving the Credentials Committee report. The Governing Body shall then take final action on the application within forty five 45 days. The time periods specified herein are to assist those named in accomplishing their tasks, and are subject to change in accordance with deferral of action for further investigation or consideration or pendency of any appeal under Article IX, extension for good cause, and shall not be deemed to create any right for the applicant to have his/her application processed within those periods.

6.5 Reappointments

6.5-1 Application for Reappointment; Schedule for Review

a) At least one hundred eighty 180 days prior to the expiration date of each Medical Staff Member's appointment, Medical Staff Administration shall mail a reappointment application to each Staff member.

b) At least ninety days prior to the appointment expiration date, each Medical Staff member shall submit to Medical Staff Administration a completed reappointment application. The application shall be in writing, on a form prescribed by the Medical Staff, and it shall require detailed information concerning the changes in the applicant's qualifications described in Section 6.3 since his/her last review. The application must also include evidence of the applicant's participation in continuing medical education in the minimum amount required by the State of California for licensure. It must include the reappointment fee and any other applicable fee(s) as established by the Medical Staff Executive Committee with the Governing Body's approval. Each Medical Staff member shall submit appropriate evidence of the renewal of his/her state professional license prior to, or as soon as reasonably possible following, its expiration date. The form shall also require information as to whether the applicant requests any change in Medical Staff status or clinical privileges. A request for additional privileges must be supported by the type and nature of evidence, which would be necessary for such privileges to be granted in an initial application.

6.5-2 Verification Information

Medical Staff Administration shall transmit the completed reappointment application and supporting materials to the Chief(s) of Service in which the applicant is a member and/or has privileges sixty days prior to the expiration of appointment. Medical Staff Administration shall gather reports from Risk Management, Patient Safety and Reliability, Hospital Epidemiology, Utilization Management, and Health Information Management for the Service Chief(s) to review. Additional Service requirements shall be collected by the requesting Clinical Service.

6.5-3 Credentials Committee, Medical Staff Executive Committee and Governing Body Action

The actions of the Credentials Committee, Medical Staff Executive Committee and Governing Body shall be in accordance with those provided in Sections 6.4-4 through 6.4-10 for initial appointments.

a) The Credentials Committee shall review the malpractice history, the report(s) and recommendations submitted by the Chief(s) of Service, including performance profiles and such other relevant information as may be necessary. The Credentials Committee shall transmit to the Medical Staff Executive Committee its report and recommendation in accordance with Section

b) 6.4-6. The Committee may also request further information prior to taking action.

c) After receipt of the Credentials Committee report and recommendations, the Medical Staff Executive Committee shall consider the Credentials Committee and Chief(s) of Service's reports and such other relevant information as may be available. The Committee shall then forward to the Governing Body its written report and recommendations in accordance with Section

d) 6.4-6. The Committee may also request further information prior to taking action.

e) After receipt of the Medical Staff Executive Committee report and recommendations, the Governing Body shall act upon the report as delineated in Section 6.4-8.

6.5-4 Failure to File reappointment Application

Failure to file a complete application for reappointment (including all required supporting documentation as well as current address and telephone number) by the date specified by the Medical Staff Executive Committee shall result in an automatic determination by the Medical Staff Executive Committee that the Medical Staff membership and clinical privileges have been voluntarily relinquished.

6.6 Review of Appointment in the Event of Changed Information

A Medical Staff member's appointment shall be subject to review in the event that changes are reported by the member or other responsible parties in the information submitted in the member's appointment or reappointment application or documentation supporting the application subsequent to the submission of the application. The Chief of the member's Clinical Service shall be responsible for verifying, if appropriate, and evaluating the information changes to determine whether there is reason to believe the member no longer meets the qualifications applicable to his appointment.

If the Chief of Service reasonably believes the reported information changes indicate that one or more criteria for initiation of corrective action are met, then s/he shall initiate corrective action as provided in Article VIII. Otherwise s/he shall initiate a review process for consideration of the information changes in accordance with the procedures for review of reappointment applications as

set forth in Section 6.5-2 through Section 6.5-3. A change in practice location or status, or a change in faculty appointment shall be cause for review of the member's Medical Staff appointment.

No person or entity duly authorized by these Bylaws shall be precluded by this Section 6.6 from making a request for or initiating corrective action, as provided in Section 8.1-1, based on the matter to which the information changes relate.

Section 1.07 Article VII: Clinical Privileges

The Medical Center Governing Body on the advice of the Medical Staff Executive Committee shall determine what privileges will be offered (to Medical Staff members) and which Clinical Service or combination of Clinical Services shall be responsible for recommending the granting of those privileges. The approval of "Service Privilege Forms" shall be a mechanism by which this responsibility is assigned. When a Medical Staff member requests privileges that the Clinical Service to which he/she has been assigned has not been granted the authority to recommend, the Credentials Committee shall designate a Clinical Service to have the responsibility to review such a request and to make a recommendation regarding granting the requested privileges. The Medical Staff may develop and implement "Multi-Service Privilege Forms" to use in the granting and administration of privileges by multiple Clinical Services.

7.1 Exercise of Clinical Privileges

Except as otherwise provided in these Bylaws, a member providing clinical services at the Medical Center shall be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be specific to the Medical Center and within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restriction thereon, and shall be subject to the Rules and Regulations of the Clinical Service and the authority of the Chief of Service and the Medical Staff. Medical Staff privileges can be exercised in those areas that the Medical Center has designated as being appropriately equipped and staffed. Medical Staff clinical privileges may be granted, continued, modified or terminated by the Governing Body of this Medical Center only upon recommendation of the Medical Staff, only for reasons directly related to quality of patient care and other provisions of the Medical Staff Bylaws, and only following the procedures outlined in these Bylaws.

7.2 Delineation of Clinical Privileges in General

7.2-1 Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. A request by a member for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request.

7.2-2 Basis for Clinical Privileges Determination

Requests for clinical privileges must be supported by documentation and shall be evaluated on the basis of the member's education, training, experience, current health status and demonstrated ability and judgment. Specific elements to be considered in making determinations regarding privileges, whether in connection with periodic reappointment or otherwise, shall include education, training, observed clinical performance and judgment, performance of a sufficient number of procedures over an appropriate period of time to develop and maintain the practitioner's skills and knowledge, and the documented results of quality review, evaluation, and monitoring activities required by these Bylaws and the Medical Center Corporate Bylaws to be conducted at the Medical Center. The number of procedures necessary to satisfy the requirement of a "sufficient number of procedures" shall be proposed by the Clinical Service if only one Clinical Service has been authorized to grant the procedure; otherwise, the Credentials Committee shall have the responsibility for specifying the number of procedures necessary. The number of procedures necessary shall

be the same regardless of the member's specialty and/or the Clinical Service to which the member is assigned. Privilege determinations shall also take into account pertinent information concerning clinical performance obtained from other sources, including other institutions and health care settings where the member exercises clinical privileges.

7.2-3 Practitioners Applying For Clinical Privileges in a Recognized Specialty

Each Medical Staff member who applies for clinical privileges in a recognized specialty must demonstrate ability to provide a standard of care that is consistent with the special requirements and standards necessary for Loma Linda Medical Center to maintain and enhance its reputation and meet its patient care responsibilities in its function as a tertiary care teaching institution. In the determination as to whether an applicant meets this standard, the minimum criteria which each applicant must demonstrate compliance with shall be:

a) Satisfactory completion of the educational requirements for board certification in the relevant specialty.

b) Each applicant must also demonstrate aptitude for an interest in participating in the clinical education and training programs conducted at LLUMC, as required.

7.2-4 Procedure

All requests for clinical privileges at LLUMC shall be processed pursuant to the procedures as outlined in Article VI.

7.3 Conditions for Clinical Privileges of Limited Licensed Practitioners

7.3-1 Admissions

a) Oral surgeons who are members of the Medical Staff may admit patients, provide the required current history and physical examination, and assume responsibility for arranging for the care of the patient's other medical problems (present at the time of admission or which may arise during hospitalization) by a physician member of the Medical Staff.

b) When dentists (other than oral surgeons) or podiatrists, who are members of the Medical Staff admit patients, a physician member of the Medical Staff must conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry or podiatry) and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited licensed practitioner's lawful scope of practice.

7.3-2 Surgery

All surgical procedures performed in the O.R. by dentists (other than oral surgeons) shall be under the overall supervision of the Chief of Surgery Service or the Chief's designee. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chief of Orthopedic Surgery Service, or the Chief's designee.

7.3-3 Medical Appraisal

All patients admitted for care in the Medical Center by a dentist or podiatrist shall receive the same basic medical appraisal as patients admitted to other services. Where a dispute exists regarding proposed treatment between a physician member and a limited licensed practitioner based upon medical or surgical factors outside of the scope of licensure of the limited licensed practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate service(s).

7.4 Initial Professional Performance Evaluation (IPPE)/Proctoring Requirement

Except as otherwise determined by the Medical Staff Executive Committee, all initial appointees to the Medical Staff and all members granted new clinical privileges which are substantially different from previously granted clinical privileges, shall be subject to a an initial period of Initial Professional Performance Evaluation (IPPE) also called proctoring.

7.4-1 IPPE/ProctoringDefinition

IPPE/Proctoring is a process whereby privilege/procedure specific competence of a practitioner is evaluated, in addition to the practitioner's ability to discharge the basic responsibilities of Medical Staff Membership as contained in these Bylaws (refer to Section 4.3, Provisional Staff), accompanying Rules and Regulations (Section C), and individual Service Rules and Regulations.

7.4-2 IPPE/ProctoringProcess

The member's Service and/or Section Chief shall determine whether such review shall be concurrent or immediate retrospective in nature. IPPE/Proctoring for procedural privileges may include an element of direct observation. The member's Service Chief shall designate another member(s) of the Active Medical Staff with privileges similar to those sought by the member subject to IPPE/Proctoring to serve as the member's proctor(s). It shall be the responsibility of the member subject to IPPE/Proctoring to contact the assigned proctor at the time care in the Medical Center is initiated for a patient in the Medical Center during the period of IPPE/Proctoring.

Where the nature of the member subject to IPPE/Proctoring practice limits the volume of care at the Medical Center, the member's Service and/or Section Chief may instruct the assigned proctor(s) to review IPPE/Proctoring records from the past two (2) years from another LLU affiliated site (as defined on p. 3 of these Bylaws) to satisfy up to 100% of the IPPE/Proctoring requirement. IPPE/Proctoring records from the past two (2) years from another CMS recognized institution may also be accepted at the Service and/or Section Chief's discretion, as long as they are in alignment with the Medical Center IPPE/Proctoring criteria, to satisfy up to 50% of the IPPE/Proctoring requirement.

If IPPE/Proctoring from a LLU affiliated site (as defined on p. 3 of these Bylaws) or another CMS recognized institution occurred over two (2) years ago but the practitioner has been actively carrying out the privilege within the past two years, evidence of current competency may be obtained in lieu of IPPE/Proctoring reports. This evidence should be from performance data based on Ongoing Professional Practice (OPPE) outcomes from at least the prior eight (8) months. In addition, there should be activity equal to or greater than the number of cases that would be needed to fulfill the Medical Center IPPE/Proctoring requirements. If the Service and/or Section Chief deem that the OPPE is acceptable in lieu

of IPPE/proctoring, at least one (1) case/patient contact must be proctored at the Medical Center.

In the circumstance where there are no proctors available with a California license and who hold the privilege, 100% reciprocal IPPE/Proctoring or evidence of current competence from performance data based on Ongoing Professional Practice (OPPE) outcomes from another CMS recognized institution may be considered at the Section and/or Service Chief's discretion. Other evidence of expertise could also be considered by the Credentials Committee.

Supervision by an Active Medical Staff member at a LLU affiliated site(as defined on p. 3 of these Bylaws), while the member subject to IPPE/Proctoring was in a graduate medical education program within the 2 years immediately preceding initial appointment, may be substituted for a portion of the required IPPE/Proctoring at the Service and/or Section Chief's discretion.

7.4-3 Term/Completion of IPPE/Proctoring

a) For an initial appointee, it is expected that their IPPE/Proctoring be completed by their first Ongoing Professional Practice Evaluation (OPPE). At the Section and/or Service Chief's discretion, the initial appointee's IPPE/Proctoring term may be:
   1) Extended to the practitioner's second OPPE;
   2) Under special circumstances extended to the practitioner's third OPPE/Reappointment.
   3) Under no circumstances extended beyond their third OPPE/Reappointment.

b) For a practitioner granted new clinical privileges which are substantially different from previously granted clinical privileges and who are subject to IPPE/Proctoring, it is expected that the IPPE/Proctoring of these new privileges be completed by their next scheduled OPPE, however the term may be extended one additional OPPE period at the Section and/or Service Chief's discretion.

c) The IPPE/Proctoring term shall extend until the relevant Service and/or Section Chief of Service submits a report to Medical Staff Administration stating all IPPE/Proctoring and related requirements have been satisfactorily completed and the practitioner subject to IPPE/Proctoring has been released from IPPE/Proctoring requirements. The report from the Service and/or Section Chief should include the types and numbers of cases reviewed and the evaluation of the practitioner's performance; a statement that the practitioner appears to meet all of the qualifications for unsupervised practice in that Service and/or Section; a statement that the practitioner has discharged all of the responsibilities of Medical Staff membership; and a statement that the practitioner has not exceeded or abused the prerogatives of their category of Medical Staff membership; with the completed IPPE/Proctoring forms attached, which shall be submitted to Medical Staff Administration to begin the Committee review and Governing Body approval process. While patient care will not be held up after the Section and/or Service Chief recommends completion of IPPE/Proctoring, the practitioner may remain subject to IPPE/Proctoring until they have been released from IPPE/Proctoring requirements by the Governing Body.

d) If the practitoner fails to satisfactorily complete IPPE/Proctoring because of concern regarding his/her professional performance and/or privilege-specific competence during the period of IPPE/Proctoring, the IPPE/Proctoring period may be extended to include a more intense focused evaluation of the specific concerns with an action plan for these specific concerns to be addressed and improved within a specific time period as determined by the Service and/or Section Chief. Failure to meet the requirements of the action plan may be deemed as failure to satisfactorily complete the IPPE/Proctoring requirements which also may result in the termination of Medical Staff membership and/or privileges. If the termination is due to a medical disciplinary cause or reason, it may be reportable to the California Medical Board and the NPDB, and the affected practitioner will be provided notice by the Governing Body that they have the right to appeal and request a hearing pursuant to Section 9.3-2. Thereafter the procedure set forth in Article IX shall be followed.

e) If an initial appointee fails to complete their IPPE/Proctoring, due to no or low volume, prior to the expiration of their appointment then s/he shall not be eligible for re-appointment. The practitioner will be provided written notice by the Governing Body that s/he has been automatically resigned due to not completing the IPPE/Proctoring requirements due to no or low volume. In the case of automatic resignation due to no or low volume, the practitioner does not have any appeal or hearing rights.

7.5 Temporary Clinical Privileges

The granting of temporary clinical privileges does not entitle a practitioner to Medical Staff membership. The Medical Staff Executive Committee shall develop and implement, upon approval of the Governing Body, specific policies and procedures for application and verification of qualifications for and granting of temporary clinical privileges. All persons requesting or receiving temporary clinical privileges shall be bound by the Bylaws and Rules and Regulations of the Medical Staff. The types of Temporary Clinical Privileges available at LLUMC are:

- Temporary Clinical Privileges for Applicants
- Temporary Clinical Privileges for Care of a Specific Group of Patients
- Temporary Clinical Privileges for Consultation on a Single Patient
- Temporary Clinical Privileges for Transplantation Purposes

The types of Emergency Clinical Privileges available at LLUMC are:

- Emergency Temporary Clinical Privileges to Care for a Single Patient
- Emergency Temporary Privileges As a Part of the Medical Center's Emergency Management Plan

7.5-1 General Conditions That Apply To All Instances of Temporary Clinical Privileges

a) Temporary clinical privileges shall not be recommended or granted without adequate information regarding qualifications, ability and judgment.

b) All requests for temporary clinical privileges shall be in writing and shall be signed by the applicant.

c) Prior to the granting of any temporary clinical privileges, the appropriate Chief of Service shall interview the applicant and shall contact at least one (1) professional peer who has recently worked with the applicant and has directly observed the applicant's professional performance over a reasonable time and who provides reliable information regarding the applicant's current professional competence, ethical character, and ability to work well with others so as not to adversely affect patient care.

d) If granted temporary clinical privileges, the applicant shall act under the supervision of the Chief of Service to which the applicant has been assigned, and shall ensure that the Chief of Service, or the Chief's designee, is kept closely informed as to the applicant's activities within the Medical Center.

e) If granted, temporary clinical privileges shall be granted for a specified period of time not to exceed ninety 90 days.

f) Temporary clinical privileges shall automatically terminate at the end of the designated period unless affirmatively renewed following the procedure as set forth in Section 7.5-2.

g) Temporary privileges may at any time be terminated by the Medical Staff President with the concurrence of the Chief of Service or their designee(s), subject to prompt review by the Medical Staff Executive Committee. In such cases, the appropriate Chief of Service or, in the Chief's absence, the Chair of the Medical Staff Executive Committee, shall assign a member of the Medical Staff to assume responsibility for the care of such member's patient(s).

h) Requirements for IPPE/Proctoring and monitoring shall be imposed on such terms as may be appropriate under the circumstances upon any individual granted temporary privileges.

i) A practitioner shall not be entitled to the procedural rights afforded by Article IX because his/her request for temporary privileges is refused or because all or any portion of those temporary privileges are terminated unless the action taken requires a report to the Medical Board of California under Section 805 of the California Business and Professions Code.

7.5-2 Temporary Clinical Privileges For Applicants

Temporary clinical privileges shall not routinely be granted to applicants. In situations when necessary to avoid undue hardship to the applicant and the applicant's patients, the Administrator (or designee) may, after receipt of a completed application for Medical Staff appointment and specific clinical privileges, and upon the recommendation of the appropriate Chief of Service, as well as the recommendation of the President of the Medical Staff, grant temporary clinical privileges to an applicant for a limited period of time. Renewal(s) of temporary clinical privileges may be made by the same procedure during the application processing period. In exercising any clinical privileges granted under this section, the applicant shall act under the supervision of the Chief (or appropriate designee) of the Service in which the applicant has requested clinical privileges.

7.5-3 Temporary Clinical Privileges for Care Of A Specific Group of Patients

Temporary clinical privileges for the care of specific patients may be granted by the Administrator (or designee), upon the recommendation of the appropriate Chief of Service as well as the recommendation of the President of the Medical Staff (or designee), to a practitioner who is not an applicant for appointment provided that no clinical privileges will be recommended or granted until adequate information about the applicant's education, training, experience, and malpractice insurance has been obtained and confirmed as appropriate. Such individual's signed acknowledgment to be bound by the Medical Staff Bylaws and Rules and Regulations, and Medical Center policies must also be obtained. In addition, the Medical Board of California (or Dental Board) must confirm that it is legal for the practitioner to practice in the state of California. Such clinical privileges granted pursuant to this paragraph shall be restricted to the specific patients for which they are granted.

7.5-4 Temporary Clinical Privileges For Consultation On A Specific Patient

Temporary clinical privileges limited to the rendering of a consultative opinion and recommendation in a single case may be granted to a practitioner by the Administrator (or designee) upon the written request of a member of the Active Medical Staff. If the requested consultant is not licensed in the State of California, then the requirements of California Business and Professions Code Section 2060 must be met. It shall be the responsibility of the Administrator to provide notification to the Nursing Service and the Medical Staff Administration office regarding the granting of temporary clinical privileges under these circumstances.

7.5-5 Temporary Clinical Privileges for Transplantation Purposes

If a practitioner wishes to obtain temporary clinical privileges for the harvesting of organs for transplantation purposes from a specified individual prior to the determination of death of the individual (such as for participation in the surgical removal of a kidney from an otherwise healthy patient), the practitioner shall be required to apply for Temporary Clinical Privileges for the Non-Applicant pursuant to Section 7.5-1,b). Prior to the granting of such temporary clinical privileges by the President of the Medical Staff, or designee, and the Administrator, or designee, the practitioner shall certify in writing that s/he has been designated by a specified health facility or institution to perform the requested harvesting functions, and is a member of the Medical Staff in good standing at that facility or institution. A practitioner receiving temporary clinical privileges under this subsection shall not be entitled to admit patients to the Medical Center.

7.5-6 Emergency Clinical Privileges

In the case of an emergency, and in the absence of a Medical Staff member with appropriate privileges, any practitioner, to the degree permitted by his/her license and regardless of Clinical Service, Medical Staff status, or clinical privileges, shall be permitted to do, and shall be assisted by Medical Center personnel in doing everything reasonable to save a patient in such an emergency. Emergency privileges expire when a Medical Staff member with appropriate privileges assumes the responsibility for care of the patient. 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.

7.5-7 Emergency Temporary Clinical Privileges As A Part of the Medical Center's Emergency Disaster Plan

a) Emergency Temporary Privileges may be granted to physicians or allied health professionals when the Medical Center's Emergency Disaster Plan has been activated and it is found that there are an insufficient number of Medical Staff members or allied health professionals with practice privileges available to provide for immediate patient needs.

b) The individual who is acting as the Medical Center administrator, in collaboration with the individual who is acting as the President of the Medical Staff shall, after consultation with the individuals acting as Chiefs of Service determine the number and type of additional physicians or allied health professionals needed.

c) The individual who is acting as the Medical Center administrator in collaboration with the individual who is acting as the President of the Medical Staff may grant Emergency Temporary Privileges to practitioners with the needed qualifications after examining the following documents presented by the candidate(s) for Emergency Clinical Privileges:

   1) A photo identification document issued by a State, Federal, or Regulatory agency, along with one of the following:

      a. For physicians or allied health professionals, a document issued by the Medical Board of California, the Osteopathic Medical Board of California, or other professional licensing boards of California indicating that the individual has a valid certificate to practice as a physician, osteopathic physician, or allied health professional. If because of the emergency, the State of California has suspended the requirement for California licensure, then a document issued by any State licensing authority granting a certificate to practice as a physician, osteopathic physician, or allied health professional may be substituted for the California issued certificate.

      b. A current hospital identification card that clearly identifies the individual's professional designation.

      c. Identification indicating that the individual is a member of a Disaster Medical Assistant Team (DMAT), Medical Reserve Corp (MRC), Emergency System for Advance Registration of Volunteer Health Professional (ESAR-VHP), or other recognized state or federal organization or group(s) approved under emergency declaration.

      d. Identification by a current member of the medical staff who possesses personal and sufficient knowledge regarding the volunteer practitioner's qualifications.

d) The practitioner granted Emergency Clinical Privileges shall exercise those privileges only under the supervision of a Medical Staff member designated by the individual acting as the Chief of the appropriate Clinical Service.

e) All Emergency Clinical Privileges shall expire immediately upon the termination of the activation of the Medical Center's Emergency Disaster Plan.

f) Any Emergency Clinical Privileges for a specific group of practitioners may be withdrawn by the individual acting as the Chief of Service or by the individual acting as the President of the Medical Staff at any time prior to termination of the activation of the Emergency Disaster Plan.

g) Any Emergency Clinical Privileges for an individual practitioner may be withdrawn by the individual acting as the Chief of Service or by the individual acting as the President of the Medical Staff at any time prior to termination of the activation of the Emergency Disaster Plan.

h) Based on this supervision, the individual who is acting as the President of the Medical Staff shall determine within 72 hours of the practitioner's arrival if granted disaster privileges should continue.

i) Immediately upon the granting of Emergency Clinical Privileges, or if due to extraordinary circumstances, primary source verification of licensure of the volunteer practitioner cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon as possible, the Medical Staff, working through Medical Staff Administration, shall commence verification of credentials and qualifications for clinical privileges by the same mechanisms used for applicants for Medical Staff membership or allied health professional practice privileges. If primary source verification cannot be completed within 72 hours of arrival due to extraordinary circumstances, the following is documented:

   i. Reason(s) why it could not be performed within 72 hours of arrival;

   ii. Evidence of the LIPs demonstrated ability to continue to provide adequate care, treatment, and services;

   iii. Evidence of the hospital's attempt to perform primary source verification as soon as possible.

j) The individual who is acting as the President of the Medical Staff shall determine within 72 hours of the practitioner's arrival if granted disaster privileges should continue.

k) Any termination of Emergency Clinical Privileges shall not entitle the practitioner to procedural rights afforded by Article IX because all or any portion of those emergency privileges are terminated unless the action taken requires a report to the Medical Board of California under Section 805 of the California Business and Professions Code.

7.6 Telemedicine/Telehealth Privileges – Providing Site Responsibilities

As a providing site, the Medical Staff shall recommend the clinical services to be provided by a Medical Staff physician through a telemedicine/telehealth link, p[(the term "providing" site is intended to correspond to the Joint Commision term "distant" site).

a) The Behavioral Medicine Center Medical Staff shall recommend which clinical services are appropriately delivered by physicians through this medium.

b) The clinical services offered shall be consistent with commonly accepted quality standards.

c) The Behavioral Medicine Center Medical Staff will oversee physician quality and will share credentialing and quality data with originating sites.

Section 1.08 Article VIII: Corrective Action

8.1 Routine Corrective Action

8.1-1 Requests for Initiation and Criteria for Initiation

An investigation or corrective action against a practitioner may be initiated as provided in this Article. Whenever a practitioner engages in activities or conduct, either within or outside of the Medical Center, and the same is, or is reasonably likely to be detrimental to patient safety or to the delivery of quality patient care within the Medical Center, to be disruptive to Medical Center operations, to violate the requirements of these Bylaws, or to constitute fraud or abuse; or the same results in the imposition of sanctions by any governmental authority; an investigation or corrective action against such person may be initiated as provided in this Article.

8.1-2 Initiation

Proposed corrective action or investigation shall be initiated by the Medical Staff Executive Committee on its own initiative or upon a written request submitted to the Medical Staff Executive Committee which identifies the specific activities or conduct alleged to constitute the grounds for proposing an investigation or specific corrective action. Written requests may be submitted by any Medical Staff Officer, the Chief of Service in which the practitioner has privileges, the Governing Body, the Chair of a standing Medical Staff committee, or the Administrator upon any complaint or request. The Medical Staff Executive Committee Chair shall promptly notify the Administrator and Governing Body, and shall continue to keep them fully informed of all action taken.

8.1-3 Investigation

The Medical Staff Executive Committee may conduct the investigation itself or may designate an appropriately charged Medical Staff officer, or Chief of Service, or Medical Staff committee to conduct the investigation. No part of such investigative process shall be deemed to be a "hearing" as that term is used in Article IX.

Whenever the proposed corrective action could result in termination, reduction, or suspension of clinical privileges, the Medical Staffhkjnv Executive Committee shall, whenever indicated, assign the task of conducting the investigation to the Chief of Service in which the affected practitioner is a member or exercises the clinical privileges which may be adversely affected. As soon as reasonably practical after receipt of the assignment the Chief of Service shall appoint an ad-hoc committee composed of members of his/her Clinical Service to assist him/her in conducting the investigation. The Clinical Service ad hoc committee shall, upon request by the practitioner or upon its own initiative, give the affected practitioner an opportunity for an interview. In the event an interview is granted, the practitioner shall be informed of the general circumstances leading to the investigation and may present relevant information. A record of the interview and any finding resulting from such interview shall be made.

If the investigation is delegated to an Officer, a Chief of Service, or Committee other than the Medical Staff Executive Committee, such official or Committee shall forward a written report of the investigation to the Medical Staff Executive Committee as soon as is practicable. In any event, such report shall be submitted within forty-five 45 days after the initiation of proposed corrective action, subject to such extensions as may be granted by the Medical Staff Executive Committee at the request of such official or Committee for additional time to complete the investigative process.

Quality review assessment such as OPPE and FPPE processes and activities of the Well Being Committee are not considered investigations within the meaning of this Article VIII of these Bylaws.

8.1-4 Executive Committee Action

As soon as practical, after the conclusion of the investigative process, but in any event, within sixty (60) days after the initiation of proposed corrective action, unless deferred pursuant to Section 8.1-5, the Medical Staff Executive Committee shall act thereon. If the proposed corrective action could result in termination, reduction, or suspension of clinical privileges or suspension or expulsion from the Medical Staff, the affected practitioner shall be given an opportunity to have an interview with the Medical Staff Executive Committee prior to the Committee's taking action. Such an interview shall be conducted in the same manner as that provided in Section 8.1-3. Medical Staff Executive Committee action on a proposal for corrective action may include, without limitation, recommending:

a) No corrective action.

b) Letter of admonition, reprimand, or warning.

c) Terms of probation or individual requirements of consultation.

d) Reduction or revocation of clinical privileges.

e) Suspension of clinical privileges.

f) Reduction of Medical Staff membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care.

g) Revocation of Medical Staff membership.

h) Other actions appropriate to the facts, which prompted the investigation.

Nothing set forth herein shall inhibit the Medical Staff Executive Committee from implementing summary suspension at any time, in the exercise of its discretion pursuant to Section 8.2.

8.1-5 Deferral

If additional time is needed to complete the investigative process, the Medical Staff Executive Committee may defer action on the request, and it shall so notify the affected practitioner. A subsequent recommendation for any one or more of the actions provided in Section 8.1-4, paragraphs a) through i) above, must be made within the time specified by the Medical Staff Executive Committee, and if no such time is specified, then within thirty 30 days of the deferral.

8.1-6 Procedural Rights

Any recommendation by the Medical Staff Executive Committee pursuant to Section 8.1-4 which constitutes grounds for a hearing, as set forth in Section 9.2, shall entitle the practitioner to the procedural rights as provided in Article IX. In such cases, the Medical Staff Executive Committee shall give the practitioner written notice of the adverse recommendation and of his/her right to request a hearing in the manner specified in Section 9.3-2.

8.2 Summary Suspension

8.2-1 Criteria for Initiation

Whenever a practitioner's conduct requires immediate action to be taken to reduce a substantial likelihood of immediate danger to the health or safety of any patient, prospective patient, employee or other person present in the Medical Center, any person or body authorized to request or initiate proposed corrective action pursuant to Section 8.1-2 hereof shall have the authority to summarily suspend the Medical Staff membership status, including any of the clinical privileges of such practitioner.

Such summary suspension shall become effective immediately upon imposition, and the person or body responsible therefore shall promptly give oral or written notice of the suspension to the practitioner, the Administrator and the President of the Medical Staff. The Administrator shall then be responsible for notifying the Governing Body and the President shall notify the Medical Staff Executive Committee and the appropriate Chief(s) of Service. Any report required under Section 805 of the California Business and Professions Code shall be filed jointly by the Vice President of Medical Administration and the Administrator. The notice of the suspension given to the Medical Staff Executive Committee shall constitute a request for corrective action and the procedures set forth in Section 8.1 shall be followed. In the event of any such suspension, the practitioner's patients shall be assigned to another practitioner by the appropriate Chief of Service or by the President. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

8.2-2 Executive Committee Action

After such summary suspension, the affected practitioner may request a Medical Staff Executive Committee meeting be convened as soon as reasonably possible, at which the Medical Staff Executive Committee shall confer with the affected practitioner and review and reconsider the summary suspension. The Medical Staff Executive Committee may thereafter modify, continue, or terminate the terms of the summary suspension order and it shall give the practitioner written notice of its decision. Such a meeting shall not be deemed a "hearing" as that term is used in Article IX and the scheduling or holding of such a meeting shall not toll the running of any time interval specified in this Article VIII or in Article IX. If the summary suspension is found to be without merit and is terminated by the Medical Staff Executive Committee, notice of such termination shall be given to those who received notice of the suspension under 8.2-1. Frivolous initiation of the summary suspension process shall be grounds for corrective action under this Article VIII.

8.2-3 Procedural Rights

Unless the Medical Staff Executive Committee terminates the suspension, it shall remain in effect during the pendency of and the completion of the corrective action process and of the hearing and appellate review process, unless the summary suspension is terminated by the Judicial Hearing Committee. The practitioner shall not be entitled to the procedural rights

afforded by Article IX until such time as the Medical Staff Executive Committee has taken action pursuant to Section 8.1-4 through 8.1-6, and then only if the action taken constitutes grounds for a hearing as set forth in Section 9.2.

8.3 Automatic Suspension

8.3-1 Criteria for Initiation

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 in Article IX of these Bylaws, or to any other procedural rights.

a) License

Whenever a practitioner's license authorizing him/her to practice in this State is revoked, restricted, suspended, expired or the practitioner is placed on probation, the action and its terms shall automatically apply to the practitioner's Medical Staff membership and/or clinical privileges as appropriate. Such practitioners shall not be entitled to the procedural rights afforded by Article IX regarding such automatic action based on revocation, restriction or suspension of license. Expiration of license will be as communicated by the Medical Board of California.

b) Drug Enforcement Administration Certification

Whenever a practitioner's DEA certificate is revoked, suspended, expires, or is subject to probation, the action and its terms shall automatically apply to the practitioner's dispensing or administering medications covered by the certificate.

c) Executive Committee Deliberation on Matters Involving License and Drug Enforcement Administration

As soon as practical, after action is taken as described in Section 8.3-1, or in Section 8.3-2, the Medical Staff Executive Committee shall convene to review and consider the facts upon which such action was predicated. The Medical Staff 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 Section 8.1-3 and following, as appropriate.

d) X-Ray Operator and Supervisor Certificates and Permits

Whenever a practitioner's X-ray Operator and Supervisor Certificate or permit is revoked, restricted, suspended or expired, the action and its terms shall automatically apply to the practitioner's clinical privileges to:

1) Actuate or energize X-ray equipment.

2) Directly control radiation exposure to the patient during X-ray procedures.

3) Supervise one or more persons who hold an appropriate certificate or permit.

4) Supervise students in an approved school when the student is operating X-ray equipment.

e) Medical Records

For failure to complete medical records in the manner and within the time limits established by the Medical Staff Rules and Regulations and Medical Center policies, a practitioner's clinical privileges (except with respect to his/her patients already in the Medical Center) and his/her prerogative to admit patients and to provide any other professional services, shall be automatically suspended as specified in the Rules and Regulations pertaining to completion of medical records and shall remain so suspended until all delinquent medical records are completed. A failure to complete the medical records within two (2) months after the date a suspension became effective pursuant to this section shall be deemed to be a voluntary resignation of the practitioner's Medical Staff membership.

Practitioners who have a repetitive and/or persistent chart completion problem resulting in suspension (s) for chart completion reasons may be subject to revocation of Medical Staff membership or practice privileges. Practitioners who have or have had a repetitive and /or persistent chart completion problem resulting in suspension(s) for chart completion reasons may be denied reappointment.

f) Failure to Maintain Required Malpractice Insurance and Failure to Pay Reappointment Fees

1) For failure to maintain the amount of professional liability insurance required under Section 15.3, a practitioner's Medical Staff membership and clinical privileges shall be automatically suspended effective immediately with the lapse of such professional liability insurance. Medical Staff membership and clinical privileges shall remain so suspended until the practitioner provides evidence to the Medical Staff Executive Committee that s/he has corrected the delinquency. A failure to provide such evidence within ninety 90 days after the date the automatic suspension became effective shall be deemed to be a voluntary relinquishment of privileges.

2) Failure to pay reappointment fees as required under Section 6.5 shall also, after written warning of the delinquency, result in automatic suspension of the practitioner's Medical Staff membership and clinical privileges. Medical Staff membership and clinical privileges shall remain so suspended until the reappointment fee has been paid. Failure to pay reappointment fees within ninety 90 days of the date the automatic suspension became effective shall be deemed a voluntary relinquishment of privileges.

8.3-2 Procedural Rights – Medical Records, Malpractice Insurance, and Failure to Pay Reappointment Fees

Practitioners whose clinical privileges are automatically suspended and/or who have resigned their Medical Staff membership pursuant to the provisions of Article VIII shall not be entitled to the procedural rights set forth in Article IX.

8.3 - 3 Medicare/Medicaid Participation

In the event that a Medical Staff member or Allied Health Professional with privileges is subject to a final exclusion or suspension decision by either the Medicare or Medicaid program, and the Medical Staff has validated that the practitioner named in the exclusion or suspension is indeed the same practitioner who is a Medical Staff member or Allied Health Professional with privileges, his/her clinical privileges shall be automatically suspended as

provided in Section 8.3-1. If the exclusion lasts for more than ninety 90 days, the member is deemed to have resigned from the Medical Staff. None of the hearing rights provided under Section 9.2 and following of these Bylaws are available in the event of an automatic denial, suspension or deemed resignation under this Section. The suspension may be lifted, or the applicant may reapply, as pertinent, when unrestricted participation in the Medicare and/or Medicaid program(s) has been reestablished.

A member is required to notify the Chief of Staff, through the Medical Staff office, in writing, immediately upon any exclusion, suspension, or change in his/her status as a participating provider in a federal or State healthcare program or of any investigation by a governmental entity relating to the member's participation in a federal or State healthcare program. Failure to do so shall be grounds for corrective action.

8.3-4 Notification of Automatic Suspension and Reassignment of Patients

Upon the occurrence of an event which gives rise to automatic suspension or voluntary resignation from the Medical Staff, following such automatic suspension, as set forth in Article VIII, or as soon thereafter as reasonably practical, the Medical Staff Executive Committee shall notify the appropriate Chief(s) of Service and the Administrator, who shall notify the Governing Body, of the resultant automatic suspension or resignation by the affected practitioner. Written confirmation of such automatic suspension or resultant voluntary resignation shall be sent to the practitioner by certified mail, return receipt requested, postage prepaid.

In the event of any such automatic suspension, the practitioner's patients whose treatment by the affected practitioner is terminated by the automatic suspension shall be assigned to another practitioner by the appropriate Chief of Service or by the President of Medical Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

Section 1.09 Article IX: Hearings and Appellate Reviews

9.1 Preamble and Definitions

9.1-1 Intra-Organizational Remedies

The intra-organizational remedies and the hearing and appellate review bodies provided for in this Article IX are strictly quasi-judicial in structure and function and, said bodies shall have no power or authority to hold quasi-legislative, notice and comment type hearings or to make quasi-legislative determinations, or determinations as to the substantive validity of the Medical Staff Bylaws and Rules and Regulations or other intra-organizational legislation. Notwithstanding the foregoing, the Governing Body may entertain challenges to the substantive validity of intra-organizational legislation and in all proper cases shall hear and decide those questions. Where the substantive validity question is the sole issue, the practitioner shall be permitted an initial hearing, in the first instance, before the Medical Staff Executive Committee, with an appeal to the Governing Body. The final determination by the body conducting such hearing shall be a condition precedent to the practitioner's right to seek judicial review in a court of law.

9.1-2 Exhaustion of Remedies

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

9.1-3 Definitions

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

“Body whose decision prompted the hearing" refers to the Medical Staff Executive Committee in all cases where the Medical Staff Executive Committee or authorized officers, members or committees of the Medical Staff took the action or rendered the decision which resulted in a hearing being requested; and refers to Governing Body in all cases where the Governing Body took the action or rendered the decision which resulted in a hearing being requested.

"Notice" refers to a written communication delivered personally to the required addressee or sent by United States Postal mail, return receipt requested, addressed to the required addressee at his/her address as it appears in the records of the Medical Center.

"Petitioner" refers to the practitioner who has requested a hearing pursuant to Section 9.3 of these Bylaws.

"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 four (4) days (excluding

days when there is no mail delivery) after being deposited, postage prepaid, in the United States mail in compliance with paragraph b) of this Section 9.1-3.

9.2 Grounds for Hearing

Any one or more of the following actions or recommended actions shall constitute grounds for a hearing if the action or recommended action would require the filing of a report to the Medical Board of California (Section 805 Report):

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 Medical Staff membership status.

e) Expulsion from Medical Staff membership.

f) Denial of requested privileges.

g) Reduction in privileges.

h) Suspension of privileges.

i) Summary suspension of privileges.

j) Termination of privileges.

k) Requirement of consultation.

Recommendation of any of these actions shall constitute an "adverse recommendation" for the purposes of these Bylaws and these actions shall constitute the sole and exclusive grounds for a hearing under these Bylaws.

9.3 Requests for a Hearing

9.3-1 Notice of Action or Proposed Action

In all cases in which the body authorized under these Bylaws has recommended or taken any action constituting grounds for hearing as set forth in Section 9.2 of this Article, then said body, through the Administrator, shall give the affected practitioner notice of its recommendation, decision, or action and of his/her right to request a hearing pursuant to Section 9.3-2, below.

9.3-2 Request for Hearing

The petitioner shall have thirty 30 days following the date of receipt of such notice to request a hearing. Said request shall be effected by notice to the President of the Medical Staff with a copy to the Administrator. If the petitioner does not request a hearing within the time and in the manner herein above set forth, s/he shall be deemed to have accepted the recommendation, decision, or action involved and it shall thereupon become the final action of the Medical Staff. Such final recommendation shall be considered by the Governing Body within forty-five 45 days of the date the petitioner's right to request a hearing expires. The Governing Body shall make a final decision on the recommendation as expeditiously as possible thereafter.

9.3-3 Time and Place for Hearing

Upon receiving a request for hearing, the President, within thirty-five (35) days after the date of receipt of the request, shall schedule and arrange 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, nor more than ninety 90 days from the date of receipt of the request for a hearing by the President; provided, however, that when the request is received from a petitioner who is under a suspension which is then in effect, the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed forty-five 45 days from the date of receipt of the request for hearing by the President.

9.3-4 Notice of Charges

As part of, or together with the notice of hearing required by Section 9.3-3 above, the President, on behalf of the Medical Staff Executive Committee, shall state in writing, the acts or omissions with which the petitioner is charged including a list of the charges in question or the grounds upon which the application was denied, where applicable. If either party, by notice, requests a list of witnesses, then each party, within fifteen (15) days of such request, shall furnish to the other a written list of the names and addresses of the individuals, as far as is then actually anticipated, who will give testimony or evidence in support of that party at the hearing. The witness list shall be amended when additional witnesses are identified.

9.3-5 Judicial Hearing Committee

When a hearing is requested, the President shall appoint a Judicial Hearing Committee consisting of at least three (3) members, and alternates as appropriate. The members selected to serve on the Judicial Hearing Committee shall be impartial and shall not have actively participated in the formal consideration of the matter at any previous level. The President shall designate a Chair who shall preside in the manner described in Sections 9.4-1 and 9.4-3 below, and handle all pre-hearing matters and preside until a hearing officer, as described in Section 9.4-3 below, is appointed.

9.3-6 Failure to Appear

Failure without good cause of the petitioner to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions involved and it shall thereupon become the final action of the Medical Staff. Such final recommendation shall be considered by the Governing Body within forty-five 45 days of the date of failure to appear. The Governing Body shall make a final decision on the recommendation as expeditiously as possible.

9.3-7 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 Judicial Hearing Committee or its Chair acting upon its behalf on a showing of good cause.

9.4 Hearing Procedure

9.4-1 Pre-hearing Procedure

It shall be the duty of petitioner and the body whose decision prompted the hearing to exercise reasonable diligence in notifying the Chair or Hearing Officer of any pending, or anticipated procedural irregularity, as far in advance of the scheduled hearing as possible, in

order that decisions concerning such matters may expeditiously be made. Objection to any such pre-hearing decisions shall be raised at the judicial hearing and when so raised shall be preserved for consideration at any appellate review hearing.

9.4-2 Representation

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on conduct or professional competency. Accordingly, neither the petitioner, nor the body whose decision prompted the hearing shall be represented at the judicial hearing or the appellate hearing by an attorney at law unless the Judicial Hearing Committee (at the judicial hearing) or the Governing Body (at the appellate hearing), in its discretion, permits both sides to be represented by legal counsel. 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. The petitioner shall be entitled to be accompanied by and represented at such hearings only by a physician, dentist or podiatrist 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 Governing Body, (whichever body's decision prompted the hearing), who shall present its recommendation, decision, or action taken and the materials in support thereof and examine witnesses.

9.4-3 The Hearing Officer

At the request of the petitioner or in its discretion, the Medical Staff Executive Committee, the Judicial Hearing Committee, or the Governing Body, or its designee may appoint a 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 with experience in Medical Staff matters. The hearing officer must not act as a prosecuting officer, an advocate for the Medical Center, Governing Body, Medical Staff Executive Committee, the body whose action prompted the hearing, or the petitioner. If requested by the Judicial Hearing Committee, the hearing officer may participate in the deliberations of such body and be a legal advisor to it, but s/he shall not be entitled to vote. If no hearing officer is appointed, the Chair of the Judicial Hearing Committee shall preside, determine the procedure to be followed, ensure that all participants have a reasonable opportunity to be heard and present evidence, and maintain proper decorum at the hearing.

9.4-4 Record of the Hearing

The Judicial Hearing Committee shall maintain a record of the hearing by one of the following methods: a certified shorthand reporter present to make a record of the hearing or a recording of the proceedings. The cost of any certified shorthand reporter shall be borne by the party requesting same.

9.4-5 Rights of the Parties

At a hearing, both sides shall have the following rights: to challenge Judicial Hearing Committee members and the hearing officer for bias, to call and examine witnesses, to introduce exhibits or other documents, to cross-examine or otherwise attempt to impeach any witness who shall have testified orally on any matter relevant to the issues, and otherwise to rebut any evidence. The petitioner may be called by the body whose decision prompted the hearing and examined as if under cross-examination.

9.4-6 Miscellaneous Rules

The rules of law relating to the examination of witnesses and presentation of evidence shall not apply in any hearing conducted hereunder. Any relevant evidence, including hearsay, shall be admitted by the presiding officer if it is the sort of evidence which responsible persons are accustomed to rely on in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a written statement in support of his/her position and the Judicial Hearing Committee may request such a statement to be filed following the conclusion of the presentation of oral testimony. The Judicial Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

9.4-7 Burden of Going Forward and Burden of Proof

At any hearing involving any of the grounds for hearing specified in Subsections a), b) or h) of Section 9.2, it shall be incumbent upon the petitioner initially to come forward with evidence in support of his/her position. In all other cases, the body whose decision prompted the hearing shall have the duty, initially, to come forward with evidence in support of such decision; thereafter the burden shall shift to the petitioner to produce evidence in support of his/her position.

Subject to the foregoing, the petitioner shall bear the ultimate burden of persuading the Judicial Hearing Committee, by a preponderance of the evidence provided at the hearing, that the reasons for the decision, assigned by the body whose decision prompted the hearing, lacked foundation in fact or that the action or decision recommended by the body whose decision prompted the hearing was otherwise arbitrary or unreasonable.

9.4-8 Adjournment and Conclusion

The hearing officer may adjourn the hearing and reconvene the same at the convenience of the participants. Upon conclusion of the presentation of oral and written evidence and argument, the hearing shall be closed. The Judicial Hearing Committee shall thereupon, outside of the presence of any other person, conduct its deliberations and render a decision and accompanying report.

9.4-9 Basis of Decision

If the Judicial Hearing Committee should find any or all of the charge(s) to be true, it shall impose such form of discipline as it shall find warranted, provided however, that such form of discipline shall not be more stringent than that recommended by the body whose decision prompted the hearing. The decision of the Judicial Hearing Committee shall be based on the evidence produced at the hearing. Such evidence may consist of the following:

Oral testimony of witnesses.

Briefs or written statements presented in connection with the hearing.

Medical Center files regarding petitioner, applications, references, medical records, and other documents which have been made part of the hearing record and any other evidence admissible at the hearing.

9.4-10 Decision and Report of the Judicial Hearing Committee

Within thirty 30 days after final adjournment of the hearing (provided that in the event the petitioner is currently under suspension, this time shall be ten (10) days), the Judicial Hearing Committee shall render a decision which shall be accompanied by a written report that contains findings of fact which shall be in sufficient detail to enable the parties, any appellate review board, and the Governing Body, to determine the basis for the Judicial Hearing Committee's decision on each matter contained in the notice of charges. The decision and report shall be delivered to the Medical Staff Executive Committee, the Administrator and the Governing Body. At the same time, a copy of the report and decision shall be delivered to the petitioner by registered or certified mail, return receipt requested. The decision of the Judicial Hearing Committee shall be considered final, subject only to the right of appeal to the Governing Body as provided in Section 9.5.

9.5 Appeals to the Governing Body

9.5-1 Time for Appeal

Within thirty 30 days after the date of receipt of the Judicial Hearing Committee decision, either the petitioner or the body whose decision prompted the hearing may request an appellate review by the Governing Body. Said request to the Governing Body shall be delivered to the Administrator in writing, in person or by certified or registered mail, return receipt requested. Said request shall include a brief statement of the reasons for the appeal. If such appellate review is not requested within such period, both sides shall be deemed to have accepted the action involved and it shall thereupon become the final action of the Medical Staff. Such final recommendation shall be considered by the Governing Body within forty-five 45 days of the date the petitioner's right to request appellate review expired. The Governing Body shall make a final decision on the recommendation as expeditiously as possible.

9.5-2 Reasons for Appeal

The reasons for appeal from the hearing shall be: a) substantial failure of any person to comply with the procedures required by these Bylaws or applicable law in the conduct of the hearing and the rendering of the decision so as to deny petitioner a fair hearing; b) the lack of substantive rationality of a Medical Staff Bylaw, Rule or Regulation relied upon by the Judicial Hearing Committee in reaching its decision; and/or c) action taken arbitrarily, unreasonably, or capriciously.

9.5-3 Time, Place and Notice

When appellate review is requested, the Governing Body shall, within thirty-five (35) days after the date of receipt of such an appeal notice, schedule and arrange for an appellate review. The Governing Body 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 for appellate review; provided, however, that when a request for appellate review is from a petitioner who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed forty-five 45 days from the date of receipt of the request for appellate review. The time for appellate review may be extended for good cause by the Governing Body, or Appeal Board (if any).

9.5-4 Appeal Board

When an appellate review is requested, the Governing Body may sit as the appeal board or it may appoint an appeal board, which shall be composed of Governing Body members and shall have at least five (5) 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. Notwithstanding the provisions of Section 9.4-2, the appeal board may be represented by counsel for purposes of receiving advice and assistance on procedural matters.

9.5-5 Hearing Procedure

The proceedings by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Hearing Committee, provided that the appeal board may accept additional oral or written evidence, subject to a showing that such evidence could not have been made available to the Judicial Hearing Committee in the exercise of reasonable diligence. Each party shall have the right to present a written statement in support of his/her position on appeal and, in its sole discretion, the appeal board may allow each party or representative to personally appear and make oral argument. For the purpose of preparation of his/her written statement and, if allowed, oral argument, the petitioner shall be given reasonable access to the record of the judicial hearing and other evidence produced at the hearing.

At the conclusion of oral argument, if allowed, the appeal board may 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 Governing Body its written recommendations as to whether the Governing Body should affirm, modify, or reverse the Judicial Hearing Committee decision, or remand the matter to the Judicial Hearing 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 Governing Body.

9.5-6 Decision

Within thirty 30 days after the conclusion of the appellate review proceedings, the Governing Body shall render a final decision in writing. The Governing Body may affirm, modify, or reverse the Judicial Hearing Committee decision, or, in its discretion, remand the matter for further review and recommendation by the Judicial Hearing Committee or any other body or person. Copies of the decision shall be delivered to the petitioner and to the Medical Staff Executive Committee, by personal delivery or by certified or registered mail, return receipt requested.

9.5-7 Further Review

Except where the matter is remanded for further review and recommendation pursuant to Section 9.5-6, the final decision of the Governing Body following the appeal procedures set forth in this Article shall be effective immediately and shall not be subject to further review. However, if the matter is remanded to the Judicial Hearing Committee or any other body or person, said committee, body or person shall promptly conduct its review and make its recommendations to the Governing Body. 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.

9.5-8 Right to One Hearing

Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one (1) evidentiary hearing and one (1) appellate review on any matter which shall have been the subject of action by either the Medical Staff Executive Committee or the Governing Body or by both.

Whenever an action is approved by the Medical Staff Executive Committee which provides hearing rights under this Article IX, and that action is based on the same facts and the actions are identical or substantially identical for the Medical Staff of LLUCH and LLUMC only one hearing will be available to the affected practitioner. The hearing shall be a consolidated hearing conducted under Article IX of all sets of Medical Staff Bylaws. Any procedural issues from this consolidated hearing process shall be decided by the Hearing Officer or, in the absence of a hearing officer, the Chair of the Judicial Hearing Committee under Section 9.4-3 of these Bylaws.

9.6 Exception to Hearing Rights

Any report, information or accusation filed, any testimony given, or any action recommended pursuant to the procedures prescribed by these Bylaws shall be deemed a privileged communication. Each applicant to the Medical Staff and each member of the Medical Staff waives any right to personal redress against the Medical Staff or any committee thereof, the Review Panel, the Governing Body, or any members thereof, or to any action taken under this Article IX.

9.6-1 Closed Staff or Exclusive Use Departments and Medico-Administrative Officers

Closed Staff or Exclusive Use Clinical Services. The fair hearing rights of Articles VIII and IX do not apply to a practitioner whose application for Medical Staff membership and privileges was denied on the basis the privileges s/he seeks are granted only pursuant to a closed staff or exclusive use policy. Such practitioners shall have the right, however, to request that the Governing Body review the denial and the Governing Body shall have the discretion to determine whether to review such a request and, if it decides to review the request, to determine whether the practitioner may personally appear before and/or submit a statement in support of his/her position to the Governing Body.

Medico-Administrative Officer. The fair hearing rights of Articles VIII and IX do not apply to those persons serving the Medical Center 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 Medical Center. However, the hearing rights of the preceding sections of Articles VIII and IX 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, unless the contract includes a specific provision establishing alternative procedural rights applicable to such decisions.

9.6-2 Allied Health Professionals

An AHP shall have the right to challenge any action that would constitute grounds for a hearing under Section 9.2 of these Bylaws, by filing a written grievance with the Chief of the Clinical Service to which the AHP has been assigned and in which s/he has practice privileges or the right to render the services in question, within fifteen (15) days of such action. Upon receipt of such a grievance, the Clinical Service Chief shall initiate a careful

investigation and afford the affected AHP an opportunity for an interview before the Clinical Service Committee. The Clinical Service Committee shall include, for the purpose of this interview, an AHP or AHPs holding the same or similar license or certificate as the affected AHP. Such AHPs shall be appointed to the committee for this purpose by the Clinical Service Chief. Before the interview, the AHP shall receive written notice of the specific reasons for the action and a copy of any documents or other information forming the basis for the action. At the interview, the AHP may present information relevant thereto. A record of the findings of such interview shall be made. Thereafter, the Clinical Services Committee shall make a written report of its findings and recommendations to the Medical Staff Executive Committee (MSEC) which shall act thereon. A copy of the report shall be provided to the affected AHP at least fifteen (15) days prior to the MSEC meeting where action will be taken on the recommendation. The affected AHP may submit a written statement of position to the MSEC. At its meeting, the MSEC shall consider all material presented to the Clinical Service Committee, the interview record, the Clinical Service Committee recommendation and the AHPs written statement, if any, used in reaching its decision. The action of the MSEC shall be final, subject to approval by the Governing Body. This Section provides the exclusive hearing rights for AHPs, which rights must be utilized prior to initiation of a lawsuit or any other legal action.

Section 1.10 Article X: Officers

10.1 Officers of the Medical Staff

10.1-1 Identification

The elected officers of the Medical Staff shall be a President, a Senior Vice-President, a Vice President, a Secretary, and a representative to the American Medical Association and the California Medical Association Organized Medical Staff Sections (CMA-OMSS).

10.1-2 Chief of Staff and Associate Chiefs of Staff

Chief of Staff:

The Chief of Staff is a member of the Active Staff or Administrative Staff who shall be the Dean of the Loma Linda University School of Medicine OR a qualified member of the Active Staff designated by the Dean.

The Chief of Staff shall be the primary liaison between the Loma Linda University School of Medicine and the Medical Staff. The Chief of Staff shall serve as an ex-officio member, with vote, of all Medical Staff committees except for the Physician Well Being Committee.

Associate Chiefs of Staff:

The Associate Chief(s) of Staff (2) are Active members of the Medical Staff and is-are appointed by the Chief of Staff in consultation with the President of the Medical Staff and subject to confirmation by the MSEC and the Governing Body.

The Associate Chief(s) of Staff shall serve as ex-officio member, with vote, of all Medical Staff committees except they will not serve on the Physician Well Being Committee.

10.1-3 Qualifications of Officers

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

10.1-4 Selection of Elected Officers

Elected Officers shall be nominated according to the process described in the Nominating Committee portion of these Bylaws. Elected Officers shall be elected at the annual meeting of the Medical Staff each year to replace those who are about to complete their term of office. Only Active Staff members shall be eligible to vote for Elected Officers. Voting shall be by secret written ballot, mailed at least thirty 30 days prior to the annual meeting and must be received no later than ten (10) days prior to the annual meeting. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote, the candidate receiving the fewest number of votes shall be eliminated from the slate and a runoff election shall be held promptly between the remaining candidates. This runoff election process shall be repeated until one (1) candidate receives a majority vote.

10.1-5 Term of and Succession of Officers

Term of office commences on July 1. The term of office for the President, Senior Vice President, Vice-President and Secretary shall be for one year. The term of office for the OMSS Representative shall be for five (5) years. All other Officers serve until a successor is elected, unless s/he shall sooner resign or be removed from office. Each Elected Officer listed above may be elected to a second term. The term of appointment for the Chief of Staff and Associate Chief of Staff shall be continuous until replaced.

10.1-6 Removal of Other Officers

Except as otherwise provided in these Bylaws, removal of an Officer may be initiated by the Medical Staff Executive Committee or upon the written request of twenty-percent (20%) of the members eligible to vote for officers. Such removal may be effected by a majority vote of the Medical Staff Executive Committee members and a two-thirds (2/3) majority vote of the members eligible to vote for officers. Voting on removal of an elected officer shall be by secret written mail ballot. The written mail ballots shall be sent to each voting member at least twenty-one (21) days before the voting date. The ballots shall be counted by the Secretary of the Medical Staff (except when s/he is the subject of the balloting, in which case the President of the Medical Staff shall count the ballots) and the Director of Medical Staff Administration. Any medical staff officer may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude by vote of two-thirds (2/3) majority of the eligible members of the Medical Staff Executive Committee and with the approval of the Governing Body whose approval shall not be withheld unreasonably.

10.1-7 Vacancies in Other Offices

In the case of vacancy in the office of President, the Senior Vice President shall immediately assume the office of President. In the case of vacancy in the office of Senior Vice President, the Vice-President shall immediately assume the office of Senior Vice President. In the case of a vacancy in the offices of Vice-President, OMSS Representative, or Secretary, the President shall appoint and the Medical Staff Executive Committee shall confirm an eligible Medical Staff member to serve in that office until the next election.

10.2 Duties of Elected Officers

10.2-1 President

The President shall serve as the Chief Executive Officer of the Medical Staff responsible for ensuring the proper functioning of the Medical Staff in fulfilling its delegated responsibilities for the quality of patient care rendered in the Medical Center. The President shall:

a) Act in coordination and cooperation with the Administrator in all matters of mutual concern within the Medical Center;

b) Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

c) Serve as Chair of the Medical Staff Executive Committee;

d) Serve as an ex-officio member of all other Medical Staff committees, except for the Physician Well Being Committee, with vote;

e) Be responsible for the enforcement of the Medical Staff Bylaws and Rules and Regulations, for the implementation of sanctions where indicated, and for the

Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

f) Be authorized to take provisional action on behalf of the Medical Staff pending action by the next meeting of the Medical Staff Executive Committee meeting:

g) Nominate, in consultation with the Chief of Staff for Medical Staff Executive Committee approval, Committee Chairs, and in consultation with the Committee Chair the members to all standing and special multi-disciplinary Medical Staff committees, except where otherwise provided by these Bylaws or by Medical Staff Rules and Regulations;

h) Represent the views, policies, needs, and grievances of the Medical Staff to the Governing Body and to the Administrator;

i) Receive and interpret the policies of the Governing Body to the Medical Staff, and report to the Governing Body on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;

j) Be a spokesperson for the Medical Staff in its external professional and public relations;

k) Make the recommendation for the granting of all Temporary Privileges;

l) Perform such other functions as may be assigned to him/her by these Bylaws, by the Medical Staff membership, by the Medical Staff Executive Committee or by the Governing Body.

10.2-2 Senior Vice President

The Senior Vice President, in the absence of the President, shall assume all duties and have the authority of the President; be a member of the Medical Staff Executive Committee, the Bylaws Committee, the Credentials Committee, and the Professional Practice Committee; serve as alternate Representative to the OMSS; (unless he/she is not a member of the California Medical Association in which case an alternate representative shall be appointed by the President); perform such other duties as may be assigned to him/her by these Bylaws, by the membership, by the Medical Staff Executive Committee, or by the Governing Body.

10.2-3 Vice President

The Vice President shall, in the absence of the Senior Vice President, assume all duties and have the authority of the Senior Vice President; be a member of the Medical Staff Executive Committee, the Bylaws Committee, the Credentials Committee, and the Health Information Systems Committee, assisting the Health Information Systems Committee Chair in resolving chart documentation and completion issues; perform such other duties as may be assigned to him/her by these Bylaws, by the membership, by the Medical Staff Executive Committee, or the Governing Body.

10.2-4 CMA-OMSS Representative

The CMA-OMSS Representative shall be a member of the Medical Staff Executive Committee and the Bylaws Committee; shall report periodically to the Medical Staff Executive Committee the issues and actions from the OMSS sessions affecting medical staff affairs; shall convey to the OMSS sessions the interests and desires of the medical staff as directed by the Medical Staff Executive Committee; perform such other duties as may be

assigned by these Bylaws, by the membership, by the Medical Staff Executive Committee, or the Governing Body. The CMA-OMSS representative is exempt from the requirement of being Active status.

10.2-5 Secretary

The Secretary shall be a member of the Medical Staff Executive Committee, Bylaws Committee, and the Credentials Committee; and shall be responsible for maintaining a roster of members; keeping accurate and complete minutes of all Medical Staff Executive Committee and Medical Staff meetings; calling meetings on the order of the President; attending to all correspondence; reviewing all minutes of all Medical Staff committees and submitting a summary of these minutes to the Medical Staff Executive Committee monthly; and performing such other duties as ordinarily pertain to the office or as may be assigned to him/her.

Section 1.11 Article XI: Clinical Services

11.1 Organization of Clinical Services

Each Clinical Service shall be organized as a separate part of the Medical Staff and shall have a Chief who shall be responsible for the overall supervision of the clinical work within that Clinical Service.

11.2 Designation of Current Clinical Services

Anesthesiology

Critical Care

Emergency Medicine

Family Medicine

Hospital Dentistry

Medicine

Neurology

Neurosurgery

Obstetrics and Gynecology

Ophthalmology

Orthopaedic Surgery

Pathology and Laboratory Medicine

Pediatrics

Physical Medicine and Rehabilitation

Preventive Medicine

Psychiatry

Radiation Medicine

Radiology

Surgery

VA11.3 Assignment to Clinical Services

Each practitioner shall be assigned membership in only one (1) Clinical Service, but may be granted clinical privileges in one or more of the other Clinical Services. The Credentials Committee shall determine which Clinical Service each practitioner shall be assigned to based on the practitioner's training and practice setting. The exercise of privileges within each Clinical Service shall be subject to the Rules and Regulations thereof and to the authority of the Chief of Service. "Clinical Service Rules and Regulations and amendments thereto shall be proposed by the Chief of Service, reviewed by the Credentials Committee and recommended to, and must be approved by, the Medical Staff Executive Committee prior to effectuation."

11.4 Chief of Service

11.4-1 Selection

The Service Chiefs of the LLU Medical Center shall be appointed by the Dean of the Loma Linda University School of Medicine (LLUSOM).

11.4-2 Qualifications, Designation, and Term of Office

When the Clinical Service corresponds to only one department of LLUSOM the Chief of Service shall:

Be the chair of the corresponding department of LLUSOM or a designee appointed by the Dean.

Be a member of the Active Staff. In the event that the Chair of the corresponding department of LLUSOM is not a member of the Active Staff, he/she shall designate a member of the Active Staff to be Chief of Service.

Be certified by the specialty board corresponding to the major clinical activities of the Clinical Service or demonstrate comparable competence through a combination of training and experience to the satisfaction of the Credentials Committee and the Medical Staff Executive Committee.

Be confirmed by the Medical Staff Executive Committee.

Continue in office as long as s/he is Chair of the corresponding department of LLUSOM or until the Chair of the corresponding department of Loma Linda University School of Medicine designates another individual to serve as Chief of Service.

When the Clinical Service corresponds to more than one department of LLUSOM, the Chief of Service shall:

a) Be nominated to be Chief of Service by the Chief of Staff from among the Chairs of one of the corresponding departments.

b) Be confirmed by the Medical Staff Executive Committee

c) Be a member of the Active Staff

d) Be certified by a specialty board corresponding to one of the major clinical activities of the Clinical Service

e) Continue in office until a replacement is recommended by the Chief of Staff and confirmed by the Medical Staff Executive Committee

The Chief of Hospital Dentistry Service shall:

a) Be the Dean of Loma Linda University School of Dentistry or designee.

b) Be a member of the Active Staff.

c) Be subject to approval by the Medical Staff Executive Committee.

d) Continue in office as long as s/he is Dean of Loma Linda University School of Dentistry or until he/she designates another individual to serve as Chief of Hospital Dentistry.

11.4-3 Duties of Chiefs of Service

Each Chief of Service shall have the following authority, duties and responsibilities:

a) Determine and manage clinically related and administrative activities within the Service unless such administrative activities are already provided by the Medical Center.

b) Maintain continuing surveillance of the professional performance of all members with delineated clinical privileges within the Service with appropriate documentation thereof.

c) Continuously assess and improve the quality of patient care, treatment and services, and maintain Quality Improvement programs, as appropriate.

d) Recommend to the Medical Staff through the Credentials Committee, the criteria for granting clinical privileges that are relevant to care provided in the Service.

e) Make recommendations to the Medical Staff through the Credentials Committee concerning granting or withholding appointments and/or reappointments, delineation of clinical privileges and release from IPPE/Proctoring requirements for each member of the Service.

f) Determine the qualifications and competence of Service personnel who are AHP LLIPs as provided in Article V of these Bylaws.

g) Recommend corrective action with respect to practitioners in the Clinical Service to the Medical Staff Executive Committee.

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

i) Access and recommend to the relevant Medical Center authority space issues, resource needs, and off-site resources needed for safe patient care, treatment, and services not rendered on site by the Service or the Medical Center.

j) Develop and implement Clinical Service programs and appoint appropriate Clinical Service Committees.

k) Develop and implement policies and procedures that guide and support the provision of care, treatment and services; the Medical Staff Bylaws, Rules and Regulations and Policies, and the Rules and Regulations of the Service (if any).

l) Appoint the Chair of the Service Quality Improvement Committee with confirmation by the Patient Safety and Accountability Committee Chair and Patient Safety Officer.

m) Appoint any Graduate Medical Education Program Directors in conjunction with the DIO-GME and Chief of Staff.

n) Enforce and implement Medical Staff Bylaws, Rules, Regulations and Policies, and Medical Center policies within the Clinical Service and actions taken by the Medical Staff Executive Committee and by the Governing Body.

o) Cooperate with the Medical Center leadership to integrate the Clinical Service into the primary function of the Medical Center and for cooperating with the nursing

service and the Medical Center administration in matters affecting patient care, including space, personnel, supplies, special regulations, standing orders, and techniques.

p) Coordinate and integrate interdepartmental and intradepartmental services.

q) Develop and implement Service programs for the orientation and continuing medical education of all persons in the specialty or specialties represented in the Service.

r) Prepare such annual reports, pertaining to the Clinical Service as may be required by the Medical Staff Executive Committee or the Governing Body.

s) Report to the Medical Staff, through its committee structure professional and administrative activities within their Clinical Service.

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

u) Perform such other duties commensurate with his/her office as may from time to time be reasonably requested of him/her by the President, the Medical Staff Executive Committee, or the Governing Body.

11.5 Functions of Clinical Services

The primary responsibility delegated to each Clinical Service is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the Clinical Service.

To carry out this responsibility, each Clinical Service shall:

a) Establish its own criteria consistent with the policies of the Medical Staff and the Governing Body, for the recommendation of clinical privileges within the Clinical Service;

b) Conduct patient care review for the purpose of analyzing, reviewing, and evaluating the quality of care provided within the Service. Such evaluations shall be conducted monthly, or in accordance with such procedures as may be adopted by the Patient Safety and Reliability Committee. Each surgical service shall also conduct a comprehensive tissue review and review of the appropriateness and acceptability of the surgical procedure followed. Endoscopic procedure use will be reviewed for appropriateness and complications by the Clinical Service employing such procedure;

c) Meet at least four times per year for the purpose of reviewing and analyzing patient care review findings and the results of the Clinical Service's other review, evaluation and monitoring activities and for the performance or reception of reports on other Clinical Service and Medical Staff functions. Based on such reviews, appropriate reports shall be prepared and submitted detailing the analysis and recommendations for improving quality of care;

d) Conduct or participate in, and make recommendations regarding the need for continuing education programs;

e) Monitor, on a continuing and concurrent basis, adherence to: (1) Medical Staff and Medical Center policies and procedures; (2) requirements for alternate coverage and

for consultations; (3) sound principles of clinical practice; and (4) fire and other regulations designed to promote patient safety;

f) Coordinate the patient care provided by the Clinical Service members with nursing and ancillary patient care services and with administrative support services.

11.6 Clinical Service Status

The functions of evaluating and improving the quality of care provided within LLUMC and peer review of Service members by each Service are processes protected by California Evidence Code Section 1157.

Each Service is considered by the LLUMC Medical Staff to be a Medical Staff Committee, whether meeting as a whole or in designated subcommittees, in the furtherance of these functions.

11.7 Clinical Sections

Clinical Service Sections may be created, removed or combined as appropriate from time to time by action of the Clinical Service with approval of the MSEC. The organization, duties and responsibilities of each Clinical Section shall be determined by the Clinical Service, subject to approval of the MSEC or by the MSEC on its own initiative.

Section 1.12 Article XII: Committees

12.1 General

12.1-1 Designation and joint meetings

The Committees described in this Article shall be the standing committees of the Medical Staff. Subcommittees of these standing committees may be established to facilitate quality improvement, peer review and related functions of the standing committee(s). These subcommittees will be established by action of the Chair of a standing committee or the President of the Medical Staff. Subcommittees will report to their respective standing committee. In addition, special committees may be created by the President, subject to approval by the Medical Staff Executive Committee on an ad-hoc basis to perform specified tasks. Such committees shall terminate at the end of the Medical Staff year unless they are renewed by the Medical Staff Executive Committee. Medical Staff committees shall report to and be responsible to the Medical Staff Executive Committee for their duties and for the duties of any subcommittee(s). All standing committees, subcommittees and special committees are Medical Staff committees subject to the protection of California Evidence Code Section 1157.

Recognizing the integral relationship of LLUCH and the LLU Medical Center, any Medical Staff committee of the Medical Center may meet in joint session with its corresponding committee at LLUCH. In cases of such joint meetings, the minutes, recommendations and actions taken must clearly demonstrate the Medical Staff to which they apply or that the application is to both Medical Staffs.

12.1-2 Designation of Committee Members and Chairs

Except as otherwise specified in these Bylaws, the members and Chairs of standing and special committees shall be nominated by the President, in conjunction with the Chief of Staff, subject to the Medical Staff Executive Committee's approval. Committee members shall be appointed by the President of the Medical Staff in consultation with the Chair of the respective Committee. If the Chair is unable to attend a meeting, the Chair or the Medical Staff President shall appoint a substitute Chair for that meeting. Only Active, or in special circumstances a member of the Administrative Medical Staff may serve as Chairs of Medical Staff committees. A majority of the voting membership of each committee shall be members of the Medical Staff. All members of the Medical Staff committees may vote, other than ex-officio non-voting members and invitees.

The Medical Staff President, the Chief of Staff, and the Vice Chief of Staff shall be ex-officio members, with the right to vote of all Medical Staff Committees except the Physicians Well Being Committee.

The President may appoint ex-officio non-voting members to Medical Staff Committees, including persons (physicians or non-physicians) who are not Medical Staff members. Such ex-officio members provide services, expertise, and/or resources to the Committee and may attend the meetings of the Committee to which they are appointed and assist the Committee in carrying out its duties as appropriate; but they may not vote on Committee matters.

The President may appoint physicians and dentists who are in graduate medical education training programs as voting members of Medical Staff committees. Such members may serve as long as they remain in training or until the end of the staff year, whichever is sooner.

12.1-3 Committee Member Terms, Removal and Vacancies

Unless otherwise specified, a Committee member shall be appointed for a term of one (1) year commencing on July 1, and shall serve for said term and until his/her successor is appointed, unless s/he resigns or is removed from the Committee.

Any Committee member who is appointed by the President or a Chief of Service may be removed by a majority vote of the Medical Staff Executive Committee. The removal of any committee member who is automatically assigned to a Committee because s/he is a general officer or other official, shall be governed by the provisions pertaining to removal of such officer or official.

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

12.1-4 Meeting Frequency and Procedures

Committees shall meet at least once each Medical Staff year and as required pursuant to these Bylaws.

Committee meetings shall be conducted and documented in the manner specified for such meetings in Article XIII.

12.2 Medical Staff Executive Committee

12.2-1 Composition

The Medical Staff Executive Committee (MSEC) shall include in its membership Active members of the Medical Staff who are physicians and may include in its membership Active members of the Medical Staff who are other licensed independent practitioners.

The MSEC shall consist of the following voting members:

Medical Staff members: elected Officers of the Medical Staff; the Chief of Staff, the Vice Chief of Staff, the Chiefs of Clinical Services or their designee, five (5) at-large members, one who has an active inpatient practice from a surgical service, one who has an active inpatient practice from a non-surgical service, one from a hospital-based service (Anesthesia, Emergency Medicine, Pathology & Laboratory, Radiation Medicine, and Radiology), one chosen to represent those Medical Staff members who are not part of the full time faculty of LLUSOM, and one from those Medical Staff members whose clinical activities are primarily in outpatient settings; the Immediate Past-President of the Medical Staff; one additional Past-President chosen for his/her familiarity with the history and function of the Medical Staff at LLUMC, the Chairs of the Credentials Committee, Chair of the Bylaws Committee, the Patient Safety and Reliability Committee, the Graduate Medical Education Committee and the Health Information Systems Committee, the CMA-OMSS representative and the Medical Staff President from Loma Linda University Children's Hospital. The CMA-OMSS representative and Medical Staff Presidents are exempt from the Active Status voting requirement.

Non-Medical Staff/non-voting attendees:

President/CEO of Medical Center

CFO of Hospital

VP of Patient Care Services

Director of Quality Management

Directors of Risk Management/Compliance

Director of Palliative Care

DIO-GME

Residents as designated by the MSEC

12.2-2 Officer Positions on MSEC

The President, Sr. Vice President, and Secretary shall serve as Chair, Vice-Chair, and Secretary of the Medical Staff Executive Committee, respectively.

12.2-3 MSEC Members–At-Large

a) The Nominating Committee (Section 12.15) shall nominate five (5) members-at-large from clinical services as specified in Section 12.2-1. Additional nominations may be made by petition in accordance with Section 12.15-3. Five (5) from these nominees will be elected at the annual meeting in the manner specified in Section 10.1-4. Members-at-Large may be removed from the Medical Staff Executive Committee pursuant to Section 10.1-6, which provides the process for removal of elected officers.

12.2-4 Duties

The duties of the Medical Staff Executive Committee shall be to:

a) Represent and act on behalf of the Medical Staff, between meetings of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

b) Coordinate the activities and general policies of the Medical Staff not otherwise established as the responsibility of the Clinical Services and Sections;

c) Receive, through delivery to the President, and act upon Committee reports, such action to be reflected in the minutes of the Medical Staff Executive Committee, and to receive and maintain copies of the minutes of all committees;

d) Implement policies of the Medical Staff not otherwise the responsibility of the Clinical Services;

e) Provide liaison between the Medical Staff, the Administrator, and the Governing Body;

f) Recommend action to the Administrator on matters of a medico-administrative nature;

g) Make recommendations on Medical Center management matters, such as long-range planning, to the Governing Body through the Administrator;

h) Fulfill the Medical Staff's accountability to the Governing Body for the medical care rendered to patients in the Medical Center;

i) Ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Medical Center;

j) Provide for the preparation of meeting programs either directly or through delegation to a program committee or other suitable agent;

k) Review the recommendations of the Credentials Committee regarding the credentials of applicants and make recommendations for Medical Staff membership, assignments to Clinical Services, and delineation of clinical or practice privileges;

l) Review periodically information available regarding the performance and clinical competence of Medical Staff members, other practitioners, and AHPs with practice privileges, and, as a result of such reviews, make recommendations for reappointments and renewals or changes in clinical or practice privileges;

m) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, AHPs and other practitioners including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;

n) Report at each general Medical Staff meeting;

o) Perform such other functions as may be assigned to it by these Bylaws, by the Medical Staff, or by the Governing Body.

12.2-5 Meetings

The Committee shall meet at least four times per year.

12.3 Bylaws Committee

12.3-1 Composition

The Bylaws Committee shall be composed of the following Medical Staff members: the Chair, who shall have been a Past President of the Medical Staff, the current President, the two (2) Immediate past Presidents of the Medical Staff of the Medical Center or Children's Hospital, the Senior Vice President of the Medical Staff, the Vice President of the Medical Staff, the Secretary of the Medical Staff, the Chair of the Credentials Committee, the CMA-OMSS representative(s), and four (4) additional voting members who are Medical Staff members.

Non-Medical Staff non-voting members who are representatives, respectively, from: Health Information Management, Patient Safety and Reliability, a nursing professional and Medical Staff Administration Support Staff. Others may be invited as necessary.

12.3-2 Duties

The Committee shall:

Conduct an annual review of the Bylaws and the Rules, Regulations, procedures, and forms promulgated in connection therewith;

Submit recommendations to the Medical Staff Executive Committee for approval of changes in these documents;

Receive and consider all additional matters specified in subparagraph a) as may be referred by the Medical Staff Executive Committee, the Credentials Committee, the Clinical Services, the Vice Chief of Staff, the Medical Staff President or the Administrator.

12.3-3 Meetings

The Committee shall meet as needed but at least annually.

12.4 Cancer Committee

12.4-1 Composition

The Cancer Committee shall consist of the following:

Medical Staff members: a Diagnostic Radiologist, Pathologist, Surgeon, Medical Oncologist, Radiation Oncologist and a Cancer Liaison Physician, and the Medical Director of the Cancer Center.

Other Non-Medical Staff required members are: The Cancer Program administrator, an oncology nurse, a social worker, a certified tumor registrar, a quality management representative, and a palliative care team member.

Other members may be appointed as needed.

12.4-2 Duties

The Cancer Committee is a multidisciplinary committee and shall:

a) Be responsible for a establishing cancer program goals, monitoring program activities, evaluating patient outcomes and improving care;

b) Be responsible for cancer educational activities;

c) Be responsible for a functional hospital cancer registry;

d) Provide consultative Tumor Board/cancer conferences for inpatients and outpatients. Review and evaluate the quality, safety, and appropriateness of patient care within the oncology units and report these findings to the Patient Safety and Reliability Committee;

e) Coordinate program activities for compliance to the American College of Surgeons Cancer Program Accreditation Requirements.

12.4-3 Meetings

The Committee shall meet at least four times per year.

12.5 Clinical Service Committees

12.5-1 Composition

Each Clinical Service designated in Article XI shall have, as appropriate, a Clinical Service Committee consisting of not less than three (3) Active Staff members who shall be appointed by the relevant Chief of Service. The Chief of Service may designate the Clinical Service as a whole to act as the Committee. The Chief of Service, or designee, shall act as Chair of the Clinical Service Committee.

12.5-2 Duties

Each Clinical Service Committee shall assist the Chief of the Clinical Service to carry out the functions described in Article XI.

12.5-3 Meetings

Each Clinical Service Committee shall meet at least four times per year.

12.6 Credentials Committee

12.6-1 Composition

The Credentials Committee shall consist of the following:

Medical Staff Members: President, Senior Vice President, , Vice President, and Secretary, of the Medical Staff, the two (2) Immediate Past Presidents of the Medical Staff, the Chair of the Patient Safety and Reliability Committee, the Chair of the Graduate Medical Education Committee, and others as nominated by the President and approved by the MSEC.

Non-Medical Staff attendees shall be a representative from Medical Center Administration.

12.6-2 Duties of the Committee

The Committee shall:

a) Review and evaluate the qualifications of each applicant for initial appointment, reappointment, or modification of appointment and /or clinical or practice privileges and, in connection therewith, obtain and consider recommendations from the Deans of the Loma Linda University School of Medicine and School of Dentistry, and from the appropriate Chief(s) of Service. In fulfilling its responsibilities, the Committee shall take appropriate steps to ensure that the applicant has fulfilled all requirements of these Bylaws related to appointment, reappointment, and/or clinical or practice privileges;

b) Submit reports to the Medical Staff Executive Committee monthly in accordance with Articles V, VI, and VII of these Bylaws on the qualifications of each applicant for Medical Staff membership or particular clinical or practice privileges. Such reports shall include recommendations with respect to appointment, staff category, Clinical Service affiliation, clinical or practice privileges, or specified services, and special conditions attached thereto.

12.6-3 Duties of the Chair of the Committee

The Chair of Credentials Committee shall:

a) Serve as an ex-officio member, with vote, of all other Medical Staff committees, including the Medical Staff Executive Committee, except s/he will not serve on the Physicians Well Being Committee;

b) Report credentials and privileging recommendations to the MSEC;

c) Collaborate with Service Chiefs to establish appropriate privileges and rules and regulations for the various services;

d) Collaborate with Service Chiefs to appropriately process appointments and reappointments of Medical Staff members privileges and Allied Health Professionals

(AHP) practice privileges; ensure IPPE/Proctoring requirements are met, and provide timely dissemination of this information to Medical Center employees;

e) Liaison between the Medical Staff and Medical Staff Administration employees.

12.6-3 Meetings

The Committee shall meet at least four times per year.

12.7 Critical Care Committee

12.7-1 Composition

The Critical Care Committee shall consist of the following:

Medical Staff members: Chair of the Patient Safety and Reliability Committee, at least one (1) member of the Medical Staff who is active in each of the following critical care units: Medical Intensive Care Unit, Surgical-Trauma Intensive Care Unit, Neuro-Multidisciplinary Critical Care Service, Coronary Intensive Care Unit, and Cardiothoracic Intensive Care Unit, and a representative from the Anesthesiology Service, Emergency Medicine Service, Pathology and Laboratory Medicine Service, and a representative from Children's Pediatric Intensive Care Unit.

Non-Medical Staff attendees: A representative from Nursing Service, Medical Center Administration, and Medical Center Department of Respiratory Care. Others may be invited as deemed necessary.

12.7-2 Duties

The Committee shall:

a) Review and evaluate the quality, safety, and appropriateness of patient care and transportation of patients within the critical care units;

b) Assist in the development of guidelines for admissions, discharges, and utilization of intensive care beds;

c) Work toward a uniform system of data collection to document the quality and cost of intensive care;

d) Standardize equipment as much as possible to avoid unnecessary duplication and wasteful diversification;

e) Establish uniform protocols for the different intensive care areas where appropriate;

f) Review cases of cardiopulmonary resuscitation (CPR) in the Medical Center and make recommendations regarding policies pertaining to the use of CPR.

12.7-3 Meetings

The Committee shall meet at least four times per year.

12.8 Graduate Medical Education Committee

12.8-1 Composition

The Graduate Medical Education Committee shall consist of the Chair of Graduate Medical Education, Vice Chief of Staff, the Associate Chief of Staff for Education of the Pettis Memorial VA Medical Center, the Director of Medical Education for Riverside University Health System or designee, and at least six 6 representatives of the Medical Staff who are Program Directors of residency programs at the designated institution, at least one (1) Medical Staff member who is not a Program Director, at least one (1) resident physician, the Executive Director of GME office of LLUMC.

12.8-2 Duties of the Committee

The Committee shall be responsible for:

a) Establishing Medical Center policies governing graduate medical education;

b) Facilitating coordination with affiliated institutions participating in graduate medical education programs sponsored by the Medical Center;

c) Approving changes in the size of residency programs and establishing or terminating residency programs;

d) Approving residency program directors;

e) Overseeing all sponsored residency programs for compliance with institutional policies and accreditation requirements.

f) Coordinating Medical Staff quality improvement activities with respect to resident physicians; and

g) Reporting regularly to the MSEC, and at least annually to the Medical Staff and the Governing Board concerning graduate medical education.

12.8-3 Duties of the Chair

a) Serves as an ex-officio member, with vote, of the Medical Staff Executive Committee, Bylaws Committee, Credentials Committee, Professional Practice Committee, Health Information Systems Committee, and Patient Safety and Reliability Committee

b) Collaborates with Service Chiefs to establish appropriate policies and procedures for the various residency programs

c) Collaborates with Service Chiefs to appoint appropriate Residency Program Directors and to oversee and assist the various Program Directors in the conduct of their duties

d) Serves as (or designates) the Designated Institutional Official in relations with the Accreditation Council on Graduate Medical Education

e) Ensures Graduate Medical Education at LLUMC is conducted in accordance with the mission and policies of LLUMC and with applicable governmental rules and regulations, accreditation requirements, and safe practices, and

f) Performs such other duties as ordinarily pertain to the office or as may be assigned to him/her by the membership, by the Medical Staff Executive Committee, by the Medical Staff President or by the Chief of Staff.

12.8-3 Meetings

The Committee shall meet at least four times per year.

12.9 Infection Control Committee

12.9-1 Composition

The Infection Control Committee shall consist of a minimum of six 6 members of the Medical Staff including the Medical Staff member who is the Medical Director of Hospital Epidemiology, a representative from Medical Center Administration, the Chair of the Patient Safety and Reliability Committee, a representative from Nursing Administration, and the Infection Control Practitioners from the Medical Center Department of Hospital Epidemiology. Other members may be added by decision of the Committee Chair.

Other individuals, representing Medical Center support services may be invited to meet with the Committee by decision of the Committee Chair.

12.9-2 Duties

The Committee shall:

a) Approve the Medical Center Infection Control Plan developed by the Medical Center Department of Hospital Epidemiology. This plan shall include:

   1) A set of definitions used to distinguish nosocomial infections from other infections;

   2) A system for identifying, analyzing, and reporting the frequency (and where appropriate, the rate) of selected nosocomial infections;

   3) A system for monitoring the Medical Center environment for selected risks associated with nosocomial infections;

   4) A program for education of Medical Center employees on issues related to control of nosocomial infections;

b) Monitor the implementation of the approved infection control plan;

c) Recommend and/or approve actions to reduce the frequency and/or risk of nosocomial infection in the Medical Center;

d) Review and approve all Medical Center and Medical Staff policies related to infection control. This shall include, but not be limited to:

   1) The Medical Center and/or Medical Staff policy relating to the authority of the Committee or its designee to institute appropriate infection control measures;

   2) Isolation policies and procedures;

   3) Disinfection/sterilization policies and procedures;

   4) Policies regarding the use of equipment in sterile environments;

5) Visitor policies as they impact on infection control;

6) Employee health policies as they relate to infection control and communicable diseases;

e) Approve the selection of antibiotics used in antimicrobial sensitivity testing by the Clinical Laboratory;

f) Report, by way of minutes, the actions taken on items a) through c) above to:

g) The Medical Staff Executive Committee;

h) The Administrator;

i) The Medical Center Senior Vice President for Patient Care Services;

j) The person responsible for Medical Center quality improvement activities.

12.9-3 Meetings

The Committee shall meet at least four times per year.

12.10 Interdisciplinary Practice Committee

12.10-1 Composition

The Interdisciplinary Practice Committee is a committee of the Medical Staff that reports to the Governing Body.

Medical Staff members of this committee are the Chair of the Credentials Committee or designee, and additional members of the Medical Staff nominated by the President and approved by the Medical Staff Executive Committee. Medical Staff membership shall be in compliance with Title 22 requirements.

Non-Medical Staff members: include a representative from Health Information Management, a representative from Advance Practice Nursing, and others as required to meet Title 22 requirements, (even membership between nursing and medical staff).

12.10-2 Duties

The Committee shall perform functions consistent with the requirements of law and regulation. The Committee shall routinely report to the Governing Body and the Medical Staff Executive Committee.

12.10-3 Meetings

The Committee shall meet at least four times per year.

12.11 Medical Ethics Committee

12.11-1 Composition

The Medical Ethics Committee shall consist of at least three (3) physicians who are members of the Active Medical Staff, one (1) of whom shall be designated as Chair, representatives from the Center for Christian Bioethics, and from Nursing Services. Others may be invited as guests to assist with a particular issue at the discretion of the Chair.

12.11-2 Duties

The Committee shall consider and discuss issues of medical ethics relative to medical practice in the Medical Center. The Committee shall also:

a) Conduct retrospective review of consults performed by ethicists;

b) Review Medical Center and Medical Staff policies such as those required by the Patient Self-Determination Act;

c) Participate in the education of patients and members of the Medical Staff in matters relating to ethical issues.

d) Serve as the Medical Staff liaison overseeing ethics consults, and reviewing the ethics call schedule for appropriateness.

The Committee shall submit reports and recommendations to the Medical Staff Executive Committee.

12.11-3 Meetings

The Committee shall meet at least four times per year.

12.12 Health Information Systems Committee

12.12-1 Composition

The Health Information Systems Committee shall consist of the following:

Medical Staff Members: Vice President of the Medical Staff, the Vice Chief of Staff (or designee), the Chair of the Patient Safety and Reliability Committee, two (2) Medical Staff representatives from the Medicine Service, the Surgery Service, and the Pediatric Service, one (1) representative each from the Family Medicine Service, the Emergency Medicine Service, and the Radiology Service, the Chair of the Graduate Medical Education Committee, the Chief Medical Informatics Officer responsible for LLUMC, and one member who is also a member of the Loma Linda University Behavioral Medicine Center Medical Staff.

Non-Medical Staff Invitees: Director of Department of Health Information Management, the Medical Center Chief Information Officer, an individual designated by Medical Center Administration to represent nursing, a Resident physician designated by the DIO-GME, a representative from the Medical Center Office of General Counsel, and the Medical Center VP of Revenue Cycle.

12.12-2 Duties of the Committee

The Committee shall include:

a) Conduct a review of medical records to determine the promptness, adequacy and completeness thereof.

b) Review, organize, and standardize the medical record in its most functional and useful form;

c) Review Medical Staff and Medical Center policies, rules and regulations relating to medical records, including forms, formats, filing, indexing, storage, destruction, and changes therein;

d) Provide liaison with Medical Center Administration and the Health Information Management professional in the employ of the Medical Center in matters relating to medical records;

e) Be responsible for ensuring medical records meet high standards of patient care usefulness and of historical validity;

f) Review the acquisition, implementation, and use of Information Services and the role Information Services plays in quality improvement.

g) Oversee the implementation of the Information Management standards of the Joint Commission.

12.12-3 Duties of the Chair of the Committee

The Chair shall:

a) be responsible for promoting best informatics practices;

b) ensure accurate and reliable collection of patient health information;

c) ensure that health information is accessible to providers;

d) safeguard protected health information;

e) optimize patient-centric and population-based health information systems for quality and safety initiatives;

f) provide regular reports to PSRC and MSEC.

12.12-3 Meetings

The Committee shall meet at least four times per year.

12.13 Patient Safety and Reliability Committee

12.13-1 Composition

The Patient Safety and Reliability Committee shall consist of the following:

Medical Staff Members: A minimum of 12 members of the Medical Staff including the Medical Staff President, the Medical Staff Senior Vice President, the Medical Staff Vice President, the Chair of the Graduate Medical Education Committee, Medical Staff members active in the quality improvement activities of the following Services: Medicine, Surgery, Obstetrics, Pediatrics, Radiology, Anesthesiology, Emergency Medicine, Pathology and Laboratory Medicine, four (4) additional Medical Staff members active in the multidisciplinary quality improvement activities of the Medical Staff,

Non-Medical Staff Members: A maximum of eight (8) members including the LLUMC Patient Safety Officer if not a member of the Medical Staff, the LLUMC Chief Executive Officer, four (4) individuals over various entities as designated by the LLUMC CEO, the VP for Risk management, and the Chief Nursing Officer.

Other individuals, representing Medical Center support services may be invited to meet with the Committee by decision of the Committee Chair.

12.13-2 Duties

The Committee shall include:

a) Advance the science of patient safety and reliability through ongoing education of safety and process improvement principles;

b) With collaboration of the Committee, develop an annual plan of priority focus areas for improvement based on the LLUMC strategic plan;

c) Build an organizational culture of patient safety and reliability through the use of standardized tools and protocols;

d) Develop the infrastructure to support ongoing patient safety and reliability improvement;

e) Oversee and coordinate the performance improvement and peer review-based quality improvement activities of the Medical Staff;

f) Monitor and coordinate activities to ensure compliance with regulatory bodies;

g) Ensure continuous survey readiness throughout health services

h) Provide ongoing, but no less than quarterly, reports of performance improvement to the MSEC, the Quality Committee of the Board and the Executive Board of LLUMC;

12.13-3 Meetings

The Committee shall meet at least four times per year.

12.14 Physician Well Being Committee

12.14-1 Composition

The Physician Well Being Committee shall consist of representatives from the Psychiatry Service, Medical Staff, House Staff, and School of Medicine faculty. Since a primary function of this committee is a support role, representatives should not include those in a position to exercise discipline.

12.14-2 Duties

The Committee shall assist Medical Staff members impaired by chemical dependency, mental illness and/or significant behavioral problems to obtain necessary assistance and/or rehabilitation services.

The specific duties of the Committee shall be to:

a) Receive reports related to the physical, mental or behavioral well-being or impairment of Medical Staff members or AHPs, including self-referrals or referrals from other organization staff, and to review and evaluate such reports for accuracy and credibility.

b) Maintaining informant confidentiality.

c) Refer any affected Medical Staff member or AHP to an appropriate internal or external resource, including the Medical Board of California Diversion Program, for diagnosis and treatment.

d) Monitor any affected Medical Staff members or AHPs progress in and adherence to any treatment program, with specific attention to patient safety, until rehabilitation, or any necessary disciplinary progress, is complete.

e) Safeguard the confidentiality of any Medical Staff member or AHP seeking referral or assistance, except as limited by law, ethical obligation, or as necessary when patient safety is threatened.

f) Report periodically and not less than four times per year, to the Medical Staff Executive Committee as to its activities and the progress of Medical Staff members and AHPs subject to its monitoring without names or other identifiers. To the extent that the Committee identifies a Medical Staff member or AHP who is or may be providing unsafe treatment, it shall report the details of concern, including identity, to the Chief of Staff or designee for appropriate corrective action, including any State or Federally mandated reporting.

g) Educating the Medical Staff and other LLUMC staff about illness and impairment recognition.

12.14-3 Meetings

The Committee shall meet as called by the Chair; at least four times per year.

12.15 Nominating Committee

12.15-1 Composition

A Nominating Committee shall consist of the following: Five (5) Active Medical Staff members each from a different Service, one of which will serve as the Chair, shall be appointed by the Medical Staff Executive Committee at least 120 days prior to the Annual Medical Staff meeting.

12.15-2 Duties

The Nominating Committee shall nominate:

a) One (1) Active Medical Staff Member as nominee for the office of President (a one year term). This individual may have previously served as President but may not be nominated to a term that will result in continuous service of three (3) years or more. It is expected that the individual nominated for President will have at least four (4) years' experience as a member of the Medical Staff Executive Committee and will within the previous three (3) years have served as President or Senior Vice-President or Vice-President.

b) One (1) Active Medical Staff Member as nominee for the office of Senior Vice-President (a one year term). This individual may have previously served as Senior Vice-President but may not be nominated to a term that will result in continuous service of three (3) years or more. It is expected that the individual nominated for Senior Vice-President will have at least three (3) years' experience as a member of the Medical Staff Executive Committee and will within the previous four (4) years have served as Senior Vice-President or Vice-President or Secretary or Member at Large or Chief of Service.

c) One (1) Active Medical Staff Member as nominee for the office of Vice-President (a one year term). This individual may have previously served as Vice-President but may not be nominated to a term that will result in continuous service of three (3) years or more. It is expected that the individual nominated for Vice-President will have at least two (2) years' experience as a member of the Medical Staff Executive

Committee and will within the previous four (4) years have served as Vice-President or Secretary or Member at Large or Chief of Service.

d) One (1) Active Medical Staff Member as nominee for the office of Secretary (a one year term). This individual may have previously served as Secretary but may not be nominated to a term that will result in continuous service of three (3) years or more. It is expected that the individual nominated for Secretary will have at least one (1) years' experience as a member of the Medical Staff Executive Committee and will within the previous five (5) years have served as Member at Large, or Chief of Service.

e) If necessary because of vacancy or end of term of office, one (1) Active Medical Staff Member (who is also a member of the California Medical Association) for the office of CMA-OMSS Representative (a five year term). This individual may have previously served as OMSS Representative. It is expected that the individual nominated for OMSS Representative will have at least two (2) years' experience as a member of the Medical Staff Executive Committee.

f) Five (5) Medical Staff Executive Committee Members at Large (a one year term that is renewable). The nominees shall be selected as follows:

1) One nominee from a surgical service
2) One nominee from a non-surgical service
3) One nominee from a hospital based service (Anesthesiology, Emergency Medicine, Pathology & Laboratory Medicine, Radiation Medicine and Radiology)
4) One nominee from Medical Staff members who are not members of the full time faculty of Loma Linda University
5) One nominee whose clinical activity is primarily in outpatient activities.

12.15-3 Additional Nominations for Elected Officers:

Further nominations may be made for any elected officer position by submitting the name of the candidate to the Chair of the Nominating Committee together with a written petition which is signed by at least fifteen (15) staff members who are eligible to vote. These nominations shall be delivered to the Chair of the Nominating Committee at least fifteen (15) days prior to the mailing of ballots to the members of the Active Medical Staff. Nominations from the floor will not be recognized.

12.15-3 Reporting

The Nominating Committee recommendations shall be presented to the Medical Staff Executive Committee at least sixty (60) days prior to the annual meeting.

12.15-3 Meetings

The Committee shall meet annually as called by the Chair.

12.16 Operating Room Committee

12.16-1 Composition

The Medical Center Operating Room Committee shall consist of the following:

Medical Staff members: Two (2) members from the Anesthesiology Service (the Chair of the Anesthesia QI Committee and one additional Anesthesiologist), one (1) Medical Staff member from the following specialties: Cardiology, Interventional Radiology, Hospital Dentistry, General Surgery, Pediatric Surgery, Gynecology and Obstetrics, Head and Neck Surgery (Otolaryngology), Neurosurgery, Ophthalmology, Orthopedic Surgery, Plastic and Reconstructive Surgery, Cardiothoracic Surgery, Oral & Maxillofacial Surgery, Urology Surgery, other specialties that operate in the Medical Center, the Chair of the Patient Safety and Reliability Committee, the Medical Director of Operating Rooms, Pre-Anesthesia Consultation and Education Medical Director. The Chief of Surgery and the Chief of Anesthesiology (or designees) shall be ex-officio voting members of the Operating Room Committee.

Non-Medical Staff attendees: Executive Director of Perioperative Services, and a representative from Administration.

12.16-2 Duties

The Committee shall:

a) Provide guidance to the Medical Director of the Operating Rooms and the Executive Director of Perioperative Services for the optimal use of the Operating Room within the Medical Center;

b) Discuss problems that arise in regard to the function of the operating suites and make recommendations to the Medical Staff regarding policy;

c) Assist Operating Room Management with overall duties;

d) Provide a forum for communication and coordination for surgeons, anesthesiologists, nursing, other Medical Staff, and hospital employees;

e) Develop management policies for the operating suites (including policies intended to reduce post-op infection risk);

f) Determine which operative procedures require an assistant surgeon or assistant to the surgeon.

g) Provide a mechanism for determing block schedule allocation within the Medical Center Operating Rooms.

12.16-3 Meetings

The Committee shall meet at least four times per year.

12.17 Pharmacy and Therapeutics Committee

12.17-1 Composition

The Pharmacy and Therapeutics Committee shall consist of at least six 6 representatives of the Medical Staff. The Patient Safety Officer shall be an ex officio member with vote. In

addition, there shall be a representative of the Nursing Service, the Director of the Medical Center Pharmacy, and a representative of the Clinical Pharmacy Section of the Pharmacy.

12.17-2 Duties

The Committee shall:

a) Be responsible for the development and implementation of a hospital formulary established and approved by the Medical Staff Executive Committee per the Rules and Regulations L. Drugs and Medications., including the evaluation of clinical data concerning new drugs or preparations requested for therapeutic use in the Medical Center,

b) Be responsible for the development and surveillance of drug utilization policies and practices within the Medical Center;

c) Assist the Medical Staff Executive Committee in the formulation of broad professional policies relating to all drugs used therapeutically in the Medical Center;

d) Serve as an advisory group to the Medical Staff and the Medical Center's Pharmacy Service on matters pertaining to the choice of available drugs;

e) Collaborate with the Loma Linda University Institutional Review Board to recommend to the Medical Staff Executive Committee policies concerning the use and control of investigational drugs and of research in the use of recognized drugs;

f) Review all adverse drug reactions;

g) Recommend guidelines, policies and procedures for the Nutritional Support Service and develop protocols for the safe and effective administration of special nutrition therapy within the Medical Center;

h) Periodically review nutrition related practices and activities in the Medical Center;

i) Recommend (as needed) policies, procedures, and guidelines regarding the safe and effective use of medical devices within the Medical Center.

12.17-3 Meetings

The Committee shall meet at least four times per year.

12.18 Professional Practice Committee

12.18-1 Composition

The Professional Practice Committee shall consist of the following:

Medical Staff members: A minimum of eight (8) members of the Medical Staff including the Chief of Staff, Medical Staff President, the Medical Staff Senior Vice President, the Chair of the Credentials Committee, the Chair of the Patient Safety and Reliability Committee. The Committee shall include Medical Staff members from each of the following Clinical Services: Medicine, Surgery, Anesthesiology, Pediatrics, Obstetrics and Gynecology, Emergency Medicine, Radiology, and Psychiatry (who must also be a member of the Medical Staff of the BMC).

Non-Medical Staff: the CEO/Administrator of the Medical Center, or designee as an ex-officio member; representative(s) from Risk Management; The Director of Patient Safety and Reliability shall be a member. Others may be invited as needed.

12.18-2 Duties

The Committee shall:

a) Review insurance carriers' recommendations regarding ways and means of reducing risks;

b) Review the care provided in selected cases brought to the committee by Risk Management or Medical Center Administration;

c) Make recommendations to the appropriate committees of the Medical Staff or departments within the Medical Center.

12.18-3 Meetings

The Committee shall meet at least four times per year.

12.19 Transfusion Committee

12.19-1 Composition

The Transfusion Committee shall consist of the following:

Medical Staff members: at least six 6 members of the Medical Staff representing these Services: Surgery and/or surgical subspecialty, Gynecology and Obstetrics, Medicine, Pathology and Laboratory Medicine, Pediatrics, and Anesthesiology. Non-Medical Staff: Additional members may be appointed to represent the nursing service and the procurement staff of the Blood Bank.

12.19-2 Duties

The Committee shall be responsible for reviewing the utilization of blood and blood products, all transfusion reactions, and for the development of policies and procedures for the administration of blood and blood products.

12.19-3 Meetings

The Committee shall meet at least four times per year.

12.20 Utilization Management Committee

12.20-1 Composition

The Utilization Management Committee shall consist of the following Medical Staff members: five (5) or more representatives of the Medical Staff, each from various Services and sites of which they practice.

Non-Medical Staff: In addition, the Committee shall have non-voting representatives from each of the following: Medical Center Administration, Medical Center Patient Business Office, Management, Social Work and shall include the Health Information Management Director. The Utilization Review Staff Assistant shall be recorder for the Committee.

12.20-2 Duties

The Utilization Management Committee shall:

a) Function in accordance with all applicable regulatory standards.

b) Conduct utilization review studies designed to evaluate the appropriateness of admissions to the Medical Center, lengths of stay, discharge practices, use of Medical Staff and Medical Center services, and related factors, which may contribute to the effective utilization of Medical Center and physician services. It shall obtain criteria relating to average or normal (usual) lengths of stay by specific disease categories and shall evaluate systems of utilization review employing such criteria. It shall also work toward the assurance of proper continuity of care upon discharge through, among other things, the accumulation of appropriate data on the availability of suitable health care facilities and services outside the Medical Center. The Committee shall communicate the results of its studies and other pertinent data to the entire Medical Staff and shall make recommendations for optimum utilization of Medical Center resources and facilities commensurate with quality of patient care and safety;

c) Formulate a written Utilization Management Plan for the Medical Center. Such plan, as approved by the Medical Staff Executive Committee, must be in effect at all times and must include all of the following elements:

   1) The organization and composition of committee(s) which will be responsible for the utilization management function;

   2) Frequency of meetings;

   3) The types of records to be kept;

   4) The method to be used in selecting cases on sample or other basis;

   5) The definition of what constitutes the period of extended duration of stay;

   6) The relationship of the utilization management plan to claims administration by a third party;

   7) Arrangements for committee reports and their dissemination;

   8) Responsibilities of the Medical Center's administrative staff in support of utilization management;

d) Evaluate the medical necessity for continued Medical Center services for particular patients where appropriate. In making such evaluations, the committee shall be guided by the following criteria:

   1) No practitioner shall have review responsibilities for any extended stay cases in which s/he was professionally involved;

   2) All decisions that further inpatient stay is not medically necessary shall be made by physician members of the committee, and only after opportunity for consultation has been given the attending physician by the committee;

   3) Where there is a significant divergence in opinion following such consultation regarding the medical necessity for continued in-hospital services for the patient, the judgment of the attending physician shall be given great weight;

4) All decisions that further inpatient stay that is not medically necessary shall be given by written notice to the Medical Staff Executive Committee, to the appropriate Chief of Service, to the Administrator, to the attending physician, to the co-admitting practitioner if applicable, and to the patient for such action as may be warranted;

5) Shall maintain a permanent record of its findings, proceedings, and actions, and shall make a report thereof to the Medical Staff Executive Committee after each meeting.

e) Shall report to the Medical Staff Executive Committee and the Board at least four times per year.

12.20-3 Meetings:

The Committee shall meet at least four times per year.

Article XIII: Meetings

13.1 Meetings

13.1-1 Annual Meetings

There shall be an annual meeting of the Medical Staff members. The principal purpose of the meeting shall be to review Medical Staff activities of general interest concerning the review and evaluation of work done in the Clinical Services and the performance of required Medical Staff functions during the preceding year. Officers and committees shall make reports.

13.1-2 Regular Meetings

Regular meetings, including the date, place and time, shall be held as determined by the Medical Staff Executive Committee. The annual meeting shall constitute a regular meeting for purposes of these Bylaws.

13.1-3 Special Meetings

Special meetings of the Medical Staff may be called at any time by the President and shall be called at the request of the Medical Staff Executive Committee, the Governing Body, or one fourth (25 %) of the Active Medical Staff members who submit to the President a signed written request stating the purpose for such a meeting. The meeting must be called within fourteen (14) days after receipt of such request. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

13.2 Committee and Clinical Service Meetings

13.2-1 Regular Meetings

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

13.2-2 Special Meetings

A special meeting of any Committee or Clinical Service may be called by or at the request of the Chair or Chief of Service, as applicable thereof, the Medical Staff Executive Committee, the President, or by at least one-third (1/3) of the group's current members, but by no less than two (2) members.

13.3 Notice of Meetings

Notice stating the place, day, and hour of the annual or any special Medical Staff meeting of any regular or special Committee or Clinical Service meeting not held pursuant to resolution shall be given either personally or by mail to each person entitled to be present thereat not less than five (5) days before the date of such meeting in the manner specified in Section 15.7. Notice of the annual meeting shall be given to the Medical Staff membership at least twenty (20) days prior to the meeting. Any such notice for a meeting of the Medical Staff shall be in writing. Personal attendance at any meeting or written consent to waiver of notice for any meeting signed by a member entitled to such notice shall constitute a waiver of notice of such meeting.

13.4 Quorum

13.4-1 Medical Staff, Committee and Clinical Service Meetings

A quorum is present if at least two (2) active members of the Medical Staff are present unless contested from the floor. If contested, a quorum of fifty percent (50%) of the voting Medical Staff membership shall be required for Medical Staff Executive Committee and Credentials Committee and thirty-five percent (35%) of the voting members of any other Medical Staff Committee. Electronic voting will require participation from at least 20% of those eligible to vote with approval by a simple majority. If qurom is not met, vote will be brought to the annual and/or additional special meeting of the Medical Staff.

13.4-2 Ex-Officio Members

Ex-officio committee members shall have the rights and privileges specified in these Bylaws, except they shall not be counted for the purpose of determining a quorum.

13.5 Manner of Action

Except as otherwise specified, the action of a majority of the members present who are eligible to vote at a Medical Staff, Committee or Clinical Service or Section meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be required by these Bylaws. Action may be taken without a meeting by a Clinical Service, Committee, or the Medical Staff Executive Committee, by a response setting forth the action so taken by a simple majority of those eligible to vote.

13.6 Minutes

Minutes of all meetings shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer and forwarded to Medical Staff Administration for presentation to the Medical Staff Executive Committee. Each Committee and Clinical Service shall also maintain a permanent file of the minutes of each meeting. Minutes, proceedings, and other records of the Medical Staff, the Clinical Services and Sections, and Committees shall be confidential and shall be kept in such a manner as determined by the Medical Staff Executive Committee to preserve their confidentiality.

13.7 Attendance Requirements

13.7-1 Regular Attendance

Each Active Staff member and Provisional Staff member shall be required to attend:

a) The Annual Medical Staff Meeting unless excused by the Medical Staff President.

b) At least fifty percent (50%) of all other Medical Staff meetings duly convened pursuant to these Bylaws unless excused by the Medical Staff President.

c) At least fifty percent (50%) of all meetings of each Clinical Service of which s/he is a member to the extent such attendance is required in the Rules and Regulations of that Clinical Service.

Each Consulting Staff member, Courtesy Staff member or Administrative/Associate Staff member shall be required to attend only such Medical Staff meetings as may be determined

by the Medical Staff Executive Committee and such Clinical Service meetings as may be determined by the Clinical Service in its Rules and Regulations.

13.7-2 Absence from Meetings

Any member who is compelled to be absent from any Medical Staff, Clinical Service, or Committee meeting shall provide to the regular presiding officer thereof the reason for such absence. Failure to meet the attendance requirements of Section 13.7-1 may be grounds for revocation of Medical Staff membership or any of the other corrective actions specified in Section 8.1-4, including, in addition, removal from such Clinical Service or Committee, unless excused for good cause by the Medical Staff Executive Committee for Medical Staff meetings or by the presiding officer for all other meetings. Reinstatement of a Medical Staff member whose Medical Staff membership has been revoked because of absence from meetings shall be made only on application, and any such application shall be processed in the same manner as an application for initial appointment.

13.7-3 Special Appearance

A practitioner whose patient's clinical course is scheduled for discussion at a regular Service meeting or Clinical Service Committee meeting may be required to attend such meeting. Whenever a practitioner's presence at such a meeting is required, the notice to the practitioner shall so state, and shall include a statement that his/her attendance at the meeting at which the alleged deviation is to be discussed is mandatory. Failure to attend after such notice is given may, unless the absence is excused, result in such corrective action as is directed by the Medical Staff Executive Committee, including suspension of all or a portion of the practitioner's privileges.

13.8 Conduct of Meetings

An agenda for each meeting shall be set by the presiding officer after appropriate consultation with interested committees, services or members of the Medical Staff. Unless otherwise specified, meetings shall be conducted according to appropriate rules of order; however, technical failures to follow such rules shall not invalidate action taken at such a meeting.

Section 1.13 Article XIV: Confidentiality, Immunity and Releases

14.1 Authorization and Conditions

By applying for or exercising clinical or practice privileges within this Medical Center, a practitioner or AHP:

a) Authorizes representatives of the Medical Center and the Medical Staff to solicit, provide, and act upon information bearing on his/her professional ability and qualifications.

b) Authorizes third parties and their representatives to provide information, including otherwise privileged or confidential information, concerning him/her to the Medical Center and its Medical Staff. For the purposes of this Article, "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Medical Center.

c) Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article and to the fullest extent authorized by law.

d) Acknowledges that the provisions of this Article are express conditions to his/her application for or acceptance of Medical Staff membership and the continuation of such Medical Staff membership, or to his/her exercise of clinical privileges at this Medical Center, or to his/her application for or acceptance of approval and exercise of practice privileges at this Medical Center.

14.2 Confidentiality of Information

14.2-1 Confidentiality of Information: General

Medical Staff or Committee minutes, files, and records, including information regarding any member or applicant to this Medical Staff or AHP status, 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, or with the express approval of the Medical Staff Executive Committee or its designee.

14.2-2 Breach of Confidentiality

Effective peer review, the consideration of the qualifications of Medical Staff members and applicants, including AHPs to perform specific procedures, the evaluation and improvement of the quality of care rendered in the Medical Center must be based on free and candid discussions. Any breach of confidentiality of the discussions or deliberations of Medical Staff committees is outside appropriate standards of conduct under these Medical Staff Bylaws. It will be deemed disruptive to the operations of the Medical Center and detrimental to quality patient care. A breach of confidentiality shall be a basis for corrective action under these Bylaws.

14.2-3 Agreements to Maintain Confidentiality

As a condition of serving upon any Medical Staff committee, a member, prospective member shall be required to execute and maintain an appropriate confidentiality agreement in a form prescribed by the Medical Staff Executive Committee. If it is determined that a breach of the agreement or of the provisions of these Bylaws regarding confidentiality has or is likely to occur, the Medical Center or Medical Staff Executive Committee are entitled to undertake such action as is deemed appropriate to ensure preservation of confidentiality. Such action may include, in addition to corrective action referenced above, application to the courts for injunctive or other relief.

14.3 Immunity From Liability

14.3-1 For Action Taken

Each representative of this Medical Center, including its Medical Staff members, shall be exempt, to the fullest extent permitted by law, from liability to a practitioner or AHP for damages or other relief for any action taken or statement or recommendation made within the scope of his/her duties as a representative.

14.3-2 For providing Information

Each representative of this Medical Center, including its Medical Staff members, and all third parties shall be exempt, to the fullest extent permitted by law, from liability to a practitioner or AHP for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative concerning such practitioner or AHP.

14.4 Activities and Information Covered

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

1. Applications for appointment, reappointment, clinical privileges, practice privileges, and prerogatives and periodic reappraisals of Medical Staff membership, privileges, and/or prerogatives;
2. Corrective action, hearings and appellate reviews;
3. Medical Center, Clinical Service, Committee, or other Medical Staff activities related to monitoring, maintaining, and improving the quality of patient care, appropriate utilization, and appropriate professional conduct;
4. National Practitioner Data Bank (NPDB) queries and reports, peer review organizations, Medical Board of California and similar reports.

4.5 Releases

Each practitioner or AHP, upon request of the Medical Center, shall execute general and specific releases in accordance with the provisions, tenor, and import of this Article. Execution of such releases shall not, however, be deemed a prerequisite to the effectiveness of this Article.

14.6 Member's Access to File

A Medical Staff member shall be granted access to his/her Medical Staff Credentials file subject to the following provisions:

1. A request for access shall be made by the member to the President of the Medical Staff, or designee from the elected officers of the Medical Staff in writing at least forty-eight (48) hours prior to access;
2. The member may review, and receive a copy of, documents provided by or addressed to the applicant in the Medical Staff Credentials file, the contents of which is defined by Medical Staff policy. Confidential letters of recommendation are not part of the Credentials file;
3. The review by the member shall take place in Medical Staff Administration, during normal working hours, in the presence of an elected officer or designee of the Medical Staff.

Article XV: General Provisions

15.1 Effect and Obligations of Medical Staff Documents

The Medical Staff Bylaws, Rules and Regulations, and Policies are compatible with each other and compliant with law and regulation. The Medical Staff complies with and enforces the Medical Staff Bylaws, Rules and Regulations and Policies by taking action or by recommending action to the Governing Body as appropriate and as provided for in its organizational documents. The Governing Body upholds the Medical Staff Bylaws, Rules and Regulations, and Policies which it has approved.

15.2 Conflict Management

In the event of a conflict between the MSEC and the Medical Staff regarding proposals to adopt or amend the Medical Staff's Rules and Regulations, Medical Staff's Policies and Procedures, or any other matter, the following process shall be followed.

a) A conflict between the MSEC and the Medical Staff shall be identified by either: (1) a majority vote of the MSEC; or (2) by a petition to be signed by at least twenty-five percent (25%) of the Active Medical Staff. Once a conflict is identified, the Chief of Staff or the President of the Medical Staff shall convene a meeting with the petitioner's representative(s).

b) If the conflict is identified by a vote of the MSEC, then the MSEC shall issue a notice to the Medical Staff to identify up to five (5) members of the voting Medical Staff who shall serve as petitioner's representatives within 30 days, through a process determined by the Medical Staff. If the Medical Staff does not identify its representatives in a timely manner, then the Chief of Staff shall appoint five members of the voting Medical Staff to serve as petitioner's representatives.

c) If the conflict is identified by petition of the Medical Staff, the foregoing petition shall include a designation of up to five (5) members of the voting Medical Staff who shall serve as petitioner's representatives. The Medical Staff Executive Committee shall be represented by an equal number of Medical Staff Executive Committee members, and the Chief of Staff or President of the Medical Staff shall select the Medical Staff Executive Committee's representatives.

d) The Medical Staff Executive Committee's and the petitioner's representatives shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Staff Executive Committee, and the safety and quality of patient care at the Medical Center. Resolution at this level requires a majority vote of the Medical Staff Executive Committee's representatives at the meeting and a majority vote of the petitioner's representatives.

e) Unresolved differences regarding a proposed Rule and Regulation or Policy and the information exchanged in relation thereto shall be submitted to the Governing Body for consideration in making its final decision. The Governing Body shall determine the method of communication.

f) Unresolved differences relating to any other matter shall be resolved through the following process. The Chief of Staff or President of the Medical Staff shall call a Special Meeting of the Medical Staff as provided in Section 13.1-3 of these Bylaws.

The sole issue to be considered at that meeting shall be the identified issue in conflict, which shall be resolved as provided in Section 13.5 of the Bylaws.

15.3 Professional Liability Insurance

15.3-1 Professional Liability Insurance

Each member granted clinical or practice privileges in the Medical Center shall maintain in force professional liability insurance in a form of coverage and in not less than the minimum amounts, if any, as from time to time may be determined by the Governing Body, or shall provide other proof of financial responsibility in such manner as the Governing Body may from time to time establish.

15.3-2 Disposition and/or Final Judgment

Each member of the Medical Staff shall report to Medical Staff Administration the disposition and/or final judgment in professional liability cases in which they are involved within thirty 30 days of disposition and/or final judgment.

15.4 Construction of Terms and Headings

Words used in these Bylaws shall be read as the masculine or feminine gender and as the singular or plural as the context and circumstances require. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

15.5 Acceptance of Principles

All members of whatever class or category, by application for Medical Staff membership in this Medical Staff, do thereby agree to be bound by the provisions of these Bylaws, a copy of which shall be delivered to each member upon initial appointment, and a copy of each amendment to these Bylaws promptly after adoption. Any violation of these Bylaws shall subject the applicant or member to such disciplinary action as the Medical Staff Executive Committee or Governing Body shall direct.

15.6 Division of Fees

The illegal division of professional fees under any guise whatsoever is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Center.

15.7 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 by United States Postal Service, first-class postage prepaid, certified or registered, return receipt requested. In the case of notice to Medical Center, Governing Body, Medical Staff or officers or committees thereof, the notice shall be addressed as follows:

(Name and proper title of addressee)

Loma Linda University Medical Center

11234 Anderson Street

Loma Linda, California 92354

In the case of a notice to a practitioner, AHP, or other party, the notice shall be addressed to the address as it appears in the records of the Medical Center. If personally delivered, such notice shall be effective upon delivery, and if mailed as provided for above, such notice shall be effective four (4) 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 as above indicated.

15.8 Compliance

The Medical Staff acknowledges that the Governing Body of the Medical Center has adopted a comprehensive Compliance Plan and the Medical Staff will cooperate and assist in the Compliance Plan's implementation.

Article XVI: Adoption and Amendment of Bylaws

16.1 Overview of Bylaws

The Medical Staff shall have the initial responsibility and authority to formulate, adopt and recommend Medical Staff Bylaws and amendments which shall be effective when approved by the Governing Body, which approval shall not be unreasonably withheld. The Medical Staff shall review the Bylaws annually and may not delegate this responsibility and authority to any other entity. The Medical Staff shall exercise such responsibility and authority in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Governing Body. Neither the Medical Staff, the Medical Staff Executive Committee, nor the Governing Body, may unilaterally amend the Bylaws of the Medical Staff.

16.2 Process for Adoption and Amendment of Bylaws

16.2-1 By the Medical Staff Executive Committee

Proposals for adoption of Bylaws or for amendments, including additions, deletions, or modifications, to the Medical Staff Bylaws shall be submitted to the Medical Staff Executive Committee when developed by the Bylaws Committee as provided in Section 12.3 of these Bylaws. The Medical Staff Executive Committee may also develop proposed amendments to the Medical Staff Bylaws. Amendments developed by the Medical Staff Executive Committee itself or through recommendations of the Bylaws Committee shall be submitted to the Medical Staff for a vote as provided in Section

16.2-3.

16.2-2 By the Medical Staff

The Medical Staff may also develop and recommend amendments, including additions, deletions, or modifications, 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 twenty-five percent (25%) of the Medical Staff members entitled to vote on Bylaw amendments. The petition shall be submitted to the Medical Staff Executive Committee which shall then arrange for a vote on the amendment as provided in Section

16.2-3. The Medical Staff 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 Governing Body in advance of the Governing Body's consideration of the amendment if it is adopted.

Proposals for adoption of Bylaws or for amendments, including additions, deletions, or modifications, to these Bylaws shall be submitted to, or developed by, the Medical Staff Bylaws Committee. The Bylaws Committee shall submit recommended amendments to the Medical Staff Executive Committee for review and adoption. Following adoption by the Medical Staff Executive Committee, amendments shall be submitted to the members of the Active Medical Staff for vote. The proposals may be submitted for paper voting or may be submitted for vote at a meeting of the Medical Staff.

16.2-3 Mechanism for Adoption, Amendment or Repeal of Bylaws
The Medical Staff Bylaws may be adopted, amended or repealed by the following combined actions described in subsections (a) and (b) below:

a) By vote of the Active Medical Staff:

1) The affirmative vote of at least two thirds (2/3) of the Active Medical Staff members present at the annual meeting, a special meeting, or voting by email ballot by the Medical Staff at which time there is a quorum (as defined in Section 13.4), provided at least thirty 30 days advance written notice, accompanied by the exact wording of the proposed Bylaws and/or alterations has been given;

or

2) The affirmative vote of two thirds (2/3) or sixty-six percent (66%) of the Active Medical Staff members responding in an electronic or mail ballot, provided that more than half (> 50%) of the Active Medical Staff members returned their ballot. The procedure for distributing, returning, and counting ballots shall be determined by the Medical Staff Executive Committee. However, the exact wording of the proposed Bylaws and/or alterations and instructions regarding the procedure for voting, shall be mailed to the last known home address of every Active Medical Staff member at least thirty 30 days prior to the voting deadline. The exact wording of the proposed changes and instructions regarding the procedure for voting shall also be available for review at the following locations: (a) The Medical Staff Administration Office; (b) The office of the Medical Center administrator; and (c) The office of each Chief of Service.

b) The approval of the Governing Body, which shall not be unreasonably withheld. If approval is withheld, the reasons for doing so shall be specified by the Governing Body in writing, and shall be forwarded to the Chief of Staff, the Medical Staff Executive Committee and the Bylaws Committee.

16.2-4 Approval of Changes to the Bylaws

Changes adopted by the Medical Staff shall become effective only after approval by the Governing Body whose approval shall not be withheld unreasonably.

16.3 Technical and Editorial Corrections

The Medical Staff 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 effected by motion and acted upon the same manner as any other motion before the Medical Staff 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 Staff Executive Committee, provided however, they may be rescinded by vote of the Medical Staff or the Governing Body within one hundred and twenty 120 days of the date of adoption by the Medical Staff Executive Committee. (For purposes of this Section, "vote of the Medical Staff" shall mean a majority of the votes cast, provided at least twenty-five percent (25%) of the voting members of the Medical Staff cast ballots.)

Article XVII: Adoption and Amendment of Medical Staff Rules and Regulations and Policies

17.1 Overview and Relation to Bylaws

These Bylaws describe the fundamental principles of Medical Staff self-governance and accountability to the Governing Body. Accordingly, the key standards for Medical Staff membership, appointment, reappointment, and privileging are set out in these Bylaws. Additional provisions including, but not limited to, detailed procedures for implementing these Medical Staff standards may be set out in Medical Staff or Clinical Service Rules and Regulations, or in Medical Staff Policies adopted or approved as described below. Upon proper adoption, all such Rules and Regulations and Policies shall be deemed an integral part of the Medical Staff Bylaws.

17.1-1 Medical Staff Rules and Regulations

The Medical Staff shall initiate and adopt such Rules and Regulations as it may deem necessary for the proper conduct of its work and shall periodically review and revise its Rules and Regulations to comply with current Medical Staff practice. Applicants and members of the Medical Staff shall be governed by such Rules and Regulations as are properly initiated and adopted. If there is a conflict between the Bylaws and Rules and Regulations and/or Policies, the Bylaws shall prevail.

17.1-2 Medical Staff Policies and Procedures

The Medical Staff shall develop Policies and Procedures where appropriate to implement its responsibilities under these Bylaws and to complement the Medical Staff component of Medical Center policies. Applicants and members of the Medical Staff shall be governed by such Policies and Procedures as are properly initiated and adopted. If there is a conflict between the Medical Staff Rules and Regulations or the Medical Staff Policies and Procedures, the Medical Staff Rules and Regulations shall prevail.

17.1-3 Clinical Service Rules and Regulations and Policies

Each Clinical Service shall formulate its own Rules and Regulations or Policies for the conduct of its affairs and the discharge of its responsibilities. Such Rules and Regulations or Policies shall not be inconsistent with these Bylaws, the Medical Staff's Rules and Regulations, Medical Staff Policies or Procedures, or other policies of the Medical Center. These Clinical Service Rules and Regulations or Policies shall be reviewed as specified in the Clinical Service Rules and Regulations. If there is a conflict between the Medical Staff Rules and Regulations, the Medical Staff Policies and Procedures, or Clinical Service Rules and Regulations or Policies, the Medical Staff Rules and Regulations shall prevail.

17.1-4 Current Medical Staff Rules and Regulations, Medical Staff Policies and Procedures, and Clinical Service Rules and Regulations

All Medical Staff Rules and Regulations, Medical Staff Policies and Procedures, and Clinical Service Rules and Regulations 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 and Procedures adopted in accordance with these Bylaws and shall continue in effect until amended pursuant to these Bylaws.

17.1-5 Delegation of Authority to the MSEC/Approval of Changes to the Rules and Regulations or Policies

By this Section 17.1-5, the Medical Staff delegates to the Medical Staff Executive Committee the authority to adopt Medical Staff Rules and Regulations and Policies and Procedures. Changes adopted by the Medical Staff Executive Committee and/or the Medical Staff shall become effective only after approval by the Governing Body, whose approval shall not be withheld unreasonably. Neither the Medical Staff, the Medical Staff Executive Committee, nor the Governing Body may unilaterally amend the Rules and Regulations of the Medical Staff. However, the Medical Staff Executive Committee may unilaterally amend the Policies and Procedures of the Medical Staff as needed.

17.2 Process for Adoption or Amendment of Medical Staff Rules and Regulations

17.2-1 By the Medical Staff Executive Committee

a) Proposals for adoption, additions, deletions or modifications of the Rules and Regulations shall be submitted to the Medical Staff Executive Committee when developed by the Bylaws Committee as provided in Section 12.3 of these Bylaws. The Medical Executive Committee may also develop proposed amendments to the Rules and Regulations.

b) Except as provided in Section 17.4 below, the Medical Staff Executive Committee must first communicate the text of any such proposed Rule or Regulation to the Medical Staff at least thirty 30 days prior to voting on adoption, together with instructions explaining how interested members may communicate comments to the Medical Staff Executive Committee. The review and comment period may be accomplished by posting proposed rules on the Medical Staff's website. A comment period of at least fifteen (15) days shall be afforded, and all comments shall be summarized and provided to the Medical Staff Executive Committee prior to Medical Staff Executive Committee action on the proposed Rule.

17.2-2 By the Medical Staff

a) If the Medical Staff seeks to propose the adoption, or amendment of a Rule or Regulation it must first submit a petition signed by no less than twenty-five percent (25%) of the Active Medical Staff proposing such a change. Any such proposal to the Medical Staff Executive Committee must contain the specific language proposed for adoption. Upon receipt, the Medical Staff Executive Committee shall consider the proposal. If the Medical Staff Executive Committee approves the proposal as outlined, it shall be adopted as provided by Section 17.3(1). If the Medical Staff Executive Committee does not approve the proposal, it shall notify the Medical Staff. The Medical Staff Executive Committee and the Medical Staff each has the option of invoking or waiving the Conflict Management process of Section 15.2.

b) If the Conflict Management process is not invoked within thirty 30 days, the right to the process shall be deemed waived. In this circumstance, the Medical Staff's proposed Rule and Regulation shall be forwarded to the Governing Body for action. The Medical Staff Executive Committee may forward comments to the Governing Body regarding the reasons it declined to approve the proposed Rule.

c) If the Conflict Management process is invoked, the proposed Rule and Regulation shall not be forwarded to the Governing Body until the Conflict Management

process has been completed, and the results of the Conflict Management process shall be communicated to the Governing Body.

d) Nothing in this Section is intended, nor will it be construed to prevent direct communication by the Medical Staff to the Governing Body on any Rule and Regulation, regardless of the manner in which it is adopted. However, the Governing Body shall establish the method for any such communication.

17.3 Final Adoption or Amendment of Medical Staff Rules and Regulations

The mechanisms described herein shall be the sole method for finalizing the adoption, amendment, or repeal of the Medical Staff Rules and Regulations:

a) The affirmative vote of a majority of the Medical Staff Executive Committee members present at a meeting at which there is a quorum (as defined in Section 13.4), in addition to the approval of the Governing Body; or

b) If the Conflict Management Process is invoked, a majority vote of the Medical Staff Executive Committee's representatives and a majority vote of the petitioner's representatives, in addition to the approval of the Governing Body; or

c) By the decision of the Governing Body if the Conflict Management Process is invoked, but differences remain unresolved.

17.4 Urgent Amendment to Rules & Regulations

In the event that urgent action is required, for example, to comply with law or regulation, the Medical Staff Executive Committee is authorized to provisionally adopt a Rule or Regulation and forward it to the Governing Body for approval and immediate implementation, subject to the following. If the Medical Staff did not receive prior notice of the proposed Rule (as described in Section 17.3 above) the Medical Staff shall be notified of the provisionally-adopted and approved Rule, and may, by petition signed by at least twenty-five percent (25%) of the voting members of the Medical Staff require the Rule and Regulation to be submitted for possible recall; provided, however, the approved Rule and Regulation shall remain effective until such time as a superseding Rule and Regulation meeting the requirements of the law or regulation that precipitated the initial urgency has been approved pursuant to any applicable provision of this Section. In the event that a petition seeking to recall the Rule and Regulation is presented, the Conflict Management process set forth in Section 15.2 shall be followed.

17.5 Process for Adoption or Amendment of Medical Staff Policies

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

ADOPTED by the Medical Staff on June 22, 2022  Jason Gatling, MD, President of the Medical Staff
 Tait Stevens, MD, Chair of the Bylaws Committee
APPROVED by the Governing Board on August 29, 2022  Richard Hart, MD, Board Officer

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No index entries found.

Article II. Medical Staff Rules and Regulations

The Rules and Regulations are a separate document that can be found on the LLUMC VIP intranet site, or on the Web at www.llu.edu/llumc/medicalstaff, or by contacting Medical Staff Administration at (909) 558-6052 or extension 66052 for a copy.

A. Recognizing the Religious Affiliation of the Medical Center
B. General Conduct of Care
C. Care of Patients Undergoing Surgical Procedures
D. Patients Receiving Obstetrical Care
E. Care of Oral Surgery/Hospital Dentistry Patients
F. Care of Pediatric Patients
G. Care of Podiatry Patients
H. Care of Patients Receiving Hemodialysis
I. Care of Patients in Intensive Care Units
J. Care of Patients in the Emergency Department
K. Drugs and Medications
L. Utilization/Bed Management
M. Safety and Disaster Plan
N. Medical Records
O. Supervision of Resident Staff
P. Supervision of Allied Health Professionals
Q. Confidentiality
R. Privacy/Patient's Rights