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## Medical Staff Bylaws

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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 paramedical personnel in a setting promoting optimal patient care, 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, and therefore refers to the Medical Center Chief Executive Officer/Administrator.

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. Based on their valid license, certificate or other legal credential an AHP at the Medical Center will be classified as a Limited License Independent Practitioner (AHP-LLIP) or a Dependent Practitioner (AHP-DP). 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.

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. **GOVERNING BODY** means the Medical Center’s Board of Trustees or a duly authorized committee thereof.

6. **MEDICAL CENTER** means Loma Linda University Medical Center.
7. **MEDICAL STAFF** or **STAFF** means the formal organization of all licensed physicians, dentists, and podiatrists who are privileged to attend patients in the Medical Center.

8. **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.

9. **PHYSICIAN** means an individual with an M.D. or D.O. degree who is licensed to practice medicine.

10. **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.

11. **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.

12. **RESIDENT** or **FELLOW** means a physician or dentist who is enrolled or registered in one of the Graduate Medical Education programs recognized by the Medical Center and the Graduate Medical Education Committee of the Medical Staff leading to completion of the educational requirements required by the applicable board for subspecialty certification.
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.
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 licensed to practice in the State of California.
   b) have current licensure,
   c) have adequate education, training, background and experience,
   d) have current competence, including good judgment, and
   e) 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.
   f) 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 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.

g) 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.

h) 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 and unsuspended certificate to practice medicine issued by the Medical Board of California or the Board of Osteopathic Examiners of the State 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) 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) a board or association with equivalent requirements approved by the 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, judgement, 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 Board of Dental Examiners 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.

### 3.2-3 Basic Responsibilities of Medical Staff Membership

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

a) Providing patients on a continuous basis 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.

e) Abiding by the lawful ethical principles of the California Medical Association or 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) Working cooperatively with members, nurses, Medical Center Administration and others so as not to adversely affect patient care.

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

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

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 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 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 any voluntary relinquishing of privileges or Medical Staff membership and sanction by a third party payor or regulatory agency.

s) Keeping the Medical Staff Administration staff informed of current address and telephone number.

3.2-4 Harassment Prohibited
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 a patient.

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.

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 of Absence from the Medical Staff for up to two (2) years or until the expiration of the current appointment, whichever occurs first. If a member chooses to have a leave (other
than Military Leave or Absence) that is longer than these restrictions allow, the
member may, upon return from leave, apply for reinstatement following the
procedures contained elsewhere in these Bylaws. Any Leave of Absence must be
approved by the Medical Staff Executive Committee after submission by the
member of a request stating the approximate period of time of the leave, which
may not exceed two (2) years. During the period of the leave, the member’s
clinical privileges and responsibilities shall be suspended.

3.4-2 Medical Leave of Absence
The Medical Staff Executive Committee (MSEC) shall determine the
circumstances under which a particular Medical Staff member shall be granted a
Leave of Absence for the purpose of obtaining treatment for a medical condition
or disability. At the discretion of the Medical Staff Executive Committee, unless
accompanied by a reportable restriction of privileges, the leave shall be deemed a
“medical leave” which is not granted for a medical disciplinary cause or reason.
All terms and conditions of 3.4-1 shall apply.

3.4-3 Military Leave of Absence
The Medical Staff Executive Committee shall grant requests for Leave of
Absence to fulfill military service obligations upon notice and review.
Reactivation of Medical Staff membership and clinical privileges previously held
shall be granted, notwithstanding the time limits in 3.4-1 and the provisions of
Section 3.4-4 and 3.5, but reactivation may be granted subject to monitoring
and/or proctoring as determined by the Medical Staff Executive Committee.

3.4-4 Termination of Leave
At least thirty (30) days prior to the termination of the leave, or at any earlier
time, the Medical Staff member may request reinstatement of his/her privileges by
submitting a written notice to that effect to the Medical Staff Credentials
Committee. If so requested by the Medical Staff Credentials Committee, the Staff
member shall submit a written summary of his/her relevant activities during the
leave. The Medical Staff Credentials Committee shall recommend to the Medical
Staff Executive Committee whether to approve the member’s request for
reinstatement of his/her Medical Staff membership and privileges. If the request
for reinstatement is approved by the Medical Staff Executive Committee the
member shall be reinstated. If the request for reinstatement is not approved by the
Medical Staff Executive Committee the applicable procedures set forth in
Sections 6.4-7 through 6.4-11 shall be followed.

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.
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.

b) A practitioner seeking an initial Active Medical Staff appointment must also have completed all General 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 for one (1) year, 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 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, 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 the duration of their initial Medical Staff appointment. Practitioners reinstated to Medical Staff membership per Section 6.5-6 are not required to serve an additional period in the Provisional category.
   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 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 the Provisional 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 General 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 one (1) but not more than twelve (12) patients in the Medical Center during each Medical Staff year unless otherwise specified in Rules and Regulations of the Clinical Service;

b) Have been a member in good standing of the Provisional Staff for at least one (1) year 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 evaluate the qualifications for continued Medical Staff membership;

c) Have completed the General 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 more than twelve (12) 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.

4.5 Consulting Staff

4.5-1 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 for at least one (1) year 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 evaluate the qualifications for continued Medical Staff membership;
   c) Have completed the General Proctoring as discussed in these Bylaws.
   d) Must be Active at another JCAHO accredited hospital. Exception may be granted for good cause as approved by the Medical Staff Executive Committee.

4.5-2 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.

4.5-3 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.

4.5-4 Responsibilities
Each Consulting Staff member shall meet the standards in Section 3.2 and responsibilities set forth in Section 3.2.
4.6 Honorary Staff

4.6-1 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.

4.6-2 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.

4.6-3 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.

4.7 Administrative Staff

4.7-1 Qualifications
The Administrative Staff shall consist of practitioners who are members of the Medical Staff who have no clinical privileges and who must:

a) Have been a member in good standing of either the Active, Courtesy, Consulting, or Provisional Staff for at least one (1) year.

b) Have completed the General Proctoring requirements, other than the requirement for review of patient care if the member does not participate in patient care, as described in these Bylaws.

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

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

e) 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.

4.7-2 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.

4.7-3 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.
4.7-4 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.

4.7-5 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 4.10.

4.8 Temporary Staff

4.8-1 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.

4.8-2 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.

4.9 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:

4.9-1 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.

4.9-2 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.

4.9-3 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, or Honorary category.

4.10 MODIFICATION OF MEDICAL STAFF MEMBERSHIP

4.10-1 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:

a) Apply in writing for transfer to another staff category.

b) 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.

c) 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.

4.10-2 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.

4.10-3 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.
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;
b) 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;
c) S/he documents his or her experience, background, training, current competence, judgement, 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;
d) 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;
e) 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;
f) The qualifications of the AHP have been reviewed by the IDP Committee, and the IDP Committee has recommended the granting of specified practice privileges;
g) Where applicable, s/he meets the same qualifications specified in Section 3.2 for Medical Staff members;
h) 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;
i) 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;
j) 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.
k) 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. If the AHP is a Physician Assistant (PA), the Supervising Medical Staff member shall hold the appropriate state license;

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

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

n) 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.
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 period extending until the end of the month in which the state license renewal is due if that month is at least 12 months and less than 18 months after the initial appointment date, otherwise the initial appointment period shall be for 12 months. All other Staff appointments and reappointments shall be for a period to extend to the end of the month in which the next license renewal is due. 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 Loma Linda University Medical Center 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 in writing, signed by the applicant and the Chief of the appropriate Clinical Service, and shall be submitted on 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) The names of at least three (3) persons who hold the same professional license as does the applicant including, one (1) of which must be the Director of the postgraduate training program(s). When appropriate, a letter from the Chief of the Department or Service(s) of previous and current hospitals should 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) 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, nonrenewal, 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;

d) 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;

e) 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);

f) Information pertaining to the condition of the applicant’s health;
g) Acknowledgement that s/he has received or has had an opportunity to review the Medical Staff Bylaws, and agree to abide by them.

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 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.

It is the responsibility of the applicant to obtain a copy of the Medical Staff Bylaws and agree to be bound by the provisions set forth.

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 and Rules and Regulations, and 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 Sections 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 Section 6 of these minutes, 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 Section 6. 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.

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 Section 3, that they can carry out the responsibilities specified in Section 3 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 E F F E C T  O F  E X E C U T I V E  C O M M I T T E E  A C T I O N

F A V O R A B L E  R E C O M M E N D A T I O N: 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.

A D V E R S E  R E C O M M E N D A T I O N: 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 Section 9 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 A C T I O N  B Y  T H E  G O V E R N I N G  B O D Y

a) O N  F A V O R A B L E  M E D I C A L  S T A F F  E X E C U T I V E  C O M M I T T E E  R E C O M M E N D A T I O N: 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) W H E R E  R E C O M M E N D A T I O N  I S  A D V E R S E: 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, the Chief Medical Officer, 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 one hundred twenty (120) 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 (60) days prior to the expiration of appointment. Medical Staff Administration shall gather reports from Risk Management, Quality Resource Management, 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 Action By Service Chiefs & Chief Medical Officer
The Chief(s) of Service in which the applicant has or requests privileges shall appoint at least two (2) Active Staff members who, together with the Chief(s) of Service, shall act as a credentials committee for the Service and upon receipt of the completed and verified application, shall review and evaluate the application. Each Chief(s) of Service concerned shall prepare, consistent with Section 6.4-3, and transmit to the Credentials Committee, the Service's written report and recommendation.

6.5-4 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 6.4-6. The Committee may also request further information prior to taking action.

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

c) 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.
6.5-5 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 that the Medical Staff membership and clinical privileges have been voluntarily relinquished.

6.5-6 Reinstatement to Medical Staff
Practitioners who, within the past seven (7) years, were members of the Medical Staff for at least three (3) continuous years and, whose appointment was terminated for other than disciplinary reasons may be eligible to apply for reinstatement via completion of the reappointment process. Expeditious reinstatement will be at the discretion of the Governing Body, based on recommendations from the Credentials Committee and the Medical Staff Executive Committee, but must include:

a) All portions of regular reappointment process;
b) Verification of activities during term of absence;
c) Letters of recommendation;
d) All previously due fees and fines.

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 6.5-6. 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.
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. When a Medical Staff member requests privileges that his/her Clinical Service has not been granted the authority to recommend, the Credentials Committee shall designate a Service which has such responsibility to review such a request and to make a recommendation regarding granting the requested privileges.

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 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 as determined by the Clinical Service 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. 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 University 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 Loma Linda University Medical Center, as required.

7.2-4 **PROCEDURE**

All requests for clinical privileges shall be processed pursuant to the procedures 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 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 period of proctoring. The proctoring required for initial appointment shall be called “General Proctoring”. General Proctoring refers to the process by which a practitioner’s ability to satisfactorily discharge the basic responsibilities of Medical Staff membership as contained in these bylaws and, when requested by the appointee, to exercise the general privileges of admitting and caring for patients, consulting and caring for patients, or caring for patients in an ambulatory setting. General Proctoring also involves the evaluation of the practitioner’s willingness to cooperate with colleagues and Medical Center employees as well as willingness to contribute to the clinical education and training programs of the Medical Center, as required. “Specific Proctoring” refers to the process by which a practitioner’s ability to satisfactorily exercise specific privileges is confirmed.

7.4-1 For Initial Appointment
Each initial appointee to the Medical Staff shall be subject to General Proctoring. General proctoring shall consist of concurrent or immediate retrospective review of at least the first 5 patients cared for in the Medical Center. The appointee’s Service Chief shall determine whether such review shall be concurrent or immediate retrospective in nature. The appointee’s Service Chief shall designate a member(s) of the Active Medical Staff with privileges similar to those sought by the appointee to serve as the appointee’s proctor(s). It shall be the responsibility of the appointee to contact the assigned proctor at the time care in the Medical Center is initiated whenever the appointee cares for a patient in the Medical Center during the period of General Proctoring. Where the nature of the appointee’s practice limits the volume of inpatient care, the appointee’s Service Chief may instruct the appointee’s proctor(s) to review outpatient records to satisfy the General Proctoring requirement. Proctoring records from another institution may not be used to satisfy the General Proctoring requirement. Supervision by an Active LLUMC Medical Staff member while the appointee was in a graduate medical education program within the 2 years immediately preceding initial appointment may be substituted for a portion of the required General Proctoring. All initial appointees shall remain subject to General Proctoring until they have been officially released from General Proctoring requirements by the Board of Trustees. A report signed by the Chief of Service to which the member is assigned describing the types and numbers of cases reviewed and the evaluation of the appointee's performance; a statement that the appointee appears to meet all of the qualifications for unsupervised practice in that
service; a statement that the appointee has discharged all of the responsibilities of Medical Staff membership; and a statement that the appointee has not exceeded or abused the prerogatives of the category to which the appointment was made, with the completed proctor forms attached, shall be submitted to Medical Staff Administration to begin the Committee review and Board approval process. Failure to satisfactorily complete General Proctoring is addressed in 7.4. Failure to adequately demonstrate the ability to cooperate with colleagues, Medical Center employees, and the educational and training activities of Medical Center shall also be subject to the provisions of 7.4.

When recommended by the Medical Staff Executive Committee, and approved by the Governing Body, Medical Staff members who change Medical Staff category or Clinical Service shall complete a period of General Proctoring in accordance with the procedures outlined in this Section for initial appointees. The minimum period of proctoring and minimum number of cases required to be completed satisfactorily shall be established by the Clinical Service.

7.4-2 Specific Proctoring for Addition or Modification of Clinical Privileges

Each Clinical Service shall determine the extent of privilege based Specific Proctoring relevant to requested privileges which it deems appropriate through it's Service Rules and Regulations; however, Specific Proctoring must include an element of direct observation. The Chief of Service to whom the practitioner is assigned shall designate an Active Medical Staff member(s) to serve as the member’s proctor(s). Supervision by a member of Active LLUMC Medical Staff within 2 years immediately preceding the onset of Specific Proctoring while the member subject to proctoring was in a graduate medical education program may be substituted for a portion of the required privilege based Specific Proctoring. Complete records of proctoring at another institution may be accepted as a portion of the required Specific Proctoring if so allowed in the applicable Clinical Service Rules and Regulations. In all cases, at least 50% of the required privilege based Specific Proctoring must be performed under the observation and review of an Active Medical Staff member. Specific Proctoring shall continue until proctoring requirements have been met and the proctor has indicated that Specific Proctoring has been satisfactorily completed. All Medical Staff members shall remain subject to any required Specific Proctoring until the Medical Staff Executive Committee has been furnished with the following: a report signed by the Chief of Service to which the member is assigned describing the types and numbers of cases observed and the evaluation of the member’s performance; a statement that the member appears to meet all of the qualifications for unsupervised exercise of the requested privilege(s) in that service; and a report signed by the Chief of any other Service(s) in which the member may exercise clinical privileges requiring Specific Proctoring, describing the types and number of cases observed, the evaluation of the member's performance, and a statement that the member has satisfactorily demonstrated the ability to exercise the clinical privileges granted in those services.

When recommended by the Medical Staff Executive Committee, and approved by the Governing Body, Medical Staff members who change Medical Staff category or
Clinical Service assignment or who are granted additional clinical privileges shall complete a period of privilege based Specific Proctoring in accordance with the procedures outlined in this section. The minimum period of Specific Proctoring and minimum number of cases required to be completed satisfactorily shall be established by each Clinical Service.

7.4-3 **Term of Proctoring Period**

a) The period of *General Proctoring* shall extend until the relevant Chief of Service submits a report stating all proctoring and related requirements have been satisfactorily completed and they have been officially released from General Proctoring requirements by the Board of Trustees. If the appointee *fails to satisfactorily complete proctoring* because of concern regarding his/her performance during the period of proctoring, then the Medical Staff Executive Committee Chair shall give the affected initial appointee or Medical Staff member written notice that his/her request for clinical privileges has been denied because s/he failed to satisfactorily complete the proctoring requirements, and that the affected practitioner has the right to request a hearing pursuant to Section 9.3-2. Thereafter the procedure set forth in Article IX shall *be followed*. If the appointee *fails to satisfactorily complete General Proctoring* because of an inadequate number of cases subject to proctoring or fails to submit required proctor forms and a Service Chief recommendation letter to the Credentials Committee prior to the expiration of their appointment then s/he shall not be eligible for re-appointment.

b) Privilege based *Specific Proctoring* requirements shall continue until the physician has been officially released from Specific Proctoring requirements by the Board of Trustees or until the specific privilege is withdrawn. If a member exercising new clinical privileges fails to satisfactorily complete Specific Proctoring within the time allowed by the Clinical Service and if the Service Chief fails to request an extension, those specific clinical privileges shall automatically terminate, and the member shall be entitled to a hearing, upon request, pursuant to Article IX.

7.4-4 **Medical Staff Advancement**

The failure to obtain approval for any specific clinical privileges shall not, of itself, preclude advancement in Medical Staff category of any member. If such advancement is granted absent such approval, privilege based Specific Proctoring shall continue until the Specific Proctoring is satisfactorily completed or until the time allowed by the Clinical Service has elapsed.

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 Loma Linda University Medical Center 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 Loma Linda University Medical Center 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 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 Vice President of Medical Administration or 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 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 Loma Linda University Medical Center 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 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 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 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 physicians 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.

2) A document issued by the Medical Board of California or the Osteopathic Medical Board of California indicating that the individual has a valid certificate to practice as a physician or
osteopathic physician. 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 or osteopathic physician may be substituted for the California issued certificate.

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) Immediately upon the granting of Emergency Clinical Privileges 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.

i) 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.
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 Staff 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.

**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  **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*.

8.3-2  **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 right to prescribe, dispense or administer medications covered by the certificate.

8.3-3  **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.

8.3-4  **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 rights 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.

8.3-5 Failure to Maintain Required Malpractice Insurance and Failure to Pay Reappointment Fees

a) For failure to maintain the amount of professional liability insurance required under Section 15.2, 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.

b) Failure to pay reappointment fees as required under Section 6.5-1 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.

8.3-6 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 8.3-4 and 8.3-5 shall not be entitled to the procedural rights set forth in Article IX.

8.3-7 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 Section 8.3, 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. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.
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:
a) “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.
b) "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.
c) "Petitioner" refers to the practitioner who has requested a hearing pursuant to Section 9.3 of these Bylaws.
d) "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:

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 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 intraprofessional 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:

a) Oral testimony of witnesses.

b) Briefs or written statements presented in connection with the hearing.

c) 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.

9.6 Exception to Hearing Rights

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

b) **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 Article 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.
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 President-Elect, a Vice President, a Secretary, and a representative to the American Medical Association and the California Medical Association Organized Medical Staff Sections (AMA/CMA OMSS).
The appointed officers of the Medical Staff shall be a Chief of Staff, the Chief Medical Officer, the Patient Safety Officer, and the Designated Institutional Official for Graduate Medical Education. The Dean of the Loma Linda University School of Medicine or his/her designee shall be the Chief of Staff. The Chief of Staff shall be a member of the Active or Administrative Medical Staff. All other officers shall be selected in accordance with relevant provisions of these Bylaws.

10.1-2 QUALIFICATIONS OF OFFICERS
Elected 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.
Appointed Officers must be members of the faculty of Loma Linda University School of Medicine and must be members of the Active Medical Staff or Administrative Medical Staff of Loma Linda University Medical Center at the time of their appointment. Failure to maintain such status shall immediately create a vacancy in the office involved.

10.1-3 SELECTION OF OFFICERS
a) NOMINATIONS: Nominations for Elected Officers: A Nominating Committee shall be appointed by the President of the Medical Staff at least ninety (90) days prior to the annual Medical Staff meeting. This Committee shall consist of five (5) Active Medical Staff members, each from a different Service. The Nominating Committee shall nominate one (1) nominee for the office of President, (it is expected that this nominee will either be the then current President nominated for a second term or the then current President Elect nominated for a first term), one (1) nominee for the office of President-Elect (it is expected that this nominee will either be the then current President-Elect nominated for a second term or the then current Vice-President Elect nominated for a first term), one (1) nominee for the office of Vice President (it is expected that this nominee will either be the then current Vice-President nominated for a second term or another Medical Staff member with at least one year previous experience as a member of the Medical Staff Executive Committee nominated for a first term, one (1) nominee for the office of
Secretary (if necessary), and one nominee for the office of AMA/CMA OMSS Representative (if necessary). The Nominating Committee recommendations shall be presented to the Medical Staff Executive Committee at least sixty (60) days prior to the annual meeting.

b) **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.

c) **Election:** Elected Officers shall be elected at the annual meeting of each year. Only Active Staff members shall be eligible to vote. 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.

d) **Chief of Staff:** The Dean of Loma Linda University School of Medicine shall appoint the Chief of Staff. If the Dean is a member of the Active or Administrative Staff of LLUMC, the Dean may appoint himself/herself to this position.

e) **Chief Medical Officer:** The Chief Medical Officer shall be nominated by the Medical Staff President, Chief of Staff and Administrator after consultation with one another, and shall be subject to confirmation by the Medical Staff Executive Committee and Governing Body whose approval will not be unreasonably withheld.

f) **Patient Safety Officer:** The Patient Safety Officer shall be an Active Member of the Medical Staff who shall be appointed by the Medical Staff Executive Committee in consultation with the Administrator and approved by the Governing Body whose approval will not be unreasonably withheld.

g) **Designated Institutional Official for Graduate Medical Education (DIO for GME):** The Dean of Loma Linda University School of Medicine shall nominate the DIO for GME. The President of the Medical Staff shall appoint the DIO for GME subject to approval by the Medical Center Administrator, the Medical Staff Executive Committee, and by the Governing Body (whose approval shall not be reasonably withheld).

**10.1-4 Term of and Succession of Officers**

Subject to confirmation at the annual meeting, the President-Elect shall succeed to the office of President and the Vice President to the office of President-Elect. Term of office commences on July 1. The term of office for the President,
President-Elect, Vice-President and Secretary shall be for one year. The term of office for the OMSS Representative shall be for six (6) years. All Elected 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 shall be continuous until replaced. The term of appointment for the Chief Medical Officer, the Patient Safety Officer, and the DIO for GME shall be five (5) years and may be renewed.

10.1-5 REMOVAL OF ELECTED 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.

10.1-6 VACANCIES IN ELECTED OFFICE
In the case of vacancy in the office of President, the President-Elect shall immediately assume the office of President. In the case of vacancy in the office of President-Elect, the Vice-President shall immediately assume the office of President-Elect. Vacancies in other elected offices shall be filled (until the next election) by a member appointed by the President and confirmed by the Medical Staff Executive Committee.

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) Appoint, with Medical Staff Executive Committee approval, Committee Chairs and 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;

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

h) 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;

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

j) 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 President-Elect
The President-Elect, 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, in the absence of the President-Elect, shall assume all duties and have the authority of the President-Elect; be a member of the Medical Staff Executive Committee, the Bylaws Committee, the Credentials Committee, and the Medical Record Committee, assisting the Medical Record 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 AMA/CMA OMSS Representative
The AMA/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 AMA/CMA OMSS Representative shall serve a five (5) year term.

10.2-5 Secretary
The Secretary shall be a member of the Medical Staff Executive 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.

10.3 Duties of Appointed Officers:

10.3-1 Chief of Staff: 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 Medical Staff Well Being Committee.

10.3-2 Chief Medical Officer
The Chief Medical Officer shall be responsible for assisting the President and Medical Staff Executive Committee. S/He shall report to the Medical Staff Executive Committee. The Chief Medical Officer shall:

a) Chair the Credentials Committee;
b) 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 Physician Well Being Committee;
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; ensure proctoring requirements are met and provide timely dissemination of this information to Medical Center employees;
e) Advise the President and Medical Staff Executive Committee on corrective actions to ensure the provisions of Articles VIII and IX are applied in an appropriate and equitable manner;
f) Investigate, upon request of the Medical Staff Executive Committee, matters pursuant to Article 8.1-3. (The Chief Medical Officer may appoint an ad hoc committee to assist him/her in such investigations.); and
Perform 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 President or Administrator.

10.3-3 Patient Safety Officer: The Patient Safety Officer shall be responsible for assisting the President and Medical Staff Executive Committee as well as the Administrator and Governing Board. S/He shall report to the Medical Staff Executive Committee, the Administrator and the Governing Board. S/He shall
usually be the Medical Staff member serving as the Medical Center Vice President for Quality and Patient Safety. The Patient Safety Officer shall:
a) Chair the Medical Staff Quality Improvement Committee and the Joint LLUMC-Medical Staff Quality Compliance Committee.
b) Serve as an ex-officio member, with vote, of the Medical Staff Executive Committee, Bylaws Committee, Credentials Committee, Professional Practice Committee, Pharmacy and Therapeutics Committee, Medical Record Committee, Infection Control Committee, and Operating Room Committee.
c) Collaborate with Service Chiefs, and Service QI Committees to establish appropriate best practices for the various services;
d) Collaborate with Service Chiefs and Service QI Committees to monitor practice through outcomes data and peer review;
e) Advise the President and Medical Staff Executive Committee on corrective actions to ensure patients are provided the optimal quality of care in the safest possible manner;
f) Collaborate with LLUMC Administration in improving the Quality of Care provided to patients;
g) Perform 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 President or by the Chief of Staff.

10.3-4 DESIGNATED INSTITUTIONAL OFFICIAL FOR GRADUATE MEDICAL EDUCATION (DIO FOR GME): The DIO for GME shall be responsible for assisting the President and Medical Staff Executive Committee. S/He shall report to the Medical Staff Executive Committee. The DIO for GME shall:

a) Chair the Graduate Medical Education Committee
b) Serve as an ex-officio member, with vote, of the Medical Staff Executive Committee, Bylaws Committee, Professional Practice Committee, Medical Record Committee and Quality Improvement Committee.
c) Collaborate with Service Chiefs to establish appropriate policies and procedures for the various residency programs;
d) Collaborate with Service Chiefs to appoint appropriate Residency Program Directors and to oversee and assist the various Program Directors in the conduct of their duties;
e) Serve as the Designated Institutional Official in relations with the Accreditation Council on Graduate Medical Education;
f) Ensure 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
g) Perform 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 President or by the Chief of Staff.
ARTICLE XI: CLINICAL SERVICES AND SECTIONS

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 the Service. Clinical Services may establish Clinical Sections as necessary.

11.2 DESIGNATION OF CURRENT CLINICAL SERVICES
Anesthesiology
Emergency Medicine
Family Medicine
Hospital Dentistry
Medicine
Neurology
Obstetrics and Gynecology
Ophthalmology
Orthopaedic Surgery
Pathology and Laboratory Medicine
Pediatrics
Physical Medicine and Rehabilitation
Preventive Medicine
Psychiatry
Radiation Medicine
Radiology
Surgery

11.3 ASSIGNMENT TO CLINICAL SERVICES
Each practitioner shall be assigned membership in at least one (1) Clinical Service, but may be granted membership and/or clinical privileges in one or more of the other Clinical Services. 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.

11.4 CHIEF OF SERVICE

11.4-1 QUALIFICATIONS, DESIGNATION, AND TERM OF OFFICE
Other than the Chief of Hospital Dentistry, each Chief of Service shall:

a) Be the chair of the corresponding department of Loma Linda University School of Medicine or designee. In the event that the Chair of the corresponding department of Loma Linda University School of Medicine is not a member of the Active Staff, he/she shall designate a member of the Active Staff to be Chief of Service.

b) Be a member of the Active Staff.

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

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.

11.4-2 Duties of Chiefs of Service

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

a) Be accountable for all clinical, professional and administrative activities within the Service.
b) Be accountable for monitoring the professional performance of individuals exercising privileges granted upon the recommendation of the Service.
c) Be responsible for the continuous monitoring of the quality of patient care provided by members of the service.
d) Be responsible for the development of and assessment of the effectiveness of Service specific Quality Improvement programs.
e) Be responsible for recommending to the Medical Staff the criteria to be used in determining the qualifications necessary for a member to be granted those Clinical Privileges that are relevant to care provided in the Service.
f) Be responsible for making recommendations to the Medical Staff regarding the granting of or withholding of clinical privilege for each member of the Service.
g) Be responsible for transmitting to the Credentials Committee his/her recommendations concerning appointments, reappointments, delineation of Clinical Privileges and release from proctoring requirements.
h) Be responsible for recommending to the Medical Staff Executive Committee corrective action with respect to practitioners in the Clinical Service.
i) Be responsible for assessing and recommending patient care services rendered off-site and patient care services rendered on site by outside suppliers.
j) Be responsible for developing and implementing Clinical Service programs and appointing appropriate Clinical Service Committees.
k) Be responsible for appointing the Chair of the Service Quality Improvement Committee with confirmation by the MSQI Committee Chair and Patient Safety Officer.
l) Be responsible for appointing any Graduate Medical Education Program Directors with confirmation by the DIO for GME in cases of Program Directors.
m) Be responsible for enforcing Medical Staff Bylaws, Rules, Regulations, and Medical Center policies within the Clinical Service and for implementing within the Clinical Service actions taken by the Medical Staff Executive Committee and by the Governing Body.

n) Be responsible for cooperating 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.

o) Be responsible for the orientation of all members of the Service.

p) Be responsible for providing continuing education opportunities in the specialty or specialties represented in the Service.

q) Be responsible for the preparation of such annual reports, pertaining to the Clinical Service as may be required by the Medical Staff Executive Committee or the Governing Body.

r) 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 Medical Staff Quality Improvement 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 quarterly 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.
ARTICLE XII: COMMITTEES

12.1 General

12.1-1 Designation
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 the function of the standing committee(s). These subcommittees will be established by action of the Medical Staff Executive Committee. Subcommittees will report to their respective standing committee. In addition, special committees may be created 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).

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 appointed by the President, subject to the Medical Staff Executive Committee’s approval. Only Active Medical Staff members may serve as Chairs of Medical Staff committees. A majority of the voting membership of each committee shall be members of the Medical Staff.

The President, the Chief of Staff, and the Active Medical Staff member who is the Vice President for Medical Administration of Loma Linda University Medical Center shall be ex-officio members, with the right to vote, of all Medical Staff Committees.

The President may appoint ex-officio non-voting members to Medical Staff Committees, including persons who are not Medical Staff members. Such ex-officio members 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 it’s membership Active members of the Medical Staff who are physicians and may include in it’s membership Active members of the Medical Staff who are other licensed independent practitioners. The MSEC shall consist of the elected and appointed officers of the Medical Staff; the Chief or designee of the following Clinical Services: Anesthesiology, Emergency Medicine, Family Medicine, Hospital Dentistry, Medicine, Neurology, Obstetrics and Gynecology, Ophthalmology, Orthopaedic Surgery, Pathology and Laboratory Medicine, Pediatrics, Physical Medicine and Rehabilitation, Preventive Medicine, Psychiatry, Radiation Medicine, Radiology, and Surgery; three (3) at-large members, one from a surgical service, one from a non-surgical service, and one from a hospital-based service (Anesthesia, Emergency Medicine, Pathology & Laboratory, Radiation Medicine, and Radiology); the Immediate Past-President of the Medical Staff; the Administrator or designee; and the Medical Staff member who is the Vice President for Medical Administration.

12.2-2 Officers
The President, President-Elect, and Secretary shall serve as Chair, Vice-Chair, and Secretary of the Medical Staff Executive Committee, respectively.

12.2-3 Members – At-Large
The Nominating Committee (Section 10.1) shall nominate three (3) members-at-large from clinical services as specified in Section 12.2-1. Additional nominations may be made by petition in accordance with Section 10. Three (3) from these nominees will be elected at the annual meeting in the manner specified in Section 10.

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 quarterly.
12.3 Bylaws Committee

12.3-1 Composition
The Bylaws Committee shall be composed of the Chair, the President-Elect of the Medical Staff, the Vice President of the Medical Staff, AMA/CMA OMSS representative, four (4) additional voting members who are Medical Staff members, and non-voting members who are representatives, respectively, from: Health Information Management, Quality Resource Management, Medical Center Administration, a nursing professional and Medical Staff Administration Support Staff. Others may be invited as necessary. The Chair of the Bylaws Committee shall have been a Past President of the Medical Staff who shall be appointed by the President of the Medical Staff and approved by the Medical Staff Executive Committee.

12.3-2 Duties
The Committee shall:

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

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

c) Receive and consider all additional matters specified in subparagraph a) as may be referred by the Medical Staff Executive Committee, Clinical Services, the Chief Medical Officer, the 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 a minimum of seven (7) members and at least one (1) member of the Medical Staff from each of the following services: Surgery, Gynecology and Obstetrics, Pediatrics, Radiology, Medicine, Pathology and Laboratory Medicine, Family Medicine, and Radiation Medicine. Other members may be appointed as needed with the Tumor Registry Coordinator being an invitee. The Director of the Cancer Institute shall Chair the Cancer Committee if eligible.

12.4-2 Duties
The Cancer Committee is a multidisciplinary committee and shall:

a) Be responsible for a functioning tumor registry and make periodic reports to the Medical Staff;

b) Be responsible for cancer educational activities;

c) Provide consultative Tumor Board services for inpatients and outpatients of the Medical Center;

d) Review and evaluate the quality, safety, and appropriateness of patient care within the Oncology units and report these findings to the Medical Staff Quality Improvement Committee;

e) Coordinate activities for ACOS accreditation.
12.4-3 Meetings
The Committee shall meet at least quarterly.

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 quarterly.

12.6 Credentials Committee

12.6-1 Composition
The Credentials Committee shall consist of the President, President-Elect, Vice President, and Secretary, of the Medical Staff, the two (2) Medical Staff members who are the Immediate Past Presidents of the Medical Staff, the Chief Medical Officer, a representative from Medical Center Administration, and any members added at the discretion of the Medical Staff President. The Chief Medical Officer shall usually chair this committee.

12.6-2 Duties
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 Meetings
The Committee shall meet at least quarterly.

12.7 Critical Care Committee

12.7-1 Composition
The Critical Care Committee shall consist of Patient Safety Officer, at least one (1) member of the Medical Staff who is active in each of the following critical care units: Pediatric Intensive Care Unit, Medical Intensive Care Unit, Surgical-Trauma Intensive Care Unit, Coronary Intensive Care Unit, and Cardiothoracic Intensive Care Unit, and a representative from the Anesthesiology Service, Emergency Medicine Service, Pathology and Laboratory Medicine Service, 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 quarterly.

12.8 Graduate Medical Education Committee

12.8-1 Composition
The Graduate Medical Education Committee shall consist of the Designated Institutional Official for Graduate Medical Education (DIO-GME), the Vice President for Medical Administration, the Associate Dean for Graduate Medical Education, the Associate Chief of Staff for Education of the Pettis Memorial VA Medical Center, the Director of Medical Education for Riverside County Regional Medical Center, or designee, and at least six (6) representatives of the Medical Staff who are Program Directors of major residency programs at the Medical
Center. The Committee Chair shall be the Medical Staff member who is the DIO-GME and/or the Director of Graduate Medical Education at the Medical Center.

12.8-2 Duties
The Committee shall be responsible for:

a) Establishing Medical Center policies governing graduate medical education;

b) Establishing and maintaining liaison with residency program directors and with the administration of all institutions participating in graduate medical education programs sponsored by the Medical Center;

c) Reviewing on a regular basis, all sponsored residency programs for compliance with institutional policies and accreditation requirements.

12.8-3 Meetings
The Committee shall meet at least quarterly.

12.9 Infection Control Committee

12.9-1 Composition
The Infection Control Committee shall consist of 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 Patient Safety Officer, 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:

      1) The Medical Staff Executive Committee;
      2) The Administrator;
      3) The Medical Center Senior Vice President for Patient Care Services;
      4) The person responsible for Medical Center quality improvement activities.

12.9-3 MEETINGS
The Committee shall meet at least quarterly.

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. Members of this committee are the Chief Medical Officer or designee, and additional members of the Medical Staff appointed by the Medical Staff Executive Committee, and a representative from Health Information Management. Medical Staff membership shall be in compliance with 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 quarterly.

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 included as committee members or as invited guests 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 physician 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.

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

12.11-3 Meetings
The Committee shall meet at least quarterly and as called.

12.12 Medical Record Committee

12.12-1 Composition
The Medical Record Committee shall consist of the Vice President of the Medical Staff, the Chief Medical Officer (or designee), the Patient Safety Officer, two (2) Medical Staff representatives from Medicine, two (2) Medical Staff representatives from Surgery, one (1) Medical Staff representative from Pediatrics, and one (1) representative from Nursing Services and Health Information Management, Medical Center Administration, and the Designated Institutional Official for Graduate Medical Education and/or

12.12-2 Duties
The Committee shall:

a) Review, organize, and standardize the medical record in its most functional and useful form;
b) Review Medical Staff and Medical Center policies, rules and regulations relating to medical records, including forms, formats, filing, indexing, storage, destruction, and changes therein;
c) 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;
d) Be responsible for ensuring medical records meet high standards of patient care usefulness and of historical validity;
e) Conduct a monthly review of currently maintained medical records to ensure they properly describe the condition and progress of the patients, the therapy provided, the results thereof, and the identification of responsibility for actions taken, and that they are sufficiently complete and legible so as to meet the criterion of medical comprehension of the case in the event of transfer of practitioner responsibility for patient care;
f) Conduct a review of records of discharged patients to determine the promptness, adequacy and completeness thereof.

12.12-3 Meetings
The Committee shall meet at least quarterly.

12.13 Medical Staff Quality Improvement Committee

12.13-1 Composition
The Medical Staff Quality Improvement Committee shall consist of at least one (1) member of the Medical Staff representing the quality improvement activities from each of the following services: Emergency Medicine, Gynecology and Obstetrics, Medicine, Pediatrics, and Surgery. The President-Elect shall be a member. The Chief Medical Officer (or designee) and the DIO-GME/Director of Graduate Medical Education shall be members ex officio with vote. In addition, the Medical Staff member who is the Vice President for Medical Administration of the Medical Center shall be a member representing the Medical Center. The Patient Safety Officer shall chair this committee. He/she shall be appointed by the President of the Medical Staff and approved by the Medical Staff Executive Committee.

Staff support to the Committee shall be provided by the Quality Resource Management Department, through the department director who shall be a permanent invitee.

12.13-2 Duties
The Committee shall:

a) Integrate and coordinate the peer review based quality improvement activities of the various clinical services of the Medical Staff;

b) Coordinate the reviewing of procedures;

c) Submit, no less than quarterly, to the Medical Staff Executive Committee a summary of the results of the quality improvement activities of the various clinical services of the Medical Staff;

d) Assist in development of appropriate educational programs at the Medical Center and Loma Linda University to address any needed educational interventions directed at members of the Medical Staff;

e) Be responsible for the Medical Staff’s documented compliance with quality improvement accreditation standards as they apply to the Medical Staff;

f) A quarterly tissue report presented by the Chair of Pathology QI Committee will address cases in which there is a major discrepancy between the pre-operative and post-operative (including histologic) diagnoses.

12.13-3 Meetings
The Committee shall meet at least quarterly.
12.14 Medical Staff Well Being Committee

12.14-1 Composition
The Medical Staff 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) 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.

c) Monitor any affected Medical Staff member’s or AHP’s progress in and adherence to any treatment program, with specific attention to patient safety, until rehabilitation, or any necessary disciplinary progress, is complete.

d) 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.

e) Report periodically, and not less than quarterly, 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.

f) 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.

12.15 Operating Room Committee

12.15-1 Composition
The Operating Room Committee shall consist of two members from Anesthesia (the Chair of the Anesthesia QI Committee and one additional Anesthesiologist), and one (1) Medical Staff member from the following Services and Sections: Hospital Dentistry, General Surgery, Pediatric Surgery, Gynecology and
Obstetrics, Head and Neck Surgery (Otorhinolaryngology), Neurosurgery, Ophthalmology, Orthopedic Surgery, Plastic and Reconstructive Surgery, Cardiothoracic Surgery, Oral & Maxillofacial Surgery, and Urology Surgery; the Medical Director of Operating Rooms, PATS Medical Director, Executive Director of Perioperative Services, and a representative from Administration. The Patient Safety Officer, the Chief of Surgery and the Chief of Anesthesiology (or designees) shall be ex-officio voting members of the Operating Room Committee.

12.15-2 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 O.R. time;
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 the Operating Room supervisor with overall duties and provide liaison between nursing and Medical Staff;
d) Provide liaison between surgeons and anesthesiologists;
e) Develop basic management policies for the operating suites.

12.15-3 Meetings
The Committee shall meet at least quarterly or as needed.

12.16 Pharmacy and Therapeutics Committee

12.16-1 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.

12.16-2 Duties
The Committee shall:

a) Be responsible for the development and implementation of a hospital formulary, including the evaluation of clinical data concerning new drugs or preparations requested for therapeutic use in the Medical Center, as well as to create, maintain, and update the Formulary;
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.

12.16-3 MEETINGS
The Committee shall meet at least quarterly.

12.17 PROFESSIONAL PRACTICE COMMITTEE

12.17-1 COMPOSITION
The Professional Practice Committee shall consist of the Medical Staff member who is Vice President for Medical Administration, or designee, who shall serve as Chair, the Chief of Staff, or the Patient Safety Officer who shall serve as Vice Chair; the DIO-GME/Director of Graduate Medical Education, the President of the Medical Staff; the President-Elect of the Medical Staff; the Chief Medical Officer (or designee); the CEO/Administrator of the Medical Center, or designee as an ex-officio member; representative(s) from Risk Management; at least six (6) additional Medical Staff members. The Committee shall include members who are from each of the following Services: Medicine, Surgery, Anesthesiology, Pediatrics, Obstetrics and Gynecology, Emergency Medicine, and Psychiatry who is also a member of the Medical Staff of the BMC. The Director of Quality Resource Management shall be a member. Others may be invited as needed.

12.17-2 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.

12.17-3 MEETINGS
The Committee shall meet at least quarterly.

12.18 TRANSFUSION COMMITTEE

12.18-1 COMPOSITION
The Transfusion Committee shall consist of 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. Additional members may be appointed to represent the nursing service and the procurement staff of the Blood Bank. A Quality Resource Management Department representative shall attend and provide service as an invitee.

12.18-2 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.

12.18-3 Meetings
The Committee shall meet at least quarterly. Additional meetings may be called from time to time by the Chair.

12.19 Utilization Management Committee

12.19-1 Composition
The Utilization Management Committee shall consist of five (5) or more representatives of the Medical Staff, each from a different service. 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.

12.19-2 Duties
The Utilization Management Committee shall:

a) 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;

b) 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;
c) 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.

12.19-3 Meetings: The Committee shall meet at least quarterly.
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 15.6. 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.

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 writing setting forth the action so taken signed by each member entitled to vote thereat.

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.
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:

a) Applications for appointment, reappointment, clinical privileges, practice privileges, and prerogatives and periodic reappraisals of Medical Staff membership, privileges, and/or prerogatives;

b) Corrective action, hearings and appellate reviews;

c) 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;

d) National Practitioner Data Bank (NPDB) queries and reports, peer review organizations, Medical Board of California and similar reports.

14.5 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:

a) 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;

b) 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;

c) 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 RULES AND REGULATIONS

15.1-1 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 conflict between the Bylaws and Rules and Regulations, the Bylaws shall prevail.

15.1-2 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.

15.1-3 CLINICAL SERVICE RULES AND REGULATIONS
Each Clinical Service shall formulate its own Rules and Regulations for the conduct of its affairs and the discharge of its responsibilities, subject to the approval of the Governing Body, which approval shall not unreasonably be withheld. Such Rules and Regulations shall not be inconsistent with these Bylaws, the general Rules and Regulations of the Medical Staff, or other policies of the Medical Center. These Rules and Regulations shall be reviewed bi-annually, or as specified in the Clinical Service Rules and Regulations.

15.2 PROFESSIONAL LIABILITY INSURANCE

15.2-1 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.

15.2-2 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.

15.3 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.

15.4 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.

15.5 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.

15.6 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.

15.7 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.

15.7-1 Chief Compliance Officer

The Chief Compliance Officer of Loma Linda University Medical Center shall serve as advisor to the Medical Staff Executive Committee, President and Chief
of Staff with respect to matters of compliance with governmental requirements and potential disciplinary actions that might arise from such issues.
ARTICLE XVI: ADOPTION AND AMENDMENT OF
BYLAWS AND RULES AND REGULATIONS

16.1 MECHANISM FOR ADOPTION OF AMENDMENTS TO THE BYLAWS

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.

16.1-1 AMENDMENTS ADOPTED BY PAPER BALLOTS

If the proposed amendments are submitted for paper voting, the following procedure shall be followed: The exact wording of the proposed changes shall be made available 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 be mailed to the last known home address of every Active Medical Staff member. The exact wording of the proposed changes and instructions regarding the procedure for voting shall be available at multiple locations:

a) The Medical Staff Administration Office
b) The office of the Medical Center administrator
c) The office of each Chief of Service

The proposed changes must be voted upon as a whole. The procedure for distributing, returning, and counting ballots shall be determined by the Medical Staff Executive Committee. Ballots for more than half (>50%) of the Active Medical Staff members must be returned. In order for the proposed changes to be adopted, the affirmative vote of two-thirds (66 2/3 %) of those returning their ballot shall be required.

16.1-2 BYLAWS AMENDMENTS VOTED AT A MEDICAL STAFF MEETING

If the proposed amendments are to be voted at a meeting, the following procedure shall be followed: The proposed amendments shall be submitted and be effected at the annual or any special meeting of the Medical Staff, provided that such notice of such business is sent to all members not less than thirty (30) days before such meeting. The notice shall include the exact wording of the proposed addition or amendment, if applicable, and the time and place of the meeting. In order to enact a change, a quorum must be present and the affirmative vote of two-thirds (66 2/3 %) of the Active Medical Staff members present at the meeting shall be required.
16.2 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. Neither the Medical Staff nor the Governing Body may unilaterally amend the Bylaws of the Medical Staff. The Bylaws shall be reviewed annually.

16.3 Mechanism for Adoption of Changes to the Rules and Regulations

Recommended changes to the Rules and Regulations shall be submitted to, or developed by, the Medical Staff Bylaws Committee. They Bylaws Committee shall submit recommended changes to the Medical Staff Executive Committee for review and adoption. Following adoption by the Medical Staff Executive Committee, such changes in the Rules and Regulations shall become effective following approval of the Governing Body whose approval shall not be withheld unreasonably. Neither the Medical Staff nor the Governing Body may unilaterally change the Rules and Regulations of the Medical Staff. The Medical Staff Rules and Regulations shall be reviewed at least annually. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, change, or repeal of the Medical Staff Rules and Regulations.

APPROVED by the Medical Staff on June 13, 2006

John Testerman, MD, President of the Medical Staff

James Couperus, MD, Chair of the Bylaws Committee

APPROVED, Governing Board, May 24, 2006

B. Lyn Behrens, MBBS, Board Officer
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Medical Staff Rules and Regulations
The Rules and Regulations are a separate document and can be found on the LLUMC VIP intranet site, Physician Resource Directory under the Clinical heading, 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