MEDICAL STAFF

Bylaws

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TORRANCE MEMORIAL MEDICAL CENTER
MEDICAL STAFF BYLAWS

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PREAMBLE

These Bylaws are adopted in order to provide for the organization of the Medical Staff of Torrance Memorial Medical Center and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes, subject to the ultimate authority of the Hospital Governing Body. These bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Trustees, and relations with applicants to and members of the Medical Staff.

DEFINITIONS

1. HOSPITAL means Torrance Memorial Medical Center.

2. BOARD OF TRUSTEES means the governing body of the Hospital.

3. ADMINISTRATOR means the person appointed by the Board of Trustees to serve as the Chief Executive Officer (CEO).

4. MEDICAL STAFF or STAFF means those physicians (M.D. or D.O.), dentists, and podiatrists who have been granted recognition as members of the Medical Staff pursuant to the terms of these Bylaws.

5. MEDICAL EXECUTIVE COMMITTEE means the executive committee of the Medical Staff, which shall constitute the governing body of the Medical Staff as described in these Bylaws.

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

7. MEMBER means, unless otherwise expressly limited, any physician (M.D. or D.O.), dentist, or podiatrist holding a current license to practice within the scope of his or her license who is a member of the Medical Staff.

8. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a Medical Staff member or allied health professional to render specific patient services.

9. ALLIED HEALTH PROFESSIONAL means a duly licensed or approved individual, other than a licensed physician, dentist, or podiatrist, whose patient care activities require that his or her authority to perform specified patient care services be processed through the usual Medical Staff channels.

10. MEDICAL STAFF YEAR means the period from January 1 to December 31 of each calendar year, except as otherwise defined in these Bylaws.

11. CHIEF OF STAFF means the chief officer of the Medical Staff elected by members of the Medical Staff.

12. PROCTORING means the organized program for establishing and implementing requirements of the Medical Staff's peer review committee and quality control activities concerning the proctoring of performance of physicians, dentists, podiatrists, and privilege holders conducted in accordance with these Bylaws, protocols and policies/procedures adopted by the Medical Executive Committee and requirements adopted by the clinical departments.

13. DAYS mean calendar days unless otherwise indicated.

14. EX OFFICIO means service as a member of a body by virtue of an office or position held, and, unless otherwise expressly provided, means without voting rights.

15. TIME LIMITS means all time limits referred to in these Bylaws are advisory only and are not mandatory unless a specific provision states that a particular right is waived by failing to take action within a specified time period.

16. SPECIAL NOTICE means written notification sent by personal delivery, messenger, certified mail, return receipt requested, by facsimile or by electronic means. Such notice sent by certified mail shall be deemed to be received on the date indicated by the return receipt or four (4) business days after mailing, whichever comes first.

ARTICLE I

NAME

The name of this organization is the Medical Staff of Torrance Memorial Medical Center.

ARTICLE II

PURPOSES AND RESPONSIBILITIES

2.1 PURPOSES

The purposes of the Medical Staff include, without limitation, the following:

2.1-1 To be the formal organizational structure through which (a) the benefits of membership on the Medical Staff may be obtained by individual practitioners and (b) the obligations of Staff membership may be fulfilled.

2.1-2 To provide a means whereby the Medical Staff may participate in the formulation and development of Hospital policy, including ongoing discussions with the Board of Trustees and Administration of the Hospital of medical and/or administrative problems within the scope of the responsibilities of the Medical Staff.

2.1-3 To promote and provide education and maintain educational standards within the Medical Staff.

2.2 RESPONSIBILITIES

2.2-1 The responsibilities of the Medical Staff include the following:

a. A credentials program, including mechanisms for appointment and reappointment and the delineation of privileges to be exercised or specified services to be performed in a manner consistent with the verified credentials and currently demonstrated performance of the applicant, staff member, or allied health professional.

b. Review and evaluation of the quality of patient care.

c. An organizational structure that allows continuous monitoring of patient care practices.

d. A utilization management program to allocate medical and health services in an efficient manner based upon determinations of the individual patient medical needs as determined under standards developed by the Medical Staff.

e. A continuing education program structured, at least in part, to meet the needs demonstrated by the performance improvement and other quality maintenance programs.

f. Provides oversight in the process of analyzing and improving patient satisfaction.

2.2-2 To recommend action to the Board of Trustees with respect to appointments, reappointments, staff categories, department assignments, privileges, specified services for Allied Health Professionals, and corrective action.

2.2-3 To initiate and pursue corrective action with respect to practitioners, when such action is warranted.

2.2-4 To assist the Hospital in identifying community health needs, in setting appropriate institutional goals, and in implementing programs to meet those needs and goals.

ARTICLE III

MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

Membership on the Medical Staff of the Hospital is a privilege that may be extended only to professionally competent M.D.'s or D.O.'s, podiatrists, and dentists who meet and continue to meet the qualifications, standards, and requirements set forth in these Bylaws. No physician, dentist, or podiatrist, including those (i) in a medical administrative position by virtue of a contract with the Hospital, or (ii) who prescribe, diagnose or otherwise render clinical treatment to Hospital patients from a remote location using electronic or other communication or diagnostic technology, shall admit or provide medical, dental, or podiatric services, respectively, to patients in the Hospital unless he or she is a member of the Medical Staff or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws. Appointment to the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws.

3.2 QUALIFICATIONS FOR MEMBERSHIP

3.2-1 GENERAL QUALIFICATIONS

The only physicians, dentists, and podiatrists who shall be deemed to possess basic qualifications for Medical Staff membership (except for the Retired Staff to which these criteria shall only apply as deemed individually applicable by the Medical Staff) shall be those who:

a. document their (I) current licensure, (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and (5) adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care.

b. are determined (l) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care, and (3) to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff. Inability to work cooperatively shall include, but not be limited to, disruptive behavior;

c. maintain in force professional liability insurance in not less than the minimum amounts as from time to time may be determined by the Board of Trustees after having considered the recommendations of the Medical Executive Committee with an insurance carrier admitted to market insurance in the State of California or shall be and remain a member of a physicians' cooperative as defined in Section 1280.7 of California Insurance Code with the same minimum amounts of coverage. In addition, professional liability insurance is required and must be consistent with privileges granted. The certification shall include the name of the insurance carrier or cooperative, the amount of coverage, the specialty or clinical privileges covered and, if practicable, be accompanied by a certificate evidencing such coverage issued by the carrier or the physician cooperative. Each member shall report any reduction, restriction, cancellation, or termination of the required professional liability insurance coverage or change in insurance carrier or cooperative as soon as reasonably practical to the Chief of Staff via the Medical Staff Services Department.

d. demonstrate their ability to speak English adequately and write clearly and legibly in the English language to the extent necessary to communicate effectively and thereby provide such medical services as may be needed by patients at the Hospital.

e. are Board Certified or meet the requirements for obtaining board certification with regard to education, training, and experience as required by the board in the respective specialties. Boards recognized to satisfy the above requirements as determined by the Medical Executive Committee based on the recommendation of the department and at a minimum including boards approved by the American Board of Medical Specialties or American Osteopathic Association, National Board of Physicians and Surgeons, American Dental Association, American Board of Podiatric Surgery, American Board of Podiatric Orthopedics and Primary Podiatric Medicine. This board certification

requirement may be waived by the Medical Executive Committee for physicians who have education, training and experience similar to that required by the relevant boards, but whom are ineligible because of the age or training in non-board eligible institutions, including Australian, European, English, Canadian and Asian institutions.

f. are eligible for participation in Medicare, Medicaid or other federal or state health program or who are not aware of the pendency of any investigation by a governmental licensure agency, which may affect the applicant's eligibility for participation in Medicare, Medicaid or other federal or state health program.

g. have never been convicted or pled guilty or nolo contendere with respect to any felony or who have never been convicted or plead guilty or nolo contendere with respect to any misdemeanor related to the following unless the Medical Executive Committee, for good cause, shall determine otherwise.

- controlled substances
- illegal drugs
- Medicare, Medicaid, or insurance fraud or abuse
- violence against another, including sexual assault or abuse
- any other illegal activity involving patients or otherwise substantially related to the practitioner's qualifications, function, or professional practice.

3.2-2 PARTICULAR QUALIFICATIONS

a. Physicians An applicant for physician membership on the Medical Staff must hold an M.D. or D.O. degree issued by a medical or osteopathic school approved at the time of the issuance of such degree by the Medical Board of California or the Board of Osteopathic Examiners of the State of California and must also hold a valid and unsuspended certificate to practice medicine issued by the Medical Board of California or the Board of Osteopathic Examiners of the State of California.

b. Dentists An applicant for dental membership on the Medical Staff must hold a D.D.S or D.M.D. or equivalent degree issued by a dental school approved at the time of the issuance of such degree by the Board of Dental Examiners of California and must also hold a valid and unsuspended certificate to practice dentistry issued by the Board of Dental Examiners of California.

c. Podiatrists An applicant for podiatric membership on the Medical Staff must hold a D.P.M. degree conferred by a school approved at the time of issuance of such degree by the Medical Board of California and must hold a valid and unsuspended certificate to practice podiatry issued by the Medical Board of California.

3.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to Medical Staff membership merely because that person holds a certain degree, is licensed to practice in this or in any other State, is a member of any professional organization, or is certified by any clinical Board, or because such person had, or presently has, Medical Staff membership or privileges at another health care facility. Medical Staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, IPA, PPO, PHO, Hospital-sponsored foundation or other organization in contracts with a third party which contracts with this Hospital.

3.4 NONDISCRIMINATION

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, or to a qualified individual with a disability.

3.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for the Retired Staff, the ongoing responsibilities of each member of the Medical Staff shall include:

a. Providing patients with quality of care meeting the professional standards of the Medical Staff of the Hospital.

b. Abiding by the Medical Staff Bylaws, Medical Staff Rules and Regulations and Medical Staff and Medical Center policies and procedures.

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. Participating actively in Medical Staff peer review programs, reporting to appropriate Medical Staff officers and/or committees questionable quality of care concerns or conduct of Medical Staff members and other Hospital personnel of which the member is aware, serving on peer review committees, including on Judicial Review Committees as appropriate under these Bylaws, Article IX, and testifying on all matters within the member's knowledge before such committees except legally privileged information, reporting to appropriate Medical Staff departments and committees questionable utilization patterns engaged in by Medical Staff members and Hospital personnel which are not medically necessary, serving on utilization management committees, such as the Utilization Management Committee, and testifying on all matter within his or her knowledge before such committees.

e. Preparing and completing medical records for all patients to whom the member provides care in the Hospital according to regulatory and medical staff requirements.

f. Abiding by the lawful ethical principles of the California Medical Association in the case of physicians, the California Dental Association in the case of dentists, and the California Podiatry Association in the case of podiatrists.

g. Aiding in any Medical Staff approved educational programs.

h. Working cooperatively so as not to adversely affect patient care.

i. Each member of the Medical Staff shall provide continuous coverage for his/her patients and respond appropriately to emergencies. Practitioners must designate an appropriate member of the Medical Staff who agrees to provide coverage during his/her absence or unavailability. In circumstances where the physician is the only member in the specialty or if there is a question regarding the appropriateness of the covering member, the department chief shall, with the approval of the Medical Executive Committee, determine appropriate coverage. If the physician or their designee is unavailable, the department chief (of the concerned department), or Chief of Staff will be called upon to resolve the situation.

j. Refusing to engage in improper inducements for patient referrals.

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

l. Participating in such emergency service coverage or consultation panels, as outlined in the General Staff Rules and Regulations for Emergency Call Panel and as may be determined by the Medical Executive Committee.

m. Notifying the Chief of Staff or the Vice President, Medical Staff Services, in writing within five (5) calendar days, if the member becomes aware of the pendency of any investigation or final action by a governmental licensure agency, which may affect the member’s eligibility for participation in Medicare, Medicaid or other federal or state health program in any way, if his or her medical staff membership and/or privileges at any hospital have been denied, suspended, revoked, or limited in any way, if a malpractice action has resulted in a judgment or settlement against him or her which is reportable by law to the applicable state licensing agency, if his professional liability insurance has been suspended, if he is charged with or convicted of a felony or if the member becomes subject to disciplinary action by any governmental agency. Such notification shall include the particulars of the action in question.

n. Discharging such other Medical Staff obligations, including assignment as a proctor, as may be required from time to time by the Medical Staff or Medical Executive Committee.

o. Be located close enough (office and residence) to the Hospital to provide continuous care to his or her patients. The distance to the Hospital may vary depending upon the Medical Staff category and privileges that are involved and the feasibility of arranging alternative coverage, and may be defined in the Rules or adopted by the Medical Executive Committee.

p. Attending peer review meetings, patient safety or other meetings when requested by the Chief of Staff, Department Chief or other chair of a peer review body.

3.6 STANDARDS OF CONDUCT

As a condition of membership and privileges, a Medical Staff member shall continuously meet the requirements for professional conduct established in these Bylaws. Privilege holders will be held to the same conduct requirements as members.

3.6-1 ACCEPTABLE CONDUCT

Appropriate behavior means any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership or activities of the organized Medical Staff, or to engage in professional practice including practice that may be in competition with the Hospital. Appropriate behavior is not subject to discipline under these Bylaws.

Examples of appropriate behavior include, but are not limited to, the following:

a. Criticism communicated in a reasonable manner and offered in good faith with the aim of improving patient care and safety;

b. Encouraging clear communication;

c. Expressions of concern about a patient's care and safety;

d. Expressions of dissatisfaction with policies through appropriate channels or other civil non-personal means of communication;

e. Use of cooperative approach to problem resolution;

f. Constructive criticism conveyed in a respectful and professional manner, without blame or shame for adverse outcomes;

g. Professional comments to any professional, managerial, supervisory, or administrative staff, or members of the Board of Trustees about patient care or safety provided by others;

h. Active participation in Medical Staff and Hospital meetings (i.e., comments made during or resulting from such meetings cannot be used as the basis for a complaint under this Code of Conduct, referral to the Practitioners' Well Being Committee, economic sanctions, or the filing of an action before a state or federal agency);

i. Membership on other Medical Staffs; and

j. Seeking, legal advice or the initiation of legal action for cause.

3.6-2 DISRUPTIVE AND INAPPROPRIATE CONDUCT

Disruptive and inappropriate Medical Staff member conduct affects or could affect the quality of patient care at the Hospital and includes:

a. Harassment, including any abusive conduct including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others, by a Medical Staff member against any individual involved with the Hospital, including patients, on the basis, of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation.

b. Inappropriate Conduct including:
   1. Belittling or berating statements;
   2. Name calling;
   3. Use of profanity or disrespectful language;
   4. Inappropriate comments written in the medical record;
   5. Blatant failure to respond to patient care needs or staff requests;
   6. Personal sarcasm or cynicism;
   7. Deliberate lack of cooperation without good cause;
   8. Deliberate refusal to return phone calls, pages, or other messages concerning patient care

or safety;
9. Intentionally condescending language;
10. Intentionally degrading or demeaning comments regarding patients and their families; nurses, physicians, Hospital personnel and/or the Hospital.
11. Behavior that is perceived as threatening.
12. And other behaviors as deemed inappropriate by the Medical Executive Committee.

c. Sexual harassment is unwelcome verbal or physical conduct of a sexual or gender-based nature which may include verbal harassment (such as epithets, derogatory comments, or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters). Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates and/or perpetuates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

d. Deliberate physical, visual or verbal intimidation or challenge, including disseminating threats or pushing, grabbing or striking another person involved in the Hospital and any other conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive.

e. Carrying a gun or other weapon in the Hospital.

f. Refusal or failure to comply with these member conduct requirements, the Bylaws or Rules and Regulations of the Medical Staff or departments.

3.6-3 MEDICAL STAFF CONDUCT COMPLAINTS

Complaints or reports of disruptive and inappropriate conduct by Medical Staff members are subject to review whether or not the witness or complainant requests or desires action to be taken. Complaints or reports must be in writing and will be transmitted to the department chief and Chief of the Medical Staff, or to the Medical Staff officer designated by either the Chief of Staff or Medical Executive Committee. Complaints are shared with the subject member, who will be given the opportunity to respond to the officer or, if referred, the committee handling the complaint. The Medical Staff member will be notified that attempts to confront, intimidate, or otherwise retaliate against the complainant is a violation of these Standards of Conduct and may result in corrective action against the Medical Staff member. The department chief, in consultation with the Chief of Staff may refer the matter to the Professional Relations Committee for evaluation, and for further action if needed, or no further action if the Committee determines no further action is warranted. If the Committee determines no action is warranted, the decision is reported at the next Medical Executive Committee and may be discussed and acted upon at the request of any Medical Executive Committee member. The Professional Relations Committee shall follow its procedures and determine if complaints are referred to the appropriate department for evaluation or to the Medical Executive Committee for consideration of further education, investigation and, if needed, corrective action. Any action taken shall be commensurate with the nature and severity of the conduct in question.

3.6-4 HOSPITAL STAFF CONDUCT COMPLAINTS

Medical staff members' reports or complaints about the conduct of any Hospital administrators, nurses or other employees, contractors, board members or others affiliated with the Hospital must be reduced to writing and submitted to the Chief of Staff or any Medical Staff officer. The Chief of Staff shall forward the complaint or report to the appropriate Hospital authority for action. Reports and complaints regarding Hospital staff conduct will be managed by the appropriate administrator and a summary report of the results and complaints will be presented periodically to the Medical Executive Committee.

3.6-5 ABUSE OF PROCESS

Threats or actions directed against the complainant by the subject of the complaint will not be tolerated under any circumstance. Retaliation or attempted retaliation against complainants or those who are carrying out Medical Staff duties regarding conduct will be considered inappropriate and disruptive conduct and could give rise to evaluation and corrective action pursuant to the Medical Staff Bylaws.

3.7 HISTORY AND PHYSICALS AND MEDICAL APPRAISALS

a. Members or Allied Health Professionals with appropriate privileges may perform history and physical examinations.

b. All patients admitted for care in the Hospital shall receive the basic medical appraisal and history and physical as outlined in the General Staff Rules and Regulations. A member or allied health professional with appropriate privileges shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate department(s).

c. The admitting or referring member of the Medical Staff shall assure the completion of a physical examination and medical history on all patients within 24 hours after admission (or registration for a surgery or procedure requiring anesthesia or moderate or deep sedation), or immediately before admission. This requirement may be satisfied by a complete history and physical that has been performed within the 30 days prior to admission or registration (the results of which are recorded in the Hospital's medical record) so long as an examination for any changes in the patient's condition is completed and documented in the Hospital's medical record within 24 hours after admission or registration.

d. Additionally, the history and physical must be updated prior to any surgical procedure or other procedure requiring general anesthesia or moderate or deep sedation. The practitioner responsible for administering anesthesia may, if granted clinical privileges, perform this updating history and physical.

ARTICLE IV

CATEGORIES OF MEMBERSHIP

4.1 CATEGORIES

The categories of the Medical Staff shall include the following: Active, Associate, Courtesy, Provisional, Retired, and Affiliate. At each time of reappointment, the member's staff category shall be determined.

4.2 ACTIVE STAFF

4.2-1 QUALIFICATIONS

The Active Staff shall consist of members who:

a. meet the general qualifications for membership set forth in Section 3.2;

b. admit, consult, or are otherwise involved in the care of ten (10) or more patients a year in the Hospital and attend 4 meetings of the Medical Staff as outlined in Article XIII, 13.6-1 OR care for 75 patients per calendar year.

In reviewing an applicant for initial appointment to the Active Staff, the number of patients shall be determined on the basis of the actual number of H&P's, consultations, and procedures/ surgeries (inpatient or outpatient) performed during the previous one (1) Medical Staff year. In the case of

reappointment, the number of patients shall be determined on the basis of the number of H&P's, consultations, procedures/surgeries (inpatient or outpatient), performed by the applicant at the Hospital during each of the previous two years based on the date of appointment to the Medical Staff.

c. except for good cause shown as determined by the Medical Staff, have satisfactorily completed their designated term in the Provisional Staff category and at least a one (1) year appointment in the Associate Staff category.

4.2-2 PREROGATIVES

Except as otherwise provided, the prerogatives of an Active Medical Staff Member shall be to:

a. admit patients and exercise such clinical privileges as are granted pursuant to Article VII.

b. attend and vote on all matters presented at general and special meetings of the Medical Staff and of the department and committees of which he or she is a member.

c. hold staff, section, or department office and serve as a voting member of committees to which he or she is duly appointed or elected by the Medical Staff or duly authorized representative thereof.

4.2-3 TRANSFER OF ACTIVE STAFF MEMBER

An Active Staff member's failure to meet the activity and/or attendance requirements as outlined in this section shall result in the member's automatic transfer to the appropriate staff category.

4.3 ASSOCIATE STAFF

4.3-1 QUALIFICATIONS

The Associate Staff shall consist of members who:

a. meet the general qualifications for membership set forth in Section 3.2.

b. have satisfactorily completed appointment in the provisional category.

c. admit, consult or are otherwise involved in the care of six (6) or more patients a year in the Hospital.

In reviewing an applicant for initial appointment to the Associate Staff, the number of patients shall be determined on the basis of the actual number of H&P's, consultations, procedures/ surgeries (inpatient or outpatient) during the previous one (1) Medical Staff year. In the case of reappointment, the number of patient contacts shall be determined on the basis of the actual number of H&P's, consultations, procedures/surgeries (inpatient or outpatient) performed by the applicant at the Hospital during each of the previous 2 years based on the date of appointment to the Medical Staff.

4.3-2 PREROGATIVES

a. Except as otherwise provided, the prerogatives of an Associate Staff member shall be to:
   1. admit patients and exercise such clinical privileges as are granted pursuant to Article VII; and
   2. attend meetings of the general Medical Staff in a non-voting capacity, and all meetings of the Medical Staff and department of which he or she is a member, including open committee meetings and educational programs; provided, however, that the member may vote on all matters presented at meetings of the committees and of the department of which he or she is a member.

b. Associate Staff members shall not be eligible to hold office in the Medical Staff.

4.3-3 TRANSFER OF ASSOCIATE STAFF MEMBER

Appointments to the Associate Staff category shall be for a minimum of one (1) year and if, at the completion of the appointment, an Associate Staff member qualifies for appointment to the Active Staff category, that member may be automatically transferred to the Active Staff. If an Associate Staff member fails to advance to the Active Staff category after one (1) year or fails to admit or consult on the minimum number of patients under this section 4.3, that member may be automatically transferred to the appropriate Staff category. Associate Staff members who request a change in staff status to the Active Staff must meet the necessary requirements for Active Staff status prior to being appointed to the Active Staff.

4.4 COURTESY STAFF

4.4-1 QUALIFICATIONS

The Courtesy Medical Staff shall consist of members who:

a. meet general qualifications for membership set forth in Section 3.2;

b. do not regularly care for patients in the Hospital nor are regularly involved in Medical Staff functions as determined by the Medical Staff

c. provide, as requested by the Medical Executive Committee, such evidence as the Committee may require of continuing competency. Evidence that the member is actively involved in the practice of medicine at another hospital shall be considered by the Committee in satisfaction of any such request.

d. have satisfactorily completed appointment in the Provisional Staff category.

4.4-2 PREROGATIVES

Except as otherwise provided, the Courtesy Medical Staff member shall be entitled to:

a. exercise such clinical privileges as are granted pursuant to Article VII and provide care for patients in the Hospital within the following limitations: The Courtesy Medical Staff member may (1) admit no more than five (5) patients to the Hospital; or (2) provide formal consultation concerning no more than five (5) patients at the Hospital in one (1) Medical Staff year. At the discretion of the Medical Executive Committee, this may be waived for radiologists, pathologists, anesthesiologists, emergency room physicians, or other specialists whose practice rarely involves admitting patients to a general acute care hospital;

b. attend in non-voting capacity meetings of the Medical Staff and the department of which he or she is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

c. Courtesy Staff members shall not be eligible to hold office in the Medical Staff.

d. If, in the judgment of the department, a Courtesy Staff member has insufficient clinical activity at the Hospital or other hospitals to enable assessment of current competency, the department may require that the Hospital course of any patient admitted by such Courtesy Staff member be concurrently reviewed for current competence and quality of care.

4.4-3 LIMITATION

Courtesy Staff members who admit patients or regularly care for patients at the Hospital in excess of the required number shall be automatically moved to the appropriate staff category.

4.4-4 TRANSFER OF COURTESY STAFF MEMBER

If a Courtesy Staff member fails to admit or consult on the minimum number of patients at another hospital under Section 4.4-l (b), that member, upon the recommendation of the Medical Executive Committee, may be subject to termination of his Medical Staff membership and privileges.

4.5 TELEMEDICINE STAFF

4.5-1 QUALIFICATIONS

The Telemedicine Medical Staff shall consist of members who:

a. meet general qualifications for membership set forth in Section 3.2;

b. only practice telemedicine

c. provide, as requested by the Medical Executive Committee, such evidence as the Committee may require of continuing competency. Evidence that the member is actively involved in the practice of medicine at another hospital shall be considered by the Committee in satisfaction of any such request.

d. have satisfactorily completed appointment in the Provisional Staff category.

4.6 PROVISIONAL STAFF

4.6-1 QUALIFICATIONS

The Provisional Staff shall consist of members who:
a. meet the general qualifications for membership as set forth in Section 3.2

4.6-2 PREROGATIVES

a. The Provisional Staff member shall be entitled to:
   1. exercise such clinical privileges as are granted pursuant to Article VII.
   2. attend meetings of the general Medical Staff in a non-voting capacity, and all meetings of the Medical Staff and the department of which he or she is a member, including open committee meetings and educational programs, provided, however, that the member may vote on all matters presented at meetings of the committees and of the department of which he or she is a member.

b. Provisional Staff members shall not be eligible to hold office in the Medical Staff organization, but may serve upon committees.

4.6-3 OBSERVATION OF PROVISIONAL STAFF MEMBER

Each Provisional Staff member shall undergo a period of observation by designated proctors as described in Medical Staff Policy and Procedure: Proctoring. The observation shall be designed to evaluate the member's (1) proficiency in the exercise of clinical privileges initially granted and (2) overall eligibility for continued staff membership and advancement within staff categories. Observation of Provisional Staff members shall follow whatever frequency and format each department deems appropriate in order to evaluate the Provisional Staff member satisfactorily, including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records shall be maintained. The result of the observation shall be communicated by the department chief to the Credentials Committee.

4.6-4 TERM OF PROVISIONAL STAFF STATUS

A member shall remain in the Provisional Staff category until the applicable and required proctoring requirements have been met. However, failure to fulfill the requirements of Provisional Staff status

within one (1) year may constitute a voluntary resignation by such Medical Staff member or allied health professional except upon a determination of good cause by the Medical Executive Committee (see Policy & Procedure: Medical Staff: Proctoring for more details).

4.6-5 ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS

a. If the Provisional Staff member has satisfactorily demonstrated his or her ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued Medical Staff membership, the member shall be eligible for advancement from the Provisional Staff to the requested appropriate category based on satisfaction of qualifications for the respective category, upon recommendation of the Medical Executive Committee.

b. In all other cases, the appropriate department shall advise the Credentials Committee, which shall make its report to the Medical Executive Committee, which, in turn, shall make its recommendation to the Board of Trustees regarding a modification or termination of clinical privileges.

4.7 RETIRED STAFF

4.7-1 QUALIFICATIONS

The Retired Staff will consist of physicians, dentists and podiatrists who have retired from active practice and, at the time of their retirement, were members in good standing of the Medical Staff, and who continue to adhere to appropriate professional ethical standards.

4.7-2 PREROGATIVES

Retired Staff members are not eligible to admit patients to the Hospital or to exercise clinical privileges in the Hospital, or to vote or hold office in this Medical Staff Organization, but they may serve upon committees with or without vote at the discretion of the Medical Executive Committee. They may also attend staff and department meetings, including open committee meetings and educational programs.

4.8 AFFILIATE STAFF

4.8-1 QUALIFICATIONS

The Affiliate Staff shall consist of members who meet those general qualifications for membership as they pertain to membership and privileges and must be practicing medicine, e.g., actively treating patients in the office or medical center and have malpractice insurance coverage as described in Article III of these bylaws.

4.8-2 PREROGATIVES

Affiliate Staff members may come to the Hospital and visit their patients, review those patients' medical records, and may not make entries in medical records except for histories and physicals (surgical and other invasive procedures) provided they have obtained history and physical privileges. These members may order outpatient tests and services, attend Medical Staff department meetings, CME and participate in social functions. These members are eligible for privileges to perform histories and physicals but may not manage patient care in the Hospital and may not vote on Medical Staff affairs or hold office.

Members who desire additional privileges shall submit a request. The request shall be processed as outlined in Section 6.6 of Article VI.

4.9 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these Bylaws and by the Medical Staff rules and regulations.

4.10 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership in the Medical Staff, limited license members:

a. shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the Chairman of the meeting, subject to final decision by the Medical Executive Committee; and

b. shall exercise clinical privileges only within the scope of their licensure and as set forth in Section 6.1.

4.11 MODIFICATION OF MEMBERSHIP CATEGORY

On its own, upon recommendation of the Credentials Committee, or pursuant to a request by a Member under Section 6.6-1(b), the Medical 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 care professionals (non-physicians, non-dentists, and non-podiatrists) may request clinical privileges and once granted shall be considered Allied Health Professionals. Applicants must meet the basic qualifications as set forth in Section 3.2 of these Bylaws as applicable to their professional license. The Medical Executive Committee, with the approval of the Board of Trustees, shall establish particular qualifications required on the respective Clinical Privilege Application Form.

5.2 PROCEDURE FOR SPECIFICATION OF SERVICES

Applications shall be submitted and processed in the same manner as provided in Article VI for Medical Staff membership. By filing an application to provide specified clinical privileges an applicant specifically consents to be bound by these Bylaws, the Rules and Regulations of the Medical Staff, and other rules and policies of the Medical Staff, the individual clinical departments, and the Hospital. An applicant also releases from any liability all individuals and organizations who provide or act upon information in good faith and without malice concerning the applicant's qualifications for designation as an Allied Health Professional, including information otherwise privileged or confidential.

An Allied Health Professional shall be individually assigned to the clinical department that is most appropriate based on professional training, and shall be subject to the same terms and conditions as specified for Medical Staff appointments; provided, however, that: (1)Allied Health Professionals are not and shall not be considered to be members of the Medical Staff, and (2) corrective action with regard to Allied Health Professionals, including termination or suspension of service authorized, shall be accomplished in accordance with usual Hospital personnel practices or the individual Allied Health Professional's employment agreement, if any. The hearing and appellate procedures specified in Article IX for Members of the Medical Staff shall not apply to Allied Health Professionals, except for Physician Assistants. However, when AHP privileges are denied, revoked, or revised, the Allied Health Professional may request and will be granted a hearing before the Medical Executive Committee and if unwilling to accept the decision of the Medical Executive Committee the Allied Health Professional may appeal to the Board of Trustees. The Board of Trustees' decision will be final.

5.3 PREROGATIVES

The prerogatives of Allied Health Professionals shall be as follows:

a. To provide specified patient care services under the supervision or direction of a physician member of the Medical Staff, consistent with the limitations stated in this Article V.

b. To exercise such responsibilities and fulfill such obligations as may be designated from time to time by the Medical Executive Committee or by the department to which he or she is assigned, subject to the approval of the Board of Trustees.

c. To attend Hospital continuing education programs.

d. To attend meetings of the Medical Staff and of the department to which he or she is assigned.

e. To serve on Medical Staff committees to which he or she is appointed, except the Medical Executive, Credentials, and Nominating Committees; provided however, that an Allied Health Professional may not vote on any matter.

5.4 RESPONSIBILITIES

Allied Health Professionals shall be required to discharge the following responsibilities:

a. Fulfilling the basic responsibilities for Medical Staff membership set forth in Section 3.5 of these Bylaws;

b. Retaining appropriate responsibility within their area(s) of professional competence for the care and supervision of each patient in the Hospital for whom they provide services, subject to continuing proctoring and evaluation by the Medical Staff;

c. participating, as appropriate, in patient care performance improvement activities;

d. Exercising such responsibilities and fulfilling such obligations as may be designated from time to time by the Medical Executive Committee or by the department to which he or she is assigned.

5.5 MEDICAL STAFF SUPERVISION

Members of the Medical Staff who are responsible for the supervision of Allied Health Professionals shall assure that the conduct of such personnel conforms with the dictates of these Bylaws, the Rules and Regulations of the Medical Staff, other rules and policies of the Medical Staff, and the individual departments.

ARTICLE VI

HOUSE STAFF

6.1 QUALIFICATIONS

House Staff are physicians-in-training enrolled in a Cedars Sinai Health System approved residency or fellowship program. Members of House Staff are not eligible for membership of the Medical Staff of Torrance Memorial Medical Center.

6.2 PREROGATIVES

The prerogatives of House Staff shall be as follows:

House Staff will be permitted to function clinically only in accordance with written training protocols developed by the local residency director and the director of graduate medical education. These protocols will delineate the roles, responsibilities, and patient care activities of residents and fellows, including expectations involving patient care orders and supervising physician countersignature of orders and notes.

6.3 RESPONSIBILITIES

House Staff are expected to participate in the patient safety and continuous quality improvement programs of their department and hospital as appropriate. All clinical orders and entries in the medical record made by House Staff are expected to reflect and support the plan of care developed with the supervising physician.

6.4 MEDICAL STAFF SUPERVISION

Members of the Medical Staff who are responsible for the supervision of House Staff shall assure that the conduct of such personnel conforms with the dictates of these Bylaws, the Rules and Regulations of the Medical Staff, other rules and policies of the Medical Staff, and the individual departments.

The graduate medical education program director will periodically communicate with the Medical Executive Committee and/or the Board of Trustees regarding resident performance, patient safety, and quality of care delivered by physicians-in-training.

ARTICLE VII

APPOINTMENT AND REAPPOINTMENT

7.1 GENERAL

Except as otherwise specified herein, no person (including persons (i) who prescribe, diagnose or otherwise render clinical treatment to Hospital patients from a remote location using electronic or other communication or diagnostic technology or (ii) engaged by the Hospital in administratively responsible positions) shall exercise clinical privileges in the Hospital (including by virtue of the use of electronic or other communication or diagnostic technology from a remote location) unless and until he or she applies for and receives appointment to the Medical Staff or is granted clinical privileges or is granted temporary privileges as set forth in these Bylaws. By applying to the Medical Staff for appointment or reappointment (or, in the case of members of the Retired Staff, by accepting an appointment to that category), the applicant acknowledges responsibility to review these Bylaws and agrees that throughout the application period and staff membership he or she will comply with the responsibilities of Medical Staff membership and with the Bylaws, Rules and Regulations and Policies and Procedures of the Medical Staff as they exist and as they may be modified from time to time. Appointment to the Medical Staff or the granting of clinical privileges shall confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws.

Persons wishing to exercise privileges to perform histories and physicals (surgical and other invasive procedures) for the Hospital (see Affiliate Staff Prerogatives), may submit an application for appointment to the Affiliate Staff category. Once approved, members in the Affiliate Staff category shall not exercise other privileges. Affiliate Staff members wishing to exercise additional privileges shall submit a request to add specific privileges. This will be processed as outlined in Section 6.6 of this Article.

7.2 BURDEN OF PRODUCING INFORMATION

7.2-1 BURDEN OF PRODUCING INFORMATION – INITIAL APPOINTMENT

In connection with all applications for appointment, the applicant shall have the burden of producing all information necessary for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, of satisfying requests for information and for completing orientation. The applicant's failure to sustain this burden, or undue delay in doing so, shall be grounds for automatic withdrawal of the application. Without limitations, an applicant shall be deemed to have failed to sustain such burden for failure to do so within one hundred eighty (180) days following submission of the application. This burden may include submission to a medical or psychiatric examination, at the applicant's expense, if deemed appropriate by the Medical Executive Committee, which may also select the examining physician.

The time frame for completion of orientation for applicants shall be sixty (60) business days following the date of approval of the application by the department chief. Failure to complete the orientation within this time frame shall be deemed a voluntary withdrawal of the application.

7.2-2 BURDEN OF PRODUCING INFORMATION – REAPPOINTMENT

In connection with all applications for reappointment, the applicant shall have the burden of producing all information necessary for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden, or his or her undue delay in doing so, shall be grounds for resignation of membership to the Medical Staff. Without limitations, an applicant shall be deemed to have failed to sustain such burden if he or she fails to do so in a time frame outlined in the Medical Staff Reappointment Process Policy and Procedure prior to the applicant's appointment expiration date. This burden may include submission to a medical or psychiatric examination, at the applicant's expense, if deemed appropriate by the Medical Executive Committee, which may also select the examining physician. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article IX shall not apply.

7.3 APPOINTMENT AUTHORITY

Appointments, denials and revocations of appointments to the Medical Staff shall be made as set forth in these Bylaws, but only after there has been a recommendation from the Medical Staff.

7.4 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these Bylaws, initial appointments to the Medical Staff shall be for a period of up to two (2) Medical Staff years. Reappointment shall be for a period up to two (2) Medical Staff years.

7.5 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT (Includes Medical Staff and Allied Health Professionals)

7.5-1 APPLICATION AND REAPPOINTMENT FORM:

An application form shall be developed by the Medical Executive Committee and approved by the Board of Trustees. Each application for initial appointment to the Medical Staff shall be typed or in digital font, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), signed by the applicant, and submitted to the Medical Staff Services Department at the Hospital. When an initial applicant requests an application form, he or she shall be given a copy of these Bylaws, the Medical Staff rules and regulations, and applicable policies relating to clinical practice in the Hospital, if any.

In the case of reappointment, a reapplication form developed by the Medical Executive Committee shall be mailed or delivered to the applicant (see Medical Staff Reappointment Process Policy and Procedure for more details regarding timing, etc.). Each applicant's reappointment packet shall be evaluated by the department chief and then submitted to the Credentials Committee, Medical Executive Committee and Board of Trustees for renewal of appointment and/or the granting of clinical privileges.

The initial and reappointment application form shall require detailed information which shall include, but not be limited to, information concerning:

a. The applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA registration as determined by their department, and continuing medical education information related to the clinical privileges to be exercised by the applicant;

b. when appropriate, peer references familiar with the applicant's professional competence and ethical character;

c. whether the applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced, voluntarily relinquished or not renewed at any other hospital or health care institution for any reason, and whether any of the following have ever been suspended, revoked, voluntarily relinquished or denied for any reason: (l) membership/fellowship in local, state or national professional organizations; (2) specialty board certification; (3) license to practice any profession in any jurisdiction; or (4) Drug Enforcement Agency (DEA) certificate number. If any such actions were ever taken or if any such actions are now pending, the particulars thereof shall be included;

d. requests for membership categories, departments, and clinical privileges;

e. ability to practice in an appropriate manner in accordance with Article III of these Bylaws;

f. past or pending professional disciplinary action, licensure limitations, or related matters;

g. physical and mental health status;

h. evidence of continuous professional liability insurance coverage in accordance with Section 3.2-1 (c) of these Bylaws;

i. ability to speak English adequately and write clearly and legibly in accordance with Section 3.2-1(d) of these Bylaws;

j. final judgments or settlements made against the applicant in professional liability cases, and any filed and/or served cases pending within the last five years for initial applicants and the last two years for reappointment applications.

k. currently in any diversion/treatment program, voluntary or involuntary.

7.5-2 EFFECT OF APPLICATION AND REAPPOINTMENT

In addition to the matters set forth in Section 6.1, by applying for appointment to the Medical Staff each applicant:

a. agrees to appear, if requested, before the Credentials Committee, the Medical Executive Committee, and any other authorized members of the Medical Staff who are responsible for evaluating the applicant and his or her credentials with regard to the application;

b. agrees to be charged and to pay to the Hospital a reasonable application fee, as determined from time to time by the Medical Executive Committee;

c. authorizes consultation with others who have been associated with him or her and who may have information bearing on his or her competence, qualifications, and performance, and authorizes such individuals and organizations to candidly provide all such information;

d. consents to inspection of records and documents that may be material to an evaluation of his or her qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

e. releases from any liability to the fullest extent permitted by law, all persons for their performance in connection with investigating and evaluating the applicant;

f. releases from any liability to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise privileged and/or confidential information;

g. consents to the disclosure to other hospitals, medical associations, licensing boards, and other similar organizations any information regarding his or her professional or ethical standing that the Hospital or Medical Staff may have, and releases the Medical Staff and Hospital from liability for so doing to the fullest extent permitted by law;

h. if a requirement exists for the payment of Medical Staff dues or fines, payment must be submitted to complete the reappointment application;

i. pledges to provide for continuity of quality care for his or her patients;

j. pledges to maintain an ethical practice, including refraining from illegal inducements for patient

referral, providing continuous care of his or her patients, seeking consultation whenever necessary, refraining from providing surgical or medical services unless the patient knows that he or she is performing such services, except in an emergency where the patient is not competent to possess such knowledge, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners.

7.5-3 VERIFICATION OF INFORMATION

The applicant or member shall deliver a completed application or reappointment application to the Medical Staff Services Department and at that time shall pay the full amount of applicable Medical Staff application or other fees (dues, fines, etc.). The Credentials Committee, and the Chief of Staff if his or her assistance is requested by the Credentials Committee, shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The applicant or member shall be notified of any problems in obtaining the information required, and it shall be the applicant's or member's obligation to obtain the required information. When collection and verification is accomplished, all such information shall be transmitted to the Credentials Committee and the appropriate department(s).

7.5-4 CREDENTIALS COMMITTEE ACTION

a. Application

1. Initial: The Credentials Committee shall review the application, evaluate and verify the supporting documentation. The Credentials Committee may elect to interview the applicant and seek additional information. The Credentials Committee shall refer the application to the chief of each department in which the applicant seeks privileges. Following department action on the application as set forth in Section 6.5-5, the Credentials Committee shall review the department chief's report and recommendations, and other relevant information. The Credentials Committee shall transmit to the Medical Executive Committee a written report and its recommendations as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The Committee may also recommend that the Medical Executive Committee defer action on the application

2. Reappointment: The application shall be referred to the chief of each department in which the applicant seeks privileges. Following department action on the application as set forth in Section 6.5-5, the Credentials Committee shall review the application, evaluate, and verify the supporting documentation, the department chief's report and recommendations, and other relevant information. The Credentials Committee may elect to interview the applicant and seek additional information. The Credentials Committee shall transmit to the Medical Executive Committee a written report and its recommendations as to reappointment and, if reappointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the reappointment. The Committee may also recommend that the Medical Executive Committee defer action on the application.

b. The Credentials Committee shall develop, and recommend for approval by the Medical Executive Committee, specific policies concerning confidentiality of the Medical Staff appointment and reappointment processes, and all persons participating in the appointment and/or reappointment processes shall act in accordance with such policies.

7.5-5 DEPARTMENT ACTION

After receipt of the application, the chief, or the appropriate committee of each department to which the application is submitted, shall review the application and supporting documentation and may conduct a personal interview with the applicant at the chief's or chairman's discretion. The chief or appropriate committee shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges granted, and shall transmit to the Credentials Committee a written report and recommendation as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to

be granted, and any special conditions to be attached. The chief may also request that the Medical Executive Committee defer action on the application.

7.5-6 MEDICAL EXECUTIVE COMMITTEE ACTION

At its next regular meeting after receipt of the Credentials Committee report and recommendation, or as soon thereafter as is practicable, the Medical Executive Committee shall consider the report and any other relevant information. The Medical Executive Committee may request additional information, return the matter to the Credentials Committee for further investigation, and/or elect to interview the applicant. The Medical Executive Committee shall forward to the Administrator, for prompt transmittal to the Board of Trustees, a written report and recommendation as to Medical Staff appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The Committee may also defer action on the application. The reasons for each recommendation shall be stated.

7.5-7 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

a. Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, it shall be promptly forwarded, together with supporting documentation, to the Board of Trustees.

b. Adverse Recommendation: When a final recommendation of the Medical Executive Committee is averse to the applicant, the Board of Trustees and the applicant shall be promptly informed by written notice. The applicant shall then be entitled to the procedural rights as provided in Article IX.

7.5-8 ACTION ON THE APPLICATION

The Board of Trustees may accept the recommendation of the Medical Executive Committee or may refer the matter back to the Medical Executive Committee for further consideration, stating the purpose for such referral. The following procedures shall apply with respect to action on the application:

a. If the Medical Executive Committee issues a favorable recommendation and:

   1. the Board of Trustees concurs in that recommendation, the decision of the Board shall be deemed final action.

   2. the tentative recommendations of the Board of Trustees is unfavorable, the administrator shall give the applicant written notice of the tentative adverse recommendation and the applicant shall be entitled to procedural rights set forth in Article IX. If the applicant waives his or her procedural rights, the decision of the Board shall be deemed the final action.

b. In the event the recommendation of the Medical Executive Committee, or any significant part of the recommendation, is unfavorable to the applicant, the procedural rights set forth in Article IX shall apply and the consequences shall be as set forth in one of the following three subsections, as applicable:

   1. If no Judicial Review Committee hearing is requested by the applicant, the recommendation of the Medical Executive Committee shall become the final action.

   2. If a hearing is requested and the decision of a Judicial Review Committee is unfavorable to the applicant the Board of Trustees shall take final action only after the applicant has exhausted his or her procedural rights as established by Article IX. The Board may defer final determination by referring the matter back to the Medical Executive Committee or Judicial Review Committee for further consideration, stating the purpose for the referral.

After receipt of such subsequent recommendation, if any, the Board shall make a final decision and shall affirm the decision of the Medical Executive Committee if the Medical Executive Committee's findings are supported by substantial evidence and the Medical

Executive Committee's recommendation to the Medical Executive Committee to be arbitrary, capricious, or otherwise not in accordance with the law and states the reason for its findings in writing.

7.5-9 NOTICE OF FINAL DECISION

a. Notice of the final decision shall be given to the Chief of Staff, the Medical Executive Committee, the Credentials Committee, the chief of each department concerned, the applicant, and the Administrator.

b. A decision and notice to appoint or reappoint shall include, if applicable: (1) the staff category to which the applicant is appointed; (2) the department to which he or she is assigned; (3) the clinical privileges granted; and (4) any special conditions attached to the appointment.

7.5-10 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant or member who has received a final adverse decision regarding appointment or who has been removed from the Medical Staff shall not be eligible to reapply to the Medical Staff for a period of at least one (1) year. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

7.5-11 TIMELY PROCESSING OF APPLICATIONS

After collection and verification is completed, applications for initial appointment shall be acted upon by the Medical Executive Committee within one hundred and eighty (180) days and then submitted to the Board of Trustees. The 180 day time period begins when the application is complete which is defined as all required and requested information from the applicant has been received.

Applications for reappointment shall be considered and acted upon prior the reappointment expiration date by all persons and committees required by these Bylaws to act thereon.

7.5-12 EXTENSION OF APPOINTMENT

Appointment is required, at the most, every two (2) years and extension of appointment is not allowed.

7.5-13 FAILURE TO FILE REAPPOINTMENT APPLICATION

Failure without good cause to timely file a completed application for reappointment shall result in the automatic suspension of the member's clinical privileges and prerogatives at the end of the current staff appointment. If the member fails to submit a completed application for reappointment within ninety (90) days past the date it was due, the member shall be deemed to have resigned his/her membership on the Medical Staff. A completed application for reappointment includes compliance with the terms of staff status held by the member at the time he/she is seeking reappointment.

7.5-14 REAPPOINTMENT APPLICATIONS OF SUSPENDED MEMBERS

Reappointment applications of members who are under suspension for any reason will be considered incomplete and shall not be processed for approval.

7.5-15 EVIDENCE OF CURRENT COMPETENCY

The privileges of members who fail at the time of reappointment to have demonstrated sufficient activity levels designated by the relevant departments pursuant to Section 7.2-3 shall be deemed to have expired and the procedural rights set forth in Article IX shall not be applicable.

7.6 MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

7.6-1 APPLICATION

A Medical Staff member and/or Allied Health Professional who seeks a change in staff status or modification of clinical privileges may submit such a request at any time in writing.

7.6-2 EFFECT OF APPLICATION

The effect of an application for reappointment or modification of staff status or privileges is the same as that set forth in Section 6.5-2.

7.6-3 STANDARDS AND PROCEDURE FOR REVIEW

When a staff member submits an application for modification of staff status or clinical privileges, the member shall be subject to an in-depth review generally following the procedures set forth in Sections 6.5-3 through 6.5-11, in accordance with Section 6.5-1.

7.6-4 BURDEN OF PRODUCING INFORMATION FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

In connection with all applications for modifications of staff status or privileges, the applicant or member shall have the burden of producing all information necessary for an adequate evaluation of the applicant or member's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. Failure to sustain this burden, or undue delay in doing so, shall be grounds for automatic withdrawal of the application. Without limitations, an applicant or member shall be deemed to have failed to sustain such burden if he/she fails to do so within thirty (30) days following submission of his or her application. This burden may include submission to a medical or psychiatric examination, at the applicant's or member's expense, if deemed appropriate by the Medical Executive Committee, which may also select the examining physician.

7.7 LEAVE OF ABSENCE

7.7-1 LEAVE STATUS

At the discretion of the Medical Executive Committee, a Medical Staff member may obtain a voluntary leave of absence from the staff upon submitting a written request to the Medical Executive Committee stating the approximate period of leave desired, which may not exceed one (1) year unless approved by the Medical Executive Committee for good cause, at its sole discretion for up to one (1) additional one (1) year period.

A request for an extension will be evaluated on an individual basis by the member's clinical department. During the period of the leave, the member shall not exercise clinical privileges at the Hospital, and membership rights and responsibilities shall be inactive.

The Medical Executive Committee shall make a recommendation concerning the reinstatement of the Medical Staff member's privileges and the procedures for reappointment as set forth in Article VI.

7.7-2 TERMINATION OF LEAVE

At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff member may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee. The Medical Staff member shall submit a summary of relevant activities during the leave if the Medical Executive Committee so requests. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the Medical Staff member's privileges and prerogatives, and the procedures set forth in Sections 6.1 through 6.5-11 shall be followed, in accordance with Section 6.5-1.

7.7-3 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall be entitled to the procedural rights provided in Article IX for the sole purpose of determining whether the failure to request reinstatement

was unintentional or excusable, or otherwise. 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.

ARTICLE VIII

CLINICAL PRIVILEGES

8.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws, a member providing clinical services at the Hospital shall be entitled to exercise only those clinical privileges specifically granted by the Hospital after having considered the recommendation of the Medical Staff. All such privileges and services must be Hospital specific, within the scope of any license, certificate, or other legal credential authorizing practice in this State and consistent with any restrictions thereon and shall be subject to the rules and regulations of the clinical department and the authority of the department chief and the Medical Staff.

8.2 DELINEATION OF PRIVILEGES IN GENERAL

8.2-1 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.

8.2-2 BASIS FOR PRIVILEGES DETERMINATION

Requests for clinical privileges shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, and clinical performance, as well as the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, including, without limitation, other institutions and health care settings where a member exercises clinical privileges.

8.2-3 CORE OR SPECIAL PRIVILEGES

The departments may establish requirements for core or special privileges within their relevant clinical areas and may establish required minimum activity levels for such privileges in order to maintain and document current competency.

8.3 PROCTORING

See Medical Staff Policy and Procedure: Proctoring, department rules and regulations and privilege cards/ forms regarding proctoring requirements.

8.4 CONDITIONS FOR PRIVILEGES OF DENTISTS AND PODIATRISTS

8.4-1 ADMISSIONS

Dentists, oral surgeons, and podiatrists who are members of the Medical Staff may only admit patients with a physician member of the Medical Staff who conducts the admitting history and physical examination (except the portion related to dentistry or podiatry) and assumes responsibility for the care of the patient's medical problems present at the time of admission or that may arise during hospitalization which are outside of the limited licensed practitioner's lawful scope of practice.

8.4-2 SURGERY

Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the Chief of the Department of Surgery or the Chief's designee.

8.4-3 MEDICAL APPRAISAL

All patients admitted for care in the Hospital by a dentist or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and a physician member shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a physician member and such a limited license practitioner based upon medical or surgical factors outside of the scope of licensure of the D.D.S., D.M.D. or D.P.M., the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate department(s).

8.5 TEMPORARY CLINICAL PRIVILEGES

8.5-1 CIRCUMSTANCES

a. Temporary clinical privileges may be granted under the following circumstances and may not exceed 120 days:

1. Pendency of Application: After having submitted a completed and verified application for Staff appointment which has been referred to the appropriate clinical department, an appropriately licensed applicant may be granted temporary privileges. Temporary privileges shall be granted on a case-by-case basis or for a stated period of time spanning the care of patients, with the approval of the Chief of Staff, or if absent, the Assistant Chief of Staff, and the approval of the chief of the department. In exercising such privileges, the applicant shall act under the supervision of the chief of the department.

2. To Fulfill an Important Patient Care, Treatment and Service Need: In special circumstances, pending receipt of a written request for specific temporary privileges on a form provided by the Medical Staff, an appropriately licensed practitioner of documented competence and who is a member in good standing of the Medical Staff of another hospital, accredited by an organization holding "deemed status" granted by the Centers for Medicare and Medicaid Services (CMS), may be granted temporary privileges to fulfill an important patient care, treatment and service need for one or more specific patients. Such temporary privileges shall be granted on a case-by-case basis or for a stated period of time, not to exceed 120 days and spanning the care of specific patients, with the approval of the Chief of Staff, or if absent, the Assistant Chief of Staff, and the approval of the appropriate department chief.

8.5-2 GENERAL CONDITIONS

a. If granted temporary privileges, the applicant shall act under the supervision of the chief of the department to which the applicant has been assigned.

b. Temporary privileges shall automatically terminate at the end of the designated period, which shall not exceed 120 days or until such time as the application for membership is approved, unless earlier terminated or affirmatively renewed.

c. Requirements for proctoring as outlined in the Medical Staff Policy and Procedure. Proctoring shall be imposed on such terms as may be appropriate under the circumstances upon any practitioner, granted temporary privileges by the Chief of Staff after consultation with the department chief or his designee.

d. At any time, temporary privileges may be terminated by the Chief of Staff with the concurrence of the chief of the department, or their respective designees, subject to prompt review by the Medical Executive Committee. In such cases, the appropriate department chief or, in the Chief's absence, the Chairman of the Medical Executive Committee, shall assign a member of the Medical Staff to assume responsibility for the care of affected patient(s). Where feasible, the wishes of the patient

shall be considered in the choice of a replacement Medical Staff member.

e. If a request for temporary privileges is refused or if all or any portion of temporary privileges are terminated or suspended, the affected practitioner shall not be entitled to the procedural rights afforded by Article IX.

f. All persons requesting or receiving temporary privileges shall be bound by these Bylaws and Rules and Regulations of the Medical Staff.

8.6 EMERGENCY PRIVILEGES

a. In the case of an emergency, any member of the Medical Staff, to the degree permitted by his or her license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible and appropriate to save the life of a patient or to save a patient from serious harm. The member shall make every reasonable effort to communicate promptly with the department chief concerning the need for emergency care and assistance by members of the Medical Staff with appropriate clinical privileges and, once the emergency has passed or assistance has been made available, shall defer to the department chief with respect to further care of the patient at the Hospital.

   For purposes of this section, an emergency is defined as a condition or set of circumstances in which the life of a patient is in immediate danger, or in which serious harm is likely to result to a patient, and in which any delay in administering treatment would increase the nature and/or extent of the serious harm. When such an emergency situation no longer exists, the patient shall be transferred to an appropriate member of the Medical Staff.

b. In the event of an emergency, any person shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to qualified members of the Medical Staff when it becomes reasonably available.

8.7 DISASTER PRIVILEGES

a. The Chief of Staff, Chief Medical Officer or the Chief Executive Officer shall determine that Torrance Memorial Medical Center requires additional practitioners (includes volunteer practitioners) to handle its immediate patient care needs.

b. If volunteer practitioners are needed, upon completion of credentialing process outlined in the Policy and Procedure: Disaster Privileges, the Chief of Staff, Chief Medical Officer or Chief Executive Officer shall grant approval to these volunteer practitioners.

See Medical Staff Policy and Procedure: Disaster Privileges for additional details.

8.8 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

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

8.9 LAPSE OF APPLICATION

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

ARTICLE IX

CORRECTIVE ACTION

9.1 CORRECTIVE ACTION

9.1-1 COLLEGIAL INTERVENTION

a. These Bylaws encourages the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational efforts, to address questions relating to a Medical Staff member's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

b. Collegial efforts may include, but are not limited to counseling, sharing of comparative data, monitoring, and additional training or education.

c. All collegial intervention efforts by Medical Staff leaders and Hospital management are part of the Hospital's performance improvement and professional and peer review activities.

d. The relevant Medical Staff leader(s) shall determine whether it is appropriate to include documentation of collegial interventional efforts in a Medical Staff member's credential file, the Medical Staff member will have an opportunity to review and respond in writing. The response shall be maintained in that member's credential file along with the original documentation.

e. Collegial intervention efforts are encouraged but are not mandatory and shall be within the discretion of the appropriate Medical Staff leaders and Hospital management.

f. The Chief of Staff, in conjunction with the Chief Executive Officer or Vice President, Medical Staff Services/Performance Improvement shall determine whether to direct that a matter be handled in accordance with another policy, or to direct to the Medical Executive Committee for further determination.

9.1-2 MINOR INFRACTIONS

a. The Chief of the Medical Staff, any department chief, the Medical Executive Committee, or their respective designees shall be empowered, after an investigation, to take appropriate disciplinary action in connection with minor infractions. Such disciplinary action may include, but shall not be limited to, the issuance of a warning, a letter of reprimand or an admonition.

b. For the purposes of this Section, A "minor infraction" may be any activity or conduct which is lower than the standards or aims of the Medical Staff, but which would not ordinarily trigger a recommendation for the denial, reduction, suspension, revocation or termination of privileges or Staff membership. A sanction imposed pursuant to this

Section shall constitute grounds for a hearing under Article IX of these Bylaws.

c. At the discretion of the Chief of Staff adverse actions imposed or implemented pursuant to this section may be reported to the Medical Executive Committee with a copy transmitted to the Board of Trustees. If the Medical Executive Committee determines that the violation is not a minor infraction, or that the intended disciplinary action is inappropriate and that other action is necessary, the Medical Executive Committee may institute alternative disciplinary measures in accordance with this Section or in accordance with other provisions of these Bylaws.

9.1-3 CRITERIA FOR INITIATION OF CORRECTIVE ACTION

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct, reasonably likely to be (l) detrimental to patient safety or effective delivery of quality patient care within the Hospital; (2) unethical; (3) contrary to the Medical Staff Bylaws and rules or regulations; or (4) below applicable professional standards, a request for an investigation or action against such member

may be initiated by any of the parties listed in Section 8.1-2.

9.1-4 INITIATION OF CORRECTIVE ACTION

A request for an investigation must be in writing, submitted to the chief of the department in which the member subject to the request for an investigation holds clinical privileges, and supported by reference to the specific activities or conduct alleged. The chief of such department shall immediately appoint an ad hoc committee to investigate the matter. Membership on the ad hoc committee shall be limited to the chief of the department or his designee and either two (2) or four (4) members who hold clinical privileges in the department. The ad hoc committee shall have the authority to investigate informally and independently all requests for corrective action and to reject, without action or formal records, any request for corrective action, which the ad hoc committee deems to be unworthy of further investigation.

In the event that the ad hoc committee determines that further investigation is warranted, the ad hoc committee shall complete and forward a written report of the investigation to the Medical Executive Committee. If the Medical Executive Committee initiates the request, it shall make an appropriate record of the reasons.

9.1-5 INVESTIGATION

If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself or may assign the task to an appropriate Medical Staff Officer, Medical Staff Department, or standing or ad hoc committee of the Medical Staff. If the investigation is delegated to an officer or committee other than the Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action. The member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate.

The Chairman of the Medical Executive Committee shall notify the practitioner under investigation of such investigation as soon as practicable, and such practitioner shall have the right to have an informal conference with the Medical Executive Committee if he or she makes such a request, in writing, to the Chairman of the Medical Executive Committee, by certified or registered mail, return receipt requested, posted no more than ten (10) days after such practitioner receives written notice of the investigation. Neither the Medical Staff nor the affected practitioner shall have an attorney present at the informal conference. A record of the informal conference(s) shall be kept but shall not be admissible as evidence in any subsequent hearing provided under these Bylaws. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; provided, however, that such investigation shall not constitute a "hearing" as that term is used in Article IX, nor shall the procedural rules with respect to hearings or appeals apply.

Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

9.1-6 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall take action, which may include, without limitation:

a. determining that no corrective action should be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's file.

b. deferring action for a reasonable time where circumstances warrant.

c. issuing letters of admonition, censure, reprimand, or warning. In the event such letters are issued,

the affected member may make a written response which shall be placed in the member's file.

d. recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or proctoring.

e. recommending reduction, modification, suspension, or revocation of clinical privileges.

f. recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care.

g. recommending suspension, revocation, or probation of Medical Staff membership.

h. taking other actions deemed appropriate under the circumstances.

9.1-7 SUBSEQUENT ACTION

a. If corrective action as set forth in Sections 8.2 is recommended by the Medical Executive Committee, that recommendation shall be transmitted to the Board of Trustees.

b. The recommendation of the Medical Executive Committee shall be the final action unless the member requests a hearing, in which case the final decision shall be determined as set forth in Article IX.

c. A member whose Medical Staff Membership is revoked may not apply for reinstatement until one (1) year has elapsed from the date that the action is final.

d. If the Medical Executive Committee takes any action that would give rise to a hearing pursuant to Bylaws, Article IX, Section 9.2, it shall also make a determination whether the action is a “medical disciplinary” action or an “administrative disciplinary” action. A medical disciplinary action is one taken for cause or reason that involves that aspect of a practitioner’s competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care. All other actions are deemed administrative disciplinary actions. In some cases, the reason may involve both medical disciplinary and administrative disciplinary cause or reason, in which case, the matter shall be deemed medical disciplinary for Bylaws, Article IX, Hearings and Appellate Reviews, hearing purposes.

e. If the Medical Executive Committee makes a determination that the action is medical disciplinary, it shall also determine whether the action is taken for any of the reasons required to be reported to the Medical Board of California pursuant to California Business & Professions Code Section 805.01.

9.1-8 BOARD OF TRUSTEES AUTHORITY

Should the Board of Trustees determine that the Medical Executive Committee's failure to investigate, or initiate disciplinary action, is contrary to the weight of the evidence, the Board of Trustees may direct the Medical Executive Committee to initiate an investigation or a disciplinary action, but only after consultation with the Medical Executive Committee. In the event the Medical Executive Committee fails to take action in response to a direction from the Board of Trustees, the Board of Trustees, after notifying the Medical Executive Committee in writing, may take such action on its own initiative, provided it fully complies with the procedures and rules set forth in Articles VIII and IX. If such action if favorable to the member, or constitutes an admonition, reprimand, or warning to the member, it shall become effective as the final decision of the Board of Trustees.

If such action is one of those set forth in Section 9.2, the Board of Trustees shall give the member written notice of the adverse recommendation and of his or her right to request a hearing in the manner specified in Section 9.3-2 and his or her rights shall be as provided in Article IX.

9.2 SUMMARY RESTRICTION OR SUSPENSION

9.2-1 CRITERIA FOR INITIATION

Whenever a member's conduct appears to require that immediate action be taken to protect the life or

well-being of any patient or to reduce a substantial and imminent likelihood of significant impairment of the life, health, or safety of any patient, prospective patient, or other person in the Hospital, the Chief of Staff, the Medical Executive Committee, or the chief of the department or its designee in which the member holds privileges, may summarily restrict or suspend the Medical Staff membership or clinical privileges of such member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the member, the Board of Trustees, the Medical Executive Committee, and the Administrator. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member of the department by the department chief or by the Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute member.

In the event that no person authorized in this Section 8.2-1 to summarily suspend or restrict the Medical Staff membership or clinical privileges of a member is available, the Board of Trustees, or its designee, may immediately suspend a member's clinical privileges if a failure to take such action is likely to result in an imminent danger to the life, health, or safety of any patient, prospective patient or other person in the Hospital, provided that the Board of Trustees has before a suspension, made reasonable attempts to contact the Medical Executive Committee. A suspension by the Board of Trustees which has not been ratified by the Medical Executive Committee within two working days, excluding weekends and holidays, after the suspension shall terminate automatically.

9.2-2 MEDICAL EXECUTIVE COMMITTEE ACTION

Within ten (10) days after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee shall be convened to review and consider the action. Upon the member's request, the member may attend and make a statement concerning the issues under investigation on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the member, constitute a "hearing" within the meaning of Article IX, nor shall any procedural rules apply.

The member's failure without good cause to attend any Medical Executive Committee meeting upon request shall constitute a waiver of his or her rights under Article IX. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event, it shall furnish the member with notice of its decision within ten (10) days after such meeting.

In addition to the circumstances leading to the summary suspension, the Medical Executive Committee may take into consideration any other acts or omissions that may be or have been under investigation. A decision to continue a summary suspension of a member shall be deemed to be a recommendation that membership be revoked.

9.2-3 PROCEDURAL RIGHTS

Unless the Medical Executive Committee promptly terminates the summary restriction or suspension, the member shall be entitled to the procedural rights afforded by Article IX.

In the following instances of action adverse to a member's licensure or credentialing, the affected member's privileges or membership may be deemed voluntarily relinquished or limited as described, and such member's failure to cure the deficiency in question within one hundred twenty (120) days after voluntary relinquishment or limitation went into effect be deemed to constitute such member's voluntary relinquishment of Medical Staff membership.

9.3 AUTOMATIC RELINQUISHMENT OR LIMITATION

9.3-1 LICENSURE

a. Revocation and Suspension: Whenever a member's licensure or other legal credential authorizing practice in this State is revoked or suspended, the member’s Medical Staff membership and

clinical privileges shall be automatically revoked as of the date such action becomes effective.

b. Restriction: Whenever a member's license or other legal credential authorizing practice in this State is limited or restricted by the applicable licensing or certifying authority, any clinical privileges that the member has been granted at the Hospital which are within the scope of the limitation or restriction shall, as of the date such action becomes effective and throughout its term, be automatically limited or restricted in a similar manner.

c. Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall, as of the date such action becomes effective and throughout its term, automatically become subject to the same terms and conditions of the probation.

9.3-2 CONTROLLED SUBSTANCES

a. Whenever a member's DEA certificate is revoked, limited, or suspended, the Member shall, as of the date such action becomes effective and throughout its term, automatically and correspondingly be divested of the right to prescribe medications covered by the certificate.

b. Probation: Whenever a member's DEA certificate is subject to probation, the Member's right to prescribe such medications shall, as of the date such action becomes effective and throughout its term, automatically become subject to the same terms of the probation.

9.3-3 MEDICAL RECORDS

a. Members of the Medical Staff must complete all available incomplete medical records in order to comply with the state law and in accordance with the General Rules and Regulations of the Medical Staff.

b. Failure to comply with state law or the requirements as outlined in the General Staff Rules and Regulations of the Medical Staff may result in referral to the Professional Relations Committee (PRC).

9.3-4 PROFESSIONAL LIABILITY INSURANCE

Failure of Medical Staff member, or Allied Health Professional, to whom temporary clinical privileges have been granted, to maintain professional liability insurance or other coverage certified by the California Department of Insurance shall result in the automatic voluntary relinquishment of the Medical Staff membership and clinical privileges of such Medical Staff member, or in the automatic voluntary relinquishment of the clinical privileges of such other practitioner.

The member's failure to provide such evidence within thirty (30) days after the date that the automatic voluntary relinquishment went into effect shall be deemed to constitute a voluntary relinquishment of Medical Staff membership and clinical privileges.

9.3-5 CONVICTION OF A FELONY OR MISDEMEANOR

A Medical Staff member or Allied Health Professional who has been convicted of a felony or who has been convicted of a misdemeanor related to the following shall immediately be deemed to have voluntarily relinquished Medical Staff membership and/ clinical privileges. A member who has been convicted of a misdemeanor (including a member who pleads guilty or nolo contendere) related to the following shall immediately be suspended/ terminated unless the Medical Executive Committee, for good cause, shall determine otherwise.

a. controlled substances

c. illegal drugs

d. Medicare, Medicaid, or insurance fraud or abuse

e. violence against another, including sexual assault or abuse

f. any crime of a sexual nature, or

g. any other illegal activity involving patients or otherwise substantially related to the practitioner's qualifications, function, or professional practice.

9.3-6 PENDING INVESTIGATION OR ACTION TAKEN BY A STATE OR FEDERAL HEALTH PROGRAM

Medical Staff members or Allied Health Professionals who are not eligible for participation in Medicare, Medi-Cal or other federal or California state health programs shall immediately be deemed to have voluntarily relinquished their membership and privileges.

Medical Staff members or Allied Health Professionals who are aware of the pendency of any investigation by a governmental licensure agency, which may affect the member's eligibility for participation in Medicare, Medi-Cal or other federal or California state health program must immediately notify the Medical Staff of any such investigation. The Medical Staff shall have the discretion to take action, including automatic relinquishment, if it appears that such action is required by law.

9.3-7 REAPPOINTMENT

If the reappointment application has not been fully processed due to the member's or allied health professional's failure to timely return the reappointment application or provide other documentation or cooperate before the appointment expires, the member's membership status and clinical privileges or allied health professional's privileges shall be considered as automatically relinquished.

9.3-8 MEDICAL EXECUTIVE COMMITTEE DELIBERATION

Within thirty (30) days after action is taken or warranted as described in Sections 8.3-I (b&c), or Section 8.3-2, 8.3-3, 8.3-4, 8.3-5, 8.3-6 or 8.3-7 subject to Section 8.3-8, the Medical Executive Committee shall convene to review and consider the facts and may recommend such further corrective action as it may deem appropriate following the procedures set forth in Article IX, commencing at Section 8.3.

9.3-9 PROCEDURAL RIGHTS

Practitioners whose clinical privileges are voluntarily relinquished pursuant to Section 8.3-3, 8.3-5 or 8.3-8, or revoked pursuant to Section 8.3-1(a), and/or who have been deemed to have voluntarily resigned from the Medical Staff pursuant to the provisions of Sections 8.3-3, 8.3-4, 8.3-5, 8.3-6, 8.3-7 or 8.3-8, shall not be entitled to the procedural rights set forth in Article IX.

9.3-10 NOTICE OF AUTOMATIC SUSPENSION: TRANSFER OF PATIENTS

Whenever a practitioner's clinical privileges are automatically suspended in whole or in part, notice of such suspension shall be given to the practitioner, the Medical Executive Committee, the President/CEO, and the Board of Trustees.

Giving of such notice shall not, however, be required in order for the automatic suspension to become effective. In the event of any such suspension, the practitioner shall designate their alternate coverage, to assume the care of patients (existing and elective) and this designation shall be approved by the department chief or Chief of Staff. Where feasible, the wishes of the patient shall be considered in choosing such a substitute.

9.3-11 MEDICAL EXECUTIVE COMMITTEE DISCRETION

The Medical Executive Committee shall have the discretion under unusual or extreme circumstances to apply the provisions of this "Automatic Relinquishment or Limitation" section in a manner they feel in the best interests of the Medical Staff and patients, while also complying with applicable law. The Medical Executive Committee may apply the provisions of this "Automatic Relinquishment or Limitation" section to actions by the licensing or certifying authority of any state or government.

9.4 SUSPENSION OR LIMITATION FOR VIOLATION OF PATIENT ADMINISTRATIVE POLICY

9.4-1 The Medical Executive Committee may take such action as it deems necessary, including suspension for other than a medical disciplinary cause of reason, in order to enforce a patient administrative policy adopted by the Medical Executive Committee, as described in these Bylaws at Article IX, Section 9.6. A practitioner affected by such a decision, shall not be entitled to the procedural rights set forth in Article IX, except for the Fair Review rights set forth in Section 9.6 thereof.

ARTICLE X

JUDICIAL REVIEW COMMITTEE HEARINGS AND APPELLATE REVIEW

10.1 GENERAL PROVISIONS

10.1-1 EXHAUSTION OF REMEDIES

If any adverse action described in Section 8.1 and 8.2 is taken or recommended, the applicant or member must exhaust the remedies afforded by these Bylaws before resorting to legal action.

10.1-2 APPLICATION OF ARTICLE

For purposes of this Article, the term "member" may include "applicant," as may be applicable under the circumstances.

10.2 GROUNDS FOR HEARING

a. An individual who is the subject of a final proposed action of a peer review body, for which a report is required to be filed under section 805 of the Business and Professions Code, shall be entitled to request a hearing before a Judicial Review Committee.

b. No individual shall be entitled to a hearing due to any action by the Medical Staff, the Board of Trustees, or Administration if such action does not affect the member's clinical or admitting privileges and does not result in a permanent record of such action being filed in the member's record.

10.3 REQUESTS FOR HEARING

10.3-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which action is taken or a recommendation is made as set forth in Section 9.2, the person or body taking the action or making the recommendation should give the member prompt notice of the recommendation or action, notice that the action, if adopted, shall be taken and reported pursuant to Section 805 of the Business and Professions Code, and notice of the right to request a hearing pursuant to Section 9.3-2. Such notice shall summarize the members' procedural rights at the hearing under this Article IX.

10.3-2 REQUEST FOR HEARING

The member shall have thirty (30) days following receipt of notice of such action or recommendation to request a Judicial Review Committee hearing. The request shall be in writing addressed to the Medical Executive Committee, with a copy to the Board of Trustees.

In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the action or recommendation in question, which shall thereupon become final and binding.

10.3-3 TIME AND PLACE FOR HEARING

Upon receipt of a request for hearing, the Medical Executive Committee shall schedule a Judicial Review Committee hearing and, within thirty (30) days of the request, shall give notice to the member of the (i) time, place and date of the hearing, and (ii) the reasons for the proposed action taken or recommended, including the acts or omissions with which the affected member is charged. The date of the notice shall be not less than thirty (30) days prior to the hearing.

10.3-4 LIST OF WITNESSES/NOTICE OF CHARGES

Together with the notice of hearing, the Medical Executive Committee shall set forth the names of the witnesses intended to be called to testify at the hearing on behalf of the Medical Executive Committee and shall state clearly and concisely in writing the reasons for the adverse action taken or recommended, including the acts or omissions with which the affected member is charged with reference, where applicable, by patient number to the patient and chart. The charges shall include a statement as to whether the separate charges individually support the recommendations or whether taken as a whole they support the recommendation.

10.3-5 JUDICIAL REVIEW COMMITTEE

When a hearing is requested, the Medical Executive Committee shall appoint a Judicial Review Committee, which shall be composed of not less than three (3) members of the Medical Staff who shall gain no direct financial benefit from the outcome, who have not acted as a complainant, investigator, witness, fact finder or initial decision maker in the matter leading up to the recommendation or action, and which shall include, where feasible, an individual practicing the same specialty as the affected member or applicant provided, however, that if the affected member or applicant is a dentist or podiatrist at least one (1) member of the Judicial Review Committee shall be a dentist or podiatrist, respectively. If no such dentist or podiatrist is available, there shall be a dentist or podiatrist appointed from outside of the Medical Staff. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Judicial Review Committee. In the event that it is not feasible to appoint a Judicial Review Committee from the Active Medical Staff, the Medical Executive Committee may appoint members from other staff categories or practitioners who are not members of the Medical Staff. Such appointment shall include designation of the chairman. At the outset of the hearing, the affected member shall be entitled to question the members of the Judicial Review Committee in a reasonable manner concerning their ability to provide a fair hearing. The affected member has a right to challenge the impartiality of any member of the Judicial Review Committee. The fact that a member of the committee is claimed to be in direct economic competition with the member, shall be one basis for such a challenge. Any challenge to a member of the Judicial Review Committee shall be ruled upon by the presiding officer, who shall be the hearing officer, or if a hearing officer is not selected, by the other members of the Committee.

10.3-6 FAILURE TO APPEAR OR PROCEED

A member's failure without good cause to personally attend and proceed at such a hearing in an expeditious and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

10.3-7 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws, may be permitted upon agreement of the parties or by the hearing officer upon a showing of good cause.

10.4 HEARING PROCEDURE

10.4-1 PREHEARING PROCEDURE

a. Discovery. The exclusive discovery rights, obligations, and procedures for these proceedings are

as follows:

1. At the request of either side, the Medical Executive Committee and the member shall exchange written lists of the names of witnesses who are expected to testify and copies of documents expected to be introduced at the hearing. Failure to disclose the identity of a witness or produce copies of a document at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance.

2. The affected member shall have the right to inspect and copy at the member's expense any documentary information relevant to the charges which the Medical Executive Committee has in its possession or under its control, as soon as practicable after the receipt of the member's request for hearing.

3. The Medical Executive Committee shall have the right to inspect and copy at the Medical Executive Committee's expense any documentary information relevant to the charges which the member has in his or her possession or control as soon as practicable after receipt of the Medical Executive Committee's request.

4. The failure by either party to provide access to the information sought in subsections 9.4-1(a)(2) and (3) at least thirty (30) days before the hearing shall constitute good cause for a continuance.

5. The rights provided in this Section 9.4-1(a) do not extend to confidential information referring solely to individually identifiable members, other than the member under review. The hearing officer shall consider and rule upon any request for access to information and may impose any safeguard required to protect the peer review process and the interest of justice.

6. When ruling upon requests for access to information and in determining the relevancy of the information sought, the hearing officer shall consider, among other factors, the following:
   a. Whether the information sought may be introduced to support or defend the charges.
   b. The exculpatory or inculpatory nature of the information sought, if any.
   c. The burden imposed on the party in possession of the information sought, if access is granted.
   d. Any previous request for access to information submitted or resisted by the parties to the same proceeding.

a. The affected member shall be provided with a list of the names of the members of the Judicial Review Committee and of the hearing officer at least fifteen (15) days prior to the hearing.

b. Remedies. The failure of the Medical Executive Committee to provide the names of witnesses who are expected to testify or copies of documents expected to be introduced at the hearing pursuant to subsection (a)(1) above shall constitute grounds for exclusion from the hearing of such witnesses and documents. Failure by the member/applicant to comply shall be deemed a withdrawal of the member's/applicant's request for a hearing and the member/applicant shall be deemed to have waived any right to a hearing and accepted the action or recommendation in question, which shall thereupon become final and binding.

10.4-2 REPRESENTATION

The member shall have the right to representation by an attorney-at-law, or by any other person of the member's choice at the hearing. To exercise such right he must inform the Medical Executive Committee in his request for hearing. If the member chooses to be represented by an attorney-at-law, the Medical Executive Committee may also be so represented.

10.4-3 THE HEARING OFFICER

The Hospital shall 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 but shall not have represented the Medical Staff or the Hospital in any capacity other than as a hearing officer. The hearing officer must not gain any direct financial benefit from the outcome of the hearing, must not act as a prosecuting officer or as an advocate and the hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an

efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matter of laws, procedure, or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances. The hearing officer shall participate in the deliberations of such Committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote. Under extraordinary circumstances, the Hearing Officer may recommend termination of the hearing; however, the Hearing Officer may not unilaterally terminate the hearing and may only issue an order that would have the effect of terminating the hearing (a "termination order") at the direction of the Hearing Committee. The terminating order shall be in writing and shall include documentation of the reasons, therefore. If a terminating order is against the Medical Executive Committee, the charges against the practitioner will be deemed to have been dropped. If, instead, the terminating order is against the practitioner, the practitioner will be deemed to have waived his/her right to a hearing. The party against whom termination sanctions have been ordered may appeal the terminating order to the Hospital Board of Trustees. The appeal must be requested within 10 days of the terminating order, and the scope of the appeal shall be limited to reviewing the appropriateness of the terminating order. The appeal shall be conducted in general accordance with the provisions of Bylaws, Article IX, Section 9.5. If the order is found to be unwarranted, the Hearing Committee shall reconvene and resume the hearing. If the Board of Trustees determines that the terminating order should not have been issued, the matter will be remanded to the Hearing Committee for completion of the hearing.

10.4-4 RECORD OF THE HEARING

A shorthand reporter shall be present to make a record of the hearing proceedings, as well as the pre-hearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the shorthand reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. Oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

10.4-5 RIGHTS OF THE PARTIES

Within reasonable limitations, both sides at the hearing shall be provided with all of the information made available to the trier of fact, may call, examine, and cross examine witnesses, may present, and rebut evidence determined relevant by the hearing officer, and may submit a written statement at the close of the hearing so long as these rights are exercised in an efficient and expeditious manner. The member may be called by the Medical Executive Committee and examined as if under cross-examination.

10.4-6 MISCELLANEOUS RULES

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the Judicial Review Committee may request or permit both sides to file written arguments.

10.4-7 BURDENS OF PRESENTING EVIDENCE AND PROOF

At the hearing, the Medical Executive Committee shall have the initial duty to present evidence which supports its action or recommendation. Except in the case of an initial applicant for Medical Staff membership and privileges, the Medical Executive Committee shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that its action or recommendation was reasonable and warranted. Initial applicants shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, of their qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning their current qualifications for Medical Staff membership and privileges.

Initial applicants shall not be permitted to introduce information not produced upon request of the Medical Staff during the application process unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

10.4-8 ADJOURNMENT AND CONCLUSION

After consultation with the Chairman of the Judicial Review Committee, the hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if requested, the hearing shall be closed.

10.4-9 BASIS FOR RECOMMENDATION

The recommendation of the Judicial Review Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony.

10.4-10 RECOMMENDATION OF THE JUDICIAL REVIEW COMMITTEE

Within thirty (30) days after final adjournment of the hearing, the Judicial Review Committee shall render a recommendation, which shall include the Judicial Review Committee's findings of fact with respect to the charges, and a conclusion articulating the connection between evidence produced at the hearing and its recommendation, its conclusions regarding whether each of the individual charges independently support the action taken or whether they support the charges when taken together. If the affected member is currently under suspension, the time for the decision shall be fifteen (15) days. The recommendation of the Judicial Review Committee shall be delivered to the Medical Executive Committee, to the Chief of Staff, to the Board of Trustees, and by special notice to the affected member.

10.5 APPEAL

10.5-1 TIME FOR APPEAL

Within ten (10) days after receipt of the decision of the Medical Executive Committee, the member may request an appellate review. A written request for such review shall be delivered to the Administrator, with a copy to the Medical Executive Committee. In the event that appellate review is not requested within such period, the member shall be deemed to have waived any right to an appellate review and accepted the decision which shall there upon become final and binding.

10.5-2 GROUNDS FOR APPEAL

A written request for an appeal shall include an identification of the grounds for appeal, and a clear and concise statement of the facts in support of the appeal. Grounds for appeal from the decision of the Medical Executive Committee shall be:

a. that there was substantial non-compliance with the procedures required by these Bylaws, which non-compliance has created demonstrable prejudice or;

b. that the findings are not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 9.5-5 thereof;

c. that the decision is not supported by the findings;

d. that the decision of the Medical Executive Committee is arbitrary, capricious, or otherwise not in accordance, with the law.

10.5-3 TIME, PLACE AND NOTICE

If an appellate review is to be conducted, the Chairperson of the Board of Trustees shall schedule a

review date and cause each side to be given notice of the time, place and date of the appellate review and a schedule for the submission of written statements. The written statement of the appellant shall be received by the Appeal Board at least twenty (20) days, and the written statement of the respondent at least ten (10) days, before the hearing. The date of appellate review shall not be less than thirty (30) nor more than sixty (60) days from the date of the request for appearance by the Chairperson; provided, however, that when a request for appellate review concerns a member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made. The time for appellate review may be extended by the Appeal Board for good cause, which shall include, but not be limited to, the convenience of the Appeal Board.

10.5-4 APPEAL BOARD

The Board of Trustees shall appoint as the Appeal Board sufficient of its members to constitute a quorum. 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 actively participate in the matter as a complainant, investigator, or witness, or as a member of the Judicial Review Committee. The Appeal Board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal.

10.5-5 APPEAL PROCEDURE

The proceeding by the Appeal Board shall be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Review Committee; provided, however, that (i) the Appeal Board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence, and provided that such evidence shall be subject to the same rights of cross-examination or confrontation provided at the judicial review hearing; or (ii) the Appeal Board may remand the matter to the Judicial Review Committee for the taking of further evidence and for decision. Each party shall have the right to personally appear and make oral argument at the appellate procedure, to be represented by legal counsel in connection with the appeal and to present a written statement in support of his or her position on appeal. The Appeal Board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The Appeal Board shall affirm, modify, or reverse the Judicial Review Committee decision, or remand the matter to the Judicial Review Committee for further review and decision.

10.5-6 DECISION

a. Except as otherwise provided herein, within thirty (30) days after the conclusion of the appellate review proceeding, the Appeal Board shall render a decision in writing and shall forward copies thereof to each side involved in the hearing.

b. The decision of the Board of Trustees shall affirm the decision of the Judicial Review Committee if the decision is supported by substantial evidence and its recommendation is supported by the findings or unless the Board finds the recommendations of the Judicial Review Committee to be arbitrary, capricious, or otherwise not in accordance with the law, and states the reasons for its findings in writing.

10.5-7 RIGHT TO ONE HEARING

No member shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

10.6. FAIR REVIEW

10.6-1 GROUNDS FOR FAIR REVIEW

Any action which limits, restricts, or diminishes membership or privileges but which is not reportable under Business and Professions Code 805 shall constitute grounds for a Fair Review.

10.6-2 NOTICE OF ADVERSE ACTION OR RECOMMENDED ACTION

Whenever any of the actions constituting grounds for a Fair Review under Section 9.6-1 above, has been taken or recommended, the Medical Executive Committee shall give written notice to the affected practitioner. The notice shall:

a. describe what action has been taken or recommended.

b. state the reasons for the action or recommendation.

c. state that the practitioner is entitled to a Fair Review, which must be requested in writing and the request received by the Medical Executive Committee within thirty (30) days after the practitioner's receipt of the notice of adverse action or recommended action.

10.6-3 FAIR REVIEW PROCEDURE

The procedure for requesting, arranging for and conducting a fair review shall be the same as for hearings except that, (1) there is no right to discovery, (2) the hearing shall be before an arbitrator to be designated by the Medical Executive Committee with pre-procedural rights of voir dire to confirm the proposed arbitrator is qualified and not biased, (3) the parties must exchange documents and witness lists at least five (5) working days prior to the hearing, and testimony of witnesses and copies of evidence not timely exchanged may be barred, (4) the body whose decision prompted the hearing has the initial burden of producing evidence to support its action or recommendation, with the burden then shifting to the affected practitioner to produce evidence and demonstrate that the decision was unreasonable, (5) neither party has the right to be represented by an attorney at the fair review, and (6) neither party has the right to personal attendance, oral argument or representation by an attorney at the Board of Trustees appeal.

10.7 EXCEPTIONS TO HEARING RIGHTS

10.7-1 MEDICAL-ADMINISTRATIVE OFFICERS AND CONTRACT PHYSICIANS

The procedural rights specified in Article IX shall apply to members who are directly under contract with the Hospital in a medical administrative capacity or are in a closed department, except with respect to privileges for medical services which are the subject of an exclusive contract or contracts which have been awarded to another physician or physicians. The member shall have no rights to a hearing with respect to the termination of the contract itself which shall be governed by the terms of the contract.

10.7-2 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE PRIVILEGES

No hearing is required when a member's Medical Staff membership has been suspended under Section 8.3-3 or Section 8.3-5, or revoked under Section 8.3-1(a), or voluntarily relinquished under Sections 8.3-3,8.3-4,8.3-5, 8.3-6, 8.3-7 or 8.3-8. In hearings requested with regard to Sections 8.3-1(b) or (c), 8.3-2, or 8.3-4, the issues which may be considered shall not include evidence designed to show that the determination by the licensing agency, the DEA, or the insurance company was unwarranted, but only whether the member may continue to practice in the Hospital with those limitations imposed.

ARTICLE XI

OFFICERS

11.1 OFFICERS OF THE MEDICAL STAFF

11.1-1 IDENTIFICATION

The officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, Secretary/Treasurer.

11.1-2 QUALIFICATIONS

Officers must be members of the Active Medical Staff at the time of their nomination and election and must maintain Active staff membership during their term of office. Failure to maintain such status, except for a limited suspension pursuant to Section 8.3-3, shall create a vacancy in the office involved.

11.1-3 NOMINATIONS

Nominations for officers shall be presented by the Nominating Committee at the Medical Staff meeting. Nominations may also be made from the floor with the consent of the nominee. The names of the nominees shall be mailed to each Medical Staff Member with written notice of the next Medical Staff meeting made in accordance with the requirements of Article XIII.

11.1-4 ELECTIONS

a. Unopposed Nominees. If a nominee is running unopposed, the Medical Staff may accept the nominee by a verbal vote at the same Medical Staff meeting for which written notice was given together with the names of nominees.

b. Ballot Dissemination and Counting Procedures. Nominees may be elected by majority vote on the first ballot. The procedure for distributing, returning, and counting ballots will be determined by the Medical Executive Committee; provided that a notice of nominees seeking election is sent to Active Medical Staff members at least thirty (30) days prior to the voting deadline. Ballots may be counted by an electronic means, including by a contracted entity approved by the Medical Executive Committee. The voting deadline is thirty (30) days following the mailing or electronic delivery of ballot. Ballots received after the voting deadline will not be counted.

c. Ballot Results Methodology. For an office with a single seat, the nominee receiving a majority of the valid votes cast shall be elected. If no candidate receives a majority vote on the first ballot, a runoff election shall be promptly held between the two candidates receiving the highest and second highest number of votes. In the case of a tie, the majority vote, by secret written ballot, of the Medical Executive Committee shall decide the election at its next meeting. For offices with more than one seat, the nominees receiving the highest number of votes shall be elected. The results of all elections shall be presented to the Medical Staff, the Medical Executive Committee, and the Board of Trustees.

11.1-5 TERM OF ELECTED OFFICE

Each officer shall serve a one (1) year term, commencing on the first day of the Medical Staff year following the election. Each officer shall serve in each office until the end the term, or until a successor is elected, unless the member resigns or be removed from office sooner. At the end of the term, if not reelected, the Chief of Staff shall automatically become the immediate past Chief of Staff.

11.1-6 RECALL OF OFFICERS

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. Recall of a Medical Staff officer may be initiated by the Medical Executive Committee or shall be initiated by a petition signed by at least one-third (1/3) of the members of the Medical Staff eligible to vote for officers. Recall shall be considered at a special meeting of the general staff called for that purpose. Recall shall require a two-thirds vote of the Medical Staff members eligible to vote for Medical Staff officers who cast votes by paper or electronic ballot.

11.1-7 VACANCIES IN ELECTED OFFICE

Vacancies in offices, other than Chief of Staff, shall be filled by the Medical Executive Committee. If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff shall serve as Acting Chief of Staff until the vacancy can be filled. A vacancy in the office of Chief of Staff shall be filled at the next regularly scheduled election following the occurrence of such vacancy. If a Chief of Staff is removed from office,

he shall not be eligible to serve as immediate past Chief of Staff.

11.2 DUTIES OF OFFICERS

11.2-1 CHIEF OF STAFF

The Chief of Staff shall serve as the chief officer of the Medical Staff. The duties of the Chief of Staff shall include, but not be limited to:

a. enforcing the Medical Staff Bylaws and rules and regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated.

b. calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff.

c. serving as Chairman of the Medical Executive Committee.

d. serving as an ex-officio member of all other Medical Staff committees without vote, unless his or her membership in a particular committee is required by these Bylaws.

e. interacting with the Administrator and Board of Trustees in all matters of mutual concern within the Hospital.

f. appointing committee members for all standing and special Medical Staff, liaison, or multi-disciplinary committees, except where otherwise provided by these Bylaws and, except where otherwise indicated, designating the Chairmen of these committees.

g. representing the views and policies of the Medical Staff to the Board of Trustees and to the Administrator.

h. being a spokesman for the Medical Staff in external professional and public relations.

i. performing such other functions as may be assigned to him or her by these Bylaws, the Medical Staff, or by the Medical Executive Committee.

j. serving on liaison committees with the Board of Trustees and administration, as well as outside licensing or accreditation agencies.

k. serving as an-ex officio member of the Board of Trustees, without vote.

l. advising the Board of Trustees, in conjunction with the Medical Executive Committee and the respective departments, regarding the quality, efficiency, and performance of patient care services within the Hospital, and for the effectiveness of the patient care study and other quality maintenance functions delegated to the Medical Staff.

m. initiating, where appropriate, corrective action against Medical Staff members.

11.2-2 VICE CHIEF OF STAFF

The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice Chief of Staff shall be a member of the Medical Executive Committee and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws, or by the Medical Executive Committee.

11.2-3 SECRETARY/TREASURER

The Secretary/Treasurer shall be a member of the Medical Executive Committee. The duties shall include, but not be limited to:

a. maintaining a roster of members;

b. keeping accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings;

c. attending to all appropriate correspondence and notices on behalf of the Medical Staff;

d. performing such other duties as ordinarily pertain to the Office or as may be assigned from time to time by the Chief of staff or Medical Executive Committee; and

e. receiving and safeguarding all funds of the Medical Staff.

ARTICLE XII

CLINICAL DEPARTMENTS AND SECTIONS

12.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND SECTIONS

The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a chief selected and entrusted with the authority, duties, and responsibilities specified in Section 11.5. A department may be further divided, as appropriate, into sections which shall be directly responsible to the department within which it functions, and which shall have a Section Chairman selected and entrusted with the authority, duties and responsibilities specified in Section 11.5. When appropriate, the Medical Executive Committee may recommend to the Medical Staff the creation, elimination, modification, or combination of departments or subcommittees.

12.2 CURRENT DEPARTMENTS

The current Departments are:

a. Anesthesiology

b. Emergency

c. Family Practice

d. Medicine

e. Obstetrics/Gynecology

f. Pathology

g. Pediatrics

h. Radiology

i. Surgery

12.3 ASSIGNMENT TO DEPARTMENTS

Each member shall be assigned membership in one department, and to a section, if any, within such department, but may also be granted clinical privileges in other departments or sections consistent with practice privileges granted.

12.4 CREATION OF NEW DEPARTMENTS

12.4-1 STANDARDS FOR CREATION

Departments additional to those designated in Section 11.2 may be created when there is:

a. A demonstrable need related to the provision of quality medical care, for the creation of a new department; and

b. A sufficient number of Active Staff members who will exercise privileges in the proposed department to ensure that the proposed department can undertake and fulfill the responsibilities of department status, including continuing proctoring and evaluation of the quality of medical care rendered within

the department.

12.4-2 ACTION TO CREATE NEW DEPARTMENT

The Medical Executive Committee shall consider any proposal for creation of a new department on the basis of the criteria specified above. If two-thirds (2/3) of the Medical Executive Committee members present and voting, vote in favor of the creation of the proposed department, the recommendation shall be presented to the Board of Trustees for final approval.

12.5 FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

a. Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department and submitting written reports to the Performance Improvement Committees. The number of such reviews to be conducted during the year shall be determined by the Medical Executive Committee in consultation with other appropriate committees. The department shall routinely collect information about important aspects of patient care provided in the department, periodically assesses this information, and develop objective criteria for use in evaluating patient care. For the purposes of allocating responsibility for conducting performance improvement activities in accordance with this Section 11.5, the Department of Surgery shall assume responsibility, without limitation, for all performance improvement matters that may arise in the Hospital's day surgery department. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work subject to such review is a member of that department;

b. Recommending to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the department;

c. Evaluating and making appropriate recommendations regarding the qualification of applicants seeking appointment or reappointment and clinical privileges within that department;

d. Evaluating and making recommendations regarding the need for and appropriateness of the performance of in-hospital services by Allied Health Practitioners within the department;

e. Conducting, participating, and making recommendations regarding continuing medical education programs pertinent to departmental clinical practice;

f. Reviewing and evaluating departmental adherence to: (1) Medical Staff policies and procedures; (2) sound principles of clinical practice;

g. Coordinating patient care provided by the department's members with nursing and ancillary patient care services;

h. Submitting written reports to the Medical Executive Committee concerning: (l) the department's review and evaluation activities, actions taken thereon, and the results of such action; and (2) recommendations for maintaining and improving the quality of care provided in the department and the Hospital;

i. Meeting at least quarterly for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other department and staff functions;

j. Establishing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols;

k. Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve patient care are identified;

l. Accounting to the Medical Executive Committee for all professional and Medical Staff administrative activities within the department;

m. Appointing such committees as may be necessary or appropriate to conduct department functions; and

n. Formulating recommendations for departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee and the Medical

Staff.

12.6 DEPARTMENT HEADS

12.6-1 QUALIFICATIONS

Each department shall have a chief who shall be a member of the Active Medical Staff and shall be certified by an appropriate specialty board or be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the department.

12.6-2 ELECTION

Department chiefs shall be elected every year by majority vote of those members of the department, who are eligible to vote. Nominations shall be made at the department meeting preceding the meeting at which the election is held. Write-in votes shall be permitted at the election. The election shall be conducted via electronic means, including a contracted entity approved by the Medical Executive Committee. Voting will occur on the day of the department meeting following the department meeting where nominations are presented. Members will have 72 hours from the time that the meeting is adjourned to cast their vote. Ballots received after the voting deadline will not be counted.

12.6-3 TERM OF OFFICE

Each department chief shall serve a one (1) year term which coincides with the Medical Staff year or until a successor is chosen, unless the chief sooner resigns, be removed from office, or has lost Medical Staff membership or clinical privileges in that department. Department chiefs shall be eligible to succeed themselves.

12.6-4 REMOVAL

After election and ratification, removal of department chief from office may occur for cause, including, but not limited to, gross neglect or misfeasance in office, or serious actions of moral turpitude, by two-thirds (2/3) vote of the Medical Executive Committee or by a two-thirds (2/3) vote of the department members eligible to vote on departmental matters who cast votes.

12.6-5 ROLES AND RESPONSIBILITIES

Each chief shall have the following authority, duties, and responsibilities:

a. act as presiding officer at departmental meetings

b. report to the Medical Executive Committee and to the Chief of Staff regarding all professional and administrative activities within the department;

c. oversee clinically related activities of the department;

d. continuing surveillance of the quality of patient care and professional performance rendered by members with clinical privileges in the department through a planned and systematic process; oversee the effective conduct of the patient care, evaluation, and monitoring functions of the department;

e. develop and implement departmental programs for retrospective patient care review, on-going monitoring of practice, credentials review and privileges delineation, medical education, utilization review, patient safety, and performance improvement;

f. give guidance on the overall medical policies of the Medical Staff and Hospital and make specific recommendations and suggestions regarding his or her department;

g. transmit to the Credentials Committee the department's recommendations concerning member and/or Allied Health Professional appointment and classification, reappointment, criteria for clinical privileges, monitoring of specified services;

h. transmit to the Medical Executive Committee the department's recommendations concerning corrective action with respect to persons with clinical privileges in his or her department;

i. enforce the Medical Staff Bylaws, rules, policies, and regulations within his or her own department;

j. implement within his or her own department appropriate actions taken by the Medical Executive Committee;

k. participate in the administration of the department, including coordination with the nursing service and the Hospital Administration in matter such as personnel, supplies, special regulations, techniques, and integration of the department into the primary functions of the organization;

l. assist in the preparation of such annual reports, including budgetary planning, pertaining to his department as may be required by the Medical Executive Committee;

m. recommend to the Medical Staff the criteria for clinical privileges for each member of the department that are relevant to the care provided in the department;

n. perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff or by the Medical Executive Committee;

o. the orientation and continuing education of all persons in the department;

p. assessing and recommending to the relevant Hospital authority offsite sources for needed patient care, treatment, and services not provided by the department or organization;

q. the coordination and integration of interdepartmental and intradepartmental services;

r. the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;

s. the recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

t. the determination of qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

u. recommending space and other resources needed by the department or service.

ARTICLE XIII

COMMITTEES

13.1 DESIGNATION

The committees described in this Article shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee to perform specified tasks. Unless otherwise specified, the Chairman and members of all committees shall be appointed by and may be removed by the Chief of Staff, subject to consultations with and approval by the Medical Executive Committee and each chairman shall appoint a vice-chairman from the members of the committee. Except where approved by the Medical Executive Committee, committee chairman shall serve no more than four (4) consecutive years. Medical Staff committees shall be responsible to the Medical Executive Committee. The Medical Executive Committee may, by resolution establish special committees of the Medical Staff to perform one or more of the required functions of the Medical Staff or abolish any committees.

13.2 GENERAL PROVISIONS

13.2-1 TERMS OF COMMITTEE MEMBERS

Unless otherwise specified, committee members shall be appointed for a term of one (1) year and shall serve until the end of this period or until the member's successor is appointed, unless the member shall

sooner resign or be removed from the committee.

13.2-2 REMOVAL

If a member of a committee ceases to be a member in good standing of the Medical Staff, except on the basis of a limited suspension pursuant to Section 8.3-3 or loses employment or a contract relationship with the Hospital or suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that committee member may be removed by the Medical Executive Committee.

13.2-3 VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided, however, that is an individual who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected by the Medical Executive Committee.

13.2-4 CONFIDENTIALITY OF COMMITTEE PROCEEDINGS

No person in attendance at any meeting of any committee having responsibility of evaluations and improvement of the quality of care rendered in the Hospital shall disclose what transpired at such meeting except in carrying out the business of the Hospital or the Medical Staff. Violation of this confidentiality provision shall be grounds for corrective action.

13.2-5 COMMITTEE CHAIRS TO BE APPOINTED BY THE CHIEF OF STAFF

Committee Chairs must be Active Staff members at the time of appointment and must maintain that status throughout the term of service unless said member possesses experience and/or expertise that would cause that member to be the most appropriate choice for appointment as a committee chair. In these circumstances, the chief of staff, with the approval of the Medical Executive Committee, may appoint a member of the Associate or Courtesy Staff to chair a committee.

13.3 BIOETHICS COMMITTEE

13.3-1 COMPOSITION

The Committee shall consist of Medical Staff members and such other staff members as may be deemed appropriate by the Medical Executive Committee. The Committee shall also include such lay community representatives, social workers, clergy, ethicists, attorneys, and representatives for the Hospital Administration and the Board of Trustees as may be required by law or otherwise deemed advisable by the Medical Executive Committee, provided, however, that at all times a majority of the members of the Committee shall be members of the Medical Staff.

13.3-2 DUTIES

The Committee shall participate in the development of guidelines for consideration of cases having bioethical implications; development and implementation of procedures for the review of such cases; development and/or review of institutional policies regarding care and treatment of such cases; retrospective review of cases for the evaluation of bioethical policies; consultation with concerned parties to facilitate communication and aid conflict resolution; and education of the Medical Staff and the Hospital staff on bioethical matters.

13.3-3 MEETINGS

The Committee shall meet as often as necessary at the call of its Chairman. It shall maintain a record of its activities and report to the Medical Executive Committee.

13.4 BYLAWS COMMITTEE

13.4-1 COMPOSITION

The Bylaws Committee shall consist of at least five (5) members of the Medical Staff, including at least the Chief of Staff and the immediate Past Chief of Staff.

13.4-2 DUTIES

The duties of the Bylaws Committee shall include:

a. Conducting an annual review of the Medical Staff Bylaws, as well as the rules and regulations, policies and procedures, and forms promulgated by the Medical Staff, its departments, and sections.

b. Submitting recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect current Medical Staff practices.

c. Receiving and evaluating for recommendations to the Medical Executive Committee suggestions for modification of the items specified in subsection (a) of this Section.

13.4-3 MEETINGS

The Bylaws Committee shall meet as often as necessary at the call of its Chairman, but at least annually and shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

13.5 CREDENTIALS COMMITTEE

13.5-1 COMPOSITION

The Credentials Committee shall consist of at least five (5) members of the Medical Staff. Members of the Committee shall be selected on a basis that will provide, insofar as feasible, representation of major clinical specialties.

13.5-2 DUTIES

The Credentials Committee shall:

a. Review and evaluate the qualifications of each practitioner applicant applying for initial appointment, reappointment, or modification of and for clinical privileges, and, in connection therewith, obtain and consider the recommendations of the appropriate departments.

b. Submit required reports and information on the qualifications of each member applying for membership or particular clinical privileges including recommendations with respect to appointment, membership category, department affiliation, clinical privileges, and special conditions.

c. Investigate, review and report on matters referred by the Chief of Staff or the Medical Executive Committee regarding the qualifications, conduct, professional character or competence of any applicant or Medical Staff member.

d. Submit periodic reports to the Medical Executive Committee on its activities and the status of pending applications.

13.5-3 MEETINGS

The Credentials Committee shall meet as often as necessary at the call of its Chairman. The Committee shall maintain a record of its proceedings and actions and shall report to the Medical Executive Committee.

13.6 DONOR CENTER AND TRANSFUSION COMMITTEE

13.6-1 COMPOSITION

The Donor Center and Transfusion Committee shall consist of at least two (2) Medical Staff members in addition to representatives from the Departments of Medicine, Pathology, Surgery, and non-voting representatives from the nursing service and the Hospital Administration.

13.6-2 DUTIES

The Donor Center and Transfusion Committee shall develop proposed policies and procedures for the screening, distribution, handling, and administration of blood and blood components, and related matters.

13.6-3 MEETINGS

The Committee shall meet as often as necessary, at the call of its Chairman. It shall maintain a record of its activities and shall report to the Medical Executive Committee.

13.7 HEALTH INFORMATION MANAGEMENT COMMITTEE

13.7-1 COMPOSITION

The Health Information Management Committee shall consist of at least three (3) Medical Staff members, and non-voting representatives from the nursing service, the Health Information Management Department, and Hospital Administration.

13.7-2 DUTIES

The duties of the Health Information Management Committee shall include:

a. review and evaluation of medical records, or a representative sample, to determine whether they: (1) properly describe the condition diagnosis, and progress of the patient during hospitalization and at the time of discharge, the treatment and tests provided, the results thereof, and adequate identification of individuals responsible for orders given and treatment rendered; and (2) are sufficiently complete between individuals providing patient care services in the Hospital;

b. review and make recommendations for Medical Staff and Hospital policies, rules and regulations relating to medical records, including completion, forms and formats, filing, indexing, storage, destruction, availability, and methods of enforcement;

c. provide liaison with Hospital Administration and Health Information Management Department personnel in the employ of the Hospital on matters relating to medical records practices; and

d. maintain a record of all actions taken and submit periodic reports to the Medical Executive Committee concerning medical record practices in the Hospital.

13.7-3 MEETINGS

The Health Information Management Committee shall meet as often as necessary at the call of its Chairman. It shall maintain a permanent record of its proceedings and activities and shall report to the Medical Executive Committee.

13.8 INFECTION PREVENTION/PHARMACY & THERAPEUTICS COMMITTEE

13.8-1 COMPOSITION

The Infection Prevention/Pharmacy & Therapeutics Committee shall consist of at least three (3) Medical Staff members, a non-voting individual employed in surveillance or epidemiological capacity, and non-voting representatives from the pharmaceutical service, nursing service, and Hospital Administration.

The Committee may also include non-voting consultants in microbiology and non-voting representatives from relevant Hospital services.

13.8-2 DUTIES

The duties of the Infection Prevention/Pharmacy & Therapeutics Committee shall include:

a. developing a Hospital-wide infection prevention program and maintaining surveillance over the program;

b. developing a system for reporting, identifying, and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow-up activities;

c. developing and implementing a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing, and evaluating aseptic, isolation and sanitation techniques;

d. developing written policies defining special indications for isolation requirements;

e. coordinating action on findings from the Medical Staff's review of the clinical use of antibiotics;

f. acting upon recommendations related to infection prevention received from the Chief of Staff, the Medical Executive Committee, departments, and other committees;

g. reviewing sensitivities of organisms specific to the facility.

h. assisting with the formulation of professional practices and policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and other matters relating to drugs in the Hospital, including antibiotic usage.

i. advising the Medical Staff and the pharmaceutical service on matters pertaining to the choice of available drugs.

j. making recommendations concerning drugs to be stocked on the nursing unit floors and by other services.

k. periodically developing and reviewing a formulary or drug list for use in the Hospital.

l. evaluating and distributing clinical data concerning new drugs or preparations requested for use in the Hospital.

m. establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

n. maintaining a record of all activities relating to pharmacy and therapeutics functions and submitting periodic reports and recommendations to the Medical Executive Committee concerning those activities.

o. reviewing untoward drug reactions.

13.8-3 MEETINGS

The Infection Prevention/Pharmacy & Therapeutics Committee shall meet as often as necessary at the call of the Chairman but at least quarterly. It shall maintain a record of its proceedings and shall submit reports of its activities and recommendations to the Medical Executive Committee.

13.9 INSTITUTIONAL REVIEW BOARD

13.9-1 COMPOSITION

The Institutional Review Board (the “Committee”) membership shall comply with current recommendation of the Federal Drug Administration. The Committee shall review its membership on an annual basis.

13.9-2 DUTIES

The Committee shall review and approve, disapprove, or require modifications of all research studies involving human subjects proposed to be conducted at the Hospital for compliance with federal and state statutes and regulations governing human subjects involved are adequately protected. No clinical investigation that involves an investigational drug or device or one or more human subjects, and that is regulated by the Food and Drug Administration under the Federal Food, Drug and Cosmetic Act, may be initiated at the Hospital without obtaining prior approval of the Committee. The Committee shall ascertain the acceptability of proposed research in terms of institutional commitments and regulations, and standards of professional conduct and practice. In addition, the Committee shall conduct continuing review of, and may require modification of, each investigational study it approves until the study is completed, terminated prior to its completion by sponsor, by its investigator, or by the Committee, or is discontinued by its sponsor or investigator.

13.9-3 MEETINGS

The Committee shall meet as often as necessary at the call of its Chairman. It shall maintain a record of its activities and report to the Medical Executive Committee.

13.10 INTERDISCIPLINARY PRACTICE COMMITTEE

13.10-1 COMPOSITION

The Interdisciplinary Practice Committee shall be comprised of medical directors, administrators, nursing personnel and ancillary personnel with an equal number of physicians and nursing/ancillary staff. The Chairman of the Committee shall be the Chief of Staff.

13.10-2 DUTIES

The Interdisciplinary Practice Committee shall have duties as follows:

a. Identifying functions and/or procedures which require the formulation and adoption of standardized procedure for practices beyond the scope of practice for nursing and ancillary staff.
b. Reviewing and approving all standardized procedures.
c. Recommending policies and procedures for authorization of employed staff to perform the identified functions and/or procedures.

13.10-3 MEETINGS

The Committee shall meet as needed. It shall maintain a record of its activities and report to the Medical Executive Committee.

13.11 JOINT CONFERENCE COMMITTEE

13.11-1 COMPOSITION

The Joint Conference Committee shall be composed of an equal number of members of the Board of Trustees and of the Medical Executive Committee, but the Medical Staff members shall at least include the Chief of Staff, Assistant Chief of Staff, and the immediate Past Chief of Staff. The Administrator may be a non-voting Ex-Officio member. The chairmanship of the Committee shall alternate yearly between the Board of Trustees and the Medical Staff.

13.11-2 DUTIES

The Joint Conference Committee shall constitute a forum for the discussion of matters of Hospital and Medical Staff policy, practice, and planning, and for interaction between the Board of Trustees and the Medical Staff on such matters as may be referred by the Medical Executive Committee or the Board of

Trustees. The Joint Conference Committee shall exercise other responsibilities set forth in these Bylaws.

12.11-3 MEETINGS

The Joint Conference Committee shall meet as often as necessary, at the call of its Chairman and shall transmit written reports of its activities to the Medical Executive Committee and to the Board of Trustees.

13.12 CONTINUING MEDICAL EDUCATION (CME)/LIBRARY COMMITTEE

13.12-1 COMPOSITION

The Chairman shall appoint a representative from each of the departments and such other representatives who have demonstrated an interest in education as the chairman deems appropriate.

13.12-2 DUTIES

The duties involved in organizing continuing education programs and supervising the Hospital's professional library services are to:

a. develop and plan, or participate in, programs of continuing education that are designed to keep the Medical Staff informed of significant new developments and new skills in medicine and that are responsive to audit findings;

b. evaluate the effectiveness of the educational programs developed and implemented;

c. analyze, on a continuing basis, the Hospital's and Staff's needs for professional library services;

d. act upon continuing education recommendations from the Medical Executive Committee, the departments, or other committees responsible for patient care audit and other quality maintenance and monitoring functions;

e. maintain records of education and library activities for a minimum of six (6) years and submit periodic reports to the Medical Executive Committee concerning these activities;

f. review library purchases, procedures, budget matters and renewals of medical publications;
The Continuing Medical Education (CME)/Library Committee shall report to the Medical Executive Committee.

13.12-3 MEETINGS

The Continuing Medical Education (CME)/Library Committee shall meet as often as necessary at the call of its Chairman. The Committee shall maintain a record of its proceedings and actions and shall report to the Medical Executive Committee.

13.13 MEDICAL EXECUTIVE COMMITTEE

13.13-1 COMPOSITION

The Medical Executive Committee shall consist of the following persons:

a. The Officers of the Medical Staff

b. The immediate Past Chief of Staff (in good standing)

c. The chief of the following clinical departments:
Anesthesiology
Emergency Medicine
Family Practice
Medicine
Obstetrics/Gynecology
Pathology
Pediatrics

Radiology
Surgery

d. The Chairman of the following Medical Staff committees:
Bioethics
Bylaws
Cancer
Continuing Medical Education (CME)/Library
Credentials
Donor Center and Transfusion
Health Information Management
Infection Prevention/P&T
Institutional Review Board
Interdisciplinary Practice
Performance Improvement
Practitioner Well Being
Professional Relations
Transitional Care Unit
Utilization Management

e. Three physician Members at Large from the Active Staff who shall be nominated and elected for one year term in the same manner and at the same time as provided in Sections 10.1-4 through 10.1-5 for the nomination and election of officers. The three physicians shall be elected by plurality.

f. Three physician members of the Board of Trustees shall be voting members.

g. Any other person invited by the Chief of Staff to attend who shall be a non-voting attendee.

h. The Hospital Medical Directors shall be invited to attend the Medical Executive Committee by the Chief of Staff on an as needed basis.

13.13-2 DUTIES

The duties of the Medical Executive Committee shall include, but not be limited to:

a. representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws.

b. coordinating and implementing the professional and organizational activities and policies of the Medical Staff.

c. receiving and acting upon reports and recommendations from Medical Staff departments, committees, and assigned activity groups.

d. recommending action to the Board of Trustees on matters of a medical administrative nature.

e. establishing the structure of the Medical Staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of performance improvement activities and mechanisms of the Medical Staff, termination of Medical Staff membership and fair hearing procedures, as well as other matters relevant to the operation of an organized Medical Staff.

f. evaluating the medical care rendered to patients in the Hospital.

g. participating in the development of all Medical Staff and Hospital policy, practice, and planning.

h. reviewing the qualifications, credentials, performance, and professional competence and character of applicants and staff members and making recommendations to the Board of Trustees regarding staff appointments and reappointments, assignments to departments, clinical privileges, and corrective action.

i. taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of a participation in Medical Staff corrective or review measures when warranted.

j. taking reasonable steps to develop continuing education activities and programs for the Medical

Staff.

k. designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the Chief of Staff.

l. reporting to the Medical Staff at each regular staff meeting.

m. assisting in the obtaining and maintaining of accreditation.

n. developing and maintaining of methods for the protection and care of patients and others in the event of internal or external disaster.\

o. appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff.

p. reviewing the quality and appropriateness of services provided by the contract physicians.

q. developing and enforcing Patient Administrative Policies which shall from time to time be adopted to mandate uniform compliance with policies, recommended by departments and individuals, which shall constitute best practices or consensus guidelines to protect patients, staff, Medical Staff and visitors and to provide uniform practice protocol where warranted. Such policies, except for in emergency circumstances, shall be adopted only after the Medical Staff has received notice and an opportunity to comment, and in the case of practice protocol, only after review at the department level where the Medical Staff shall have notice and an opportunity to comment.

13.13-3 MEETINGS

The Medical Executive Committee shall meet as often as necessary and shall maintain a record of its proceedings and actions.

13.13-4 REMOVAL

After election, appointment and ratification, removal of members of the Medical Executive Committee may occur for cause, including, but not limited to, gross neglect or misfeasance in appointment or office, or serious actions of moral turpitude, by two-thirds (2/3) vote of the Medical Executive Committee members.

13.14 MEDICAL STAFF INFORMATION TECHNOLOGY (IT) COMMITTEE

13.14-1 COMPOSITION

The Medical Staff Information Technology Committee shall be composed of five (5) members of the Medical Staff encompassing a variety of specialties.

13.14-2 DUTIES

The duties of the Medical Staff Information Technology Committee are to:

a. Provide strategic direction;
b. Prioritize and approve strategic projects and IT capital expenditures;
c. Approve updates to IT Strategic Plan;
d. Monitor status of strategic projects;
e. Receive updates on overall IT Project Portfolio; and
f. Review Admin IT Policies and Procedures

13.14-3 MEETINGS

The Committee shall meet as needed and shall report to the Medical Executive Committee.

13.15 NOMINATING COMMITTEE

13.15-1 COMPOSITION

The Nominating Committee shall be composed of the Officers of the Medical Staff, the immediate Past Chief of Staff, and the Chairmen of the following clinical Departments: Anesthesia, Emergency, Family Practice, Medicine, Obstetrics/Gynecology, Pathology, Pediatrics, Radiology, and Surgery.

13.15-2 DUTIES

The duties of the Nominating Committee are to nominate candidates for Chief of Staff, Vice Chief of Staff, Secretary/Treasurer, and three (3) members-at-large of the Medical Executive Committee;

13.15-3 MEETINGS

The Nominating Committee shall meet and shall report to the Medical Executive Committee.

13.16 CANCER COMMITTEE

13.16-1 COMPOSITION

The Cancer Committee membership shall comply with current recommendation of the American College of Surgeons. The Committee shall review its membership on an annual basis. Non-voting representatives from Hospital Administration, the Nursing Division, Social Services, Rehabilitation, Cancer Registry, and Performance Improvement will also attend meetings.

The Breast Cancer Program Committee shall be subcommittees of the Cancer Committee. This subcommittee shall function and report to the Cancer Committee and as deemed necessary, shall develop policies to outline its function. These policies shall be subject to approval by the Cancer Committee.

13.16-2 DUTIES

The Committee shall be responsible for monitoring and review of all matters related to the care of cancer patients within the Hospital and associated programs, including diagnosis, treatment, rehabilitation, screening, monitoring, reporting, and research. The Committee shall focus its attention on analysis, formulation, and implementation of policies relating to treatment of cancer patients, and evaluation of care provided to cancer patients.

13.16-3 MEETINGS

The Committee shall meet at least quarterly at the call of its Chairman. It shall maintain a permanent record of its proceedings and activities and shall report to the Medical Executive Committee.

13.17 PRACTITIONER WELL BEING COMMITTEE

13.17-1 COMPOSITION

The Practitioner Well Being Committee (PWBC) shall be a standing committee of the Medical Staff appointed by the Chief of Staff and shall consist of at least four (4) members of the Medical Staff.

13.17-2 PURPOSE

The PWBC exists to identify and manage matters of individual health for practitioners, which is separate from actions taken for disciplinary purposes.

13.17-3 DUTIES

The duties of the PWBC shall be:

a. Education of the Medical Staff and other Hospital staff about illness and impairment recognition issues specific to practitioners. Prevention of physical, psychiatric, and/or emotional help will be addressed.

b. To facilitate confidential diagnosis, treatment, and rehabilitation with the purpose of assisting such practitioner to function at an optimal professional level, consistent with patient protection. This can be accomplished through:
   1. Self-referral
   2. Referral by others with creation of confidentiality of informants
   3. Referral of the affected practitioner to appropriate professional internal and external resources for evaluation, diagnosis, and treatment of the condition or concern
   4. Maintenance of confidentiality of the practitioner seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the health and safety of a patient is threatened.

c. Evaluation of the credibility of a complaint, allegation, or concern.

d. Monitoring the affected practitioner and the safety of patients until the rehabilitation or any disciplinary process is complete and periodically thereafter, if required.

e. Reporting to the organized Medical Staff leadership instances in which a practitioner is providing unsafe treatment. This may be done at any time during diagnosis, treatment, or rehabilitation that a practitioner is unable to safely perform his/her privileges.

13.17-4 MEETINGS

The Committee shall meet as needed to fulfill its charges in accordance with its policies. Minutes shall not reflect the identity of any practitioner by either name or number. The Committee will report to the Medical Executive Committee, preserving the anonymity of practitioner contacts with the Practitioner Well Being Committee, insofar as is consistent with the process discussed in Section 12.15-2, to be developed, implemented, and maintained by the Practitioner Well Being Committee in partnership with TMMC Medical Staff.

The Practitioner Well Being Committee shall work with TMMC Medical Staff to ensure that the process discussed in Section 12.15-2 shall require a matter to be referred to Medical Staff leadership for corrective action if a determination is made at any time during diagnosis, treatment or rehabilitation that a physician is unable to safely perform his or her privileges.

13.18 PERFORMANCE IMPROVEMENT COMMITTEE

13.18-1 COMPOSITION

The Performance Improvement Committee shall consist of such members as may be designated by the Medical Executive Committee including at least one (1) representative from each clinical department, and non-voting representatives from the Nursing Service and from the Hospital Administration. The Chairman shall be appointed by the Chief of Staff.

13.18-2 DUTIES

The Performance Improvement Committee shall perform the following duties:

a. recommend for approval of the Medical Executive Committee plans for maintaining quality patient care within the Hospital. These may include mechanisms to:

   1. establish systems to identify potential problems in patient care;
   2. set priorities for action on problem correction;

3. refer priority problems for assessment and corrective action to appropriate departments or committees;
4. monitor the results of quality assurance activities throughout the Hospital;
5. coordinate quality management activities.

b. review the performance improvement reports received from the clinical departments; Patient Safety/PI Committee and Sentinel Event Sub-committee.

c. submit regular confidential reports to the Medical Executive Committee on the quality of medical care provided and on quality review activities conducted;

d. advise the Medical Staff regarding current accreditation status of the Hospital and the factors influencing that status.

12.18-3 MEETINGS

The Committee shall meet as often as necessary at the call of its Chairman, quarterly. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee and Board of Trustees, except that routine reports to the Board shall not include peer evaluations related to individual members.

13.19 PROFESSIONAL RELATIONS COMMITTEE

13.19-1 COMPOSITION

The Professional Relations Committee shall be chaired by the Vice Chief of Staff and shall consist of the Chief of Staff, Vice Chief of Staff, Secretary/Treasurer, Past Chief of Staff and the clinical department chiefs. The Chief Executive Officer, Chief Medical Officer, the Chief Nursing Officer, and the Vice President, Medical Staff Services/ Performance Improvement may be invited to attend.

13.19-2 DUTIES

The Committee shall have the responsibility to review and evaluate the concerns of patients, patients' family members, hospital staff and Medical Staff members regarding behavioral issues involving licensed independent practitioners at Torrance Memorial Medical Center. See also Policy and Procedure: Medical Staff: Professional Relations Committee for additional details.

13.19-3 MEETINGS

The Committee shall meet as often as needed as determined by the Chair or Chief of Staff. It shall maintain a record of its activities and report to the Medical Executive Committee.

13.20 TRANSITIONAL CARE UNIT COMMITTEE

13.20-1 COMPOSITION

The Transitional Care Unit shall have a Patient Care Policy Committee. This committee shall be composed of at least three (3) physicians, the TCU Administrator, the director of nursing service, a pharmacist, activity leader and representatives of each required service as appropriate. The Chairman shall be appointed by the Chief of Staff.

13.20-2 DUTIES

The Transitional Care Unit Patient Care Policy Committee shall have duties as follows:

a. Establish policies governing the following services: Physician, dental, nursing, dietetic, pharmaceutical, health records, housekeeping, activity programs and such additional services as are provided by the facility.

b. The Committee is responsible for reviewing and approving all policies relating to patient care. Based

on reports received from the facility administrator, the Committee shall review the effectiveness of policy implementation and shall make recommendations for the improvement of patient care.

c. The Committee shall review patient care policies annually and revise as necessary. Minutes shall list policies reviewed.

d. The Committee shall implement the provisions of the Health and Safety Code Sections 1315, 1316 and 1316.5 by means of written policies and procedures.

e. The Committee is responsible for establishing policies and procedures for the orientation of new physicians to the facility and changes in physician services and/or policies.

f. The Committee is responsible for establishing policies and procedures regarding patient evaluation visits by the attending physician and documentation of alternate schedules for such visits.

13.20-3 MEETINGS

The Committee shall meet as often as necessary. It shall maintain a record of its activities and report to the Medical Executive Committee.

13.21 UTILIZATION MANAGEMENT COMMITTEE

13.21-1 COMPOSITION

The Utilization Management Committee shall consist of sufficient members to afford, insofar as feasible, representation from the major specialty departments. Subcommittees may be appointed by the Committee for departments or sections as the Committee may deem appropriate.

13.21-2 DUTIES

The duties of the Utilization Management Committee shall include:

a. conducting utilization review studies designed to evaluate the appropriateness of admissions to the Hospital, lengths of stay, discharge practices, use of medical and Hospital services and related factors which may contribute to the effective utilization of services. The Committee shall communicate the results of its studies and other pertinent data to the Medical Staff Performance Improvement Committee and shall make recommendations for the utilization of resources and facilities commensurate with quality patient care;

b. establishing a utilization review plan, which shall be approved by the Medical Executive Committee;

c. obtaining, reviewing, and evaluating information and raw statistical data obtained or generated by the Hospital's case management system; and

d. conducting appropriate activities with regard to Diagnosis Related Groups ("DRG"), in accordance with the Rules and Regulations of the Medical Staff.

13.21-3 MEETINGS

The Utilization Management Committee shall meet as often as necessary at the call of its Chairman. It shall maintain a record of its findings, proceedings and actions, and shall make a report of its activities and recommendations to the Medical Executive Committee.

13.22 INDEPENDENT PHYSICIANS COMMITTEE

13.22-1 PURPOSE

The purpose of the Independent Physicians Committee is to provide a method of communication between solo or small group physicians directly to the Medical Executive committee to discuss issues affecting physicians in independent practice, including equipment, hospital services, perceived anti-competitive behavior, Rules & Regulations and Policies of the medical staff.

13.22-2 COMPOSITION

The Independent Physicians Committee shall consist of sufficient members to afford fair representation. Membership is open to physicians in solo practice or in practice with not more than one or two other physicians. The Committee will be chaired by an officer of the Medical Executive Committee appointed by the Chief of Staff who will be a non-voting member.

13.22-3 DUTIES

The duties of the Independent Physicians Committee shall be to serve as a conduit for communications with the Medical Executive Committee for matters of interest to its members.

13.22-4 MEETINGS

The Independent Physicians Committee shall meet as often as necessary at the call of its chair, but at least monthly provided there is business to come before the committee. Proposed business must be submitted to the committee chair one week in advance of the scheduled meeting. The committee will not meet if there is no business. It shall maintain a record of its findings, proceedings, and actions, and shall make a report of its activities and recommendations to the Medical Executive Committee following each meeting.

ARTICLE XIV

MEETINGS

14.1 MEDICAL STAFF MEETINGS

14.1-1 ANNUAL MEETING

The Annual Meeting of the Medical Staff shall be the last meeting before the end of the year. At this meeting, the retiring officers and committees shall make such reports as may be desirable, nominations for the officers for the ensuing year shall be announced, nominations will be taken from the floor.

Notice of each annual meeting shall be sent to each member, electronically (email) or by mail, addressed to each address appearing on the records of the Medical Staff, and posted not less than twenty-seven (27) days before each annual meeting. Such notice shall state the place, the day and the hour of such meeting, and such other matters as the Medical Executive Committee may determine.

14.1-2 MEETINGS

Meetings of the Medical Staff shall be held as needed, the annual meeting shall constitute a regular meeting. The date, place and time of the meetings shall be determined by the Chief of Staff, and adequate notice shall be given to the members.

14.1-3 AGENDA

The order of business at a regular meeting of the Medical Staff shall be determined by the Chief of Staff.

14.1-4 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the Medical Executive Committee and shall be called upon the written request of ten percent (10%) of the members of the Active Medical Staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the Medical Executive Committee within thirty (30) days after receipt of such request. No later than ten (10) days prior to the meeting, notice shall be mailed or delivered to the members of the staff which includes the stated purpose of the meeting. No

business shall be transacted at any special meeting except that stated in the notice to call the meeting.

14.2 COMMITTEE AND DEPARTMENT MEETINGS

14.2-1 REGULAR MEETINGS

Except as otherwise specified in these Bylaws, the Chairman of committees, departments and sections may establish the times for the holding of regular meetings. The Chairman shall make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

14.2-2 SPECIAL MEETINGS

A special meeting of any committee, department or subcommittee may be called by the Chairman thereof, the Medical Executive Committee, the Chief of Staff, and shall be called at the written request of fifteen percent (15%) of the current members, but not less than two (2) members.

14.3 QUORUM

14.3-1 STAFF MEETINGS

The presence of thirty (30) members of the Active Medical Staff at any regular or special meeting in person or through written or electronic ballot shall constitute a quorum. A quorum by written or electronic ballot may be determined by counting ballots at the end of any time permitted for submitting ballots.

14.3-2 DEPARTMENT AND COMMITTEE MEETINGS

Each Medical Staff committee or department shall determine its own policy as to what shall constitute a quorum, provided, however, that not less than two (2) voting members, shall constitute a quorum.

14.4 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which 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 specifically required by these Bylaws. Committee action may be conducted by telephone conference which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Valid action may be taken without a meeting by a committee if it is acknowledged by a writing set forth the action so taken which is signed by at least two-thirds (2/3) of the members entitled to vote.

14.5 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the votes taken on significant matters.

A copy of the minutes shall be signed by the presiding officer of the meeting and forwarded to the Medical Executive Committee.

14.6 ATTENDANCE REQUIREMENTS

14.6-1 REGULAR ATTENDANCE

Each member of the Active Staff shall attend four (4) meetings per year. These meetings include general staff, departmental, departmental subcommittees, the Medical Executive Committee, and any committee which directly reports to the Medical Executive Committee. Active Staff members who do not meet the

attendance requirements at reappointment will be moved to Associate Staff. Meeting attendance requirements are waived for each Active Staff member who has admitted, consulted, or otherwise been involved in the care of twenty or more patients in the previous year.

14.6-2 ABSENCE FROM MEETINGS

Failure to meet the attendance requirements shall result in assignment to the appropriate Staff Category.

14.6-3 SPECIAL ATTENDANCE

At the discretion of the Chairman or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular department, subcommittee, or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at any meeting with respect to which he was given such notice, unless excused by the Medical Executive Committee upon a showing of good cause, may be a basis for corrective action.

14.7 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to the current edition of Robert's Rules of Order; provided, however, that non-substantive departures from such rules shall not invalidate action taken at such a meeting.

ARTICLE XV

CONFIDENTIALITY, IMMUNITY AND RELEASES

15.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising clinical privileges within this Hospital, an applicant:

a. Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications.

b. Authorizes person and organizations to provide information concerning such member to the Medical Staff.

c. Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital who acts without malice in accordance with the provisions of this Article.

d. Acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges at this Hospital.

15.2 CONFIDENTIALITY OF INFORMATION

15.2-1 GENERAL

Medical Staff, department, subcommittee, or committee minutes, files, and records, including information regarding any member or applicant to the Medical Staff shall, to the fullest extent permitted by law, be confidential. Dissemination of such information and records shall only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff or, where no officially adopted policy exists, only with the express approval of the Medical Executive Committee.

15.2-2 BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of

confidentiality of the discussions or deliberations of Medical Staff departments, subcommittees, or committees, except in conjunction with other hospitals, professional society, or licensing authority, is outside appropriate standards of conduct for the Medical Staff. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

15.3 IMMUNITY FROM LIABILITY

15.3-1 FOR ACTION TAKEN

Each representative of the Medical Staff and Hospital shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of his or her duties as a representative of the Medical Staff or Hospital.

15.3-2 FOR PROVIDING INFORMATION

Each representative of the Medical Staff and Hospital and all third parties shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief by reason of providing information, to a representative of the Medical Staff or Hospital concerning such person who did, or does, exercise clinical privileges or provide services at this Hospital.

15.4 ACTIVITIES AND INFORMATION COVERED

15.4-1 ACTIVITIES

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

a. applications for appointment, reappointment, or clinical privileges;

b. corrective action;

c. hearings and appellate reviews;

d. utilization review;

e. other department, subcommittee, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

f. peer review organizations, MBC, and similar reports as required by law.

15.5 RELEASES

Each applicant or member shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent, of this Article.

Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

ARTICLE XVI

GENERAL PROVISIONS

16.1 STAFF RULES AND REGULATIONS AND POLICIES AND PROCEDURES

The Medical Staff shall initiate and adopt such Rules as it may deem necessary and shall periodically review and revise its Rules to comply with current Medical Staff practice. New Rules or changes to the Rules (proposed

Rules) may emanate from any responsible committee, department, Medical Staff officer, or by petition signed by at least thirty-three percent (33%) of the voting members of the Medical Staff. Proposed rules shall be submitted to the Medical Executive Committee for review and action, as follows:

a. Except as provided at Section 15.1(b) (5), below, with respect to circumstances requiring urgent action, the Medical Executive Committee shall not act on the proposed Rule until the Medical Staff has had a reasonable opportunity to review and comment on the proposed Rule. This review and comment opportunity may be accomplished by posting proposed Rules on the Medical Staff website at least thirty (30) days prior to the scheduled Medical Executive Committee meeting, together with instructions on how interested members may communicate comments. A comment period of at least fifteen (15) days shall be afforded, and all comments shall be summarized and provided to the Medical Executive Committee prior to Medical Executive Committee action on the proposed Rule.

b. Medical Executive Committee approval is required unless the proposed Rule is one generated by petition of at least thirty-three percent (33%) of the voting members of the Medical Staff. In this latter circumstance, if the Medical Executive Committee fails to approve the proposed Rule, it shall notify the Medical Staff. The Medical Executive Committee and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Section 15.8:
    1. If conflict management is not invoked within thirty (30) days it shall be deemed waived. In this circumstance, the Medical Staff's proposed Rule shall be submitted for vote, and if approved by the Medical Staff, the proposed Rule shall be forwarded to the Board of Trustees for action. The Medical Executive Committee may forward comments to the Board of Trustees regarding the reasons it declined to approve the proposed Rule.
    2. If conflict management is invoked, the proposed Rule shall not be voted upon or forwarded to the Board of Trustees until the conflict management process has been completed, and the results of the conflict management process shall be communicated to the Board of Trustees.
    3. With respect to proposed Rules generated by petition of the Medical Staff, approval of the Medical Staff requires the affirmative vote of a majority of the Medical Staff members voting on the matter by mailed secret ballot, provided at least fourteen 14 days' advance written notice, accompanied by the proposed Rule, has been given, and at least a number in excess of fifty percent (50%) of the eligible votes have been cast.
    4. Following approval by the Medical Executive Committee or favorable vote of the Medical Staff as described above, a proposed Rule shall be forwarded to the Board of Trustees for approval, which approval shall not be withheld unreasonably. The Rule shall become effective immediately following approval of the Board of Trustees or automatically within sixty (60) days if no action is taken by the Board of Trustees.
    5. Where urgent action is required to comply with law or regulation, the Medical Executive Committee is authorized to provisionally adopt a Rule and forward it to the Board of Trustees for approval and immediate implementation, subject to the following: If the Medical Staff did not receive prior notice of the proposed Rule, the Medical Staff shall be notified of the provisionally-adopted and approved Rule, and may, by petition signed by at least thirty-three percent (33%) of the voting members of the Medical Staff required for the Rule to be submitted for possible recall; provided, however, the approved Rule shall remain effective until such time as a superseding Rule meeting the requirements of the law or regulation that precipitated the initial urgency has been approved.

16.2 DEPARTMENTAL RULES AND REGULATIONS

Subject to the approval of the Medical Executive Committee, each department shall formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these Bylaws, or the Rules and Regulations of the Medical Staff.

16.3 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings of these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws. These Bylaws apply with equal force to both sexes wherever either term is used.

16.4 AUTHORITY TO ACT

Any member or members who act in the name of the Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

16.5 DIVISION OF FEES

Any division of fees by members of the Medical Staff is forbidden and any such division of fees shall be cause for exclusion from the Medical Staff.

16.6 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests, required or permitted to be mailed may be in writing, properly sealed, and sent through United States Postal Service, first-class postage prepaid. An alternative delivery mechanism may be used if it is reliable and no less expeditious, and if evidence of its use is obtained. Notification by electronic means is also acceptable.

Mailed notices to a member, applicant, or other party, shall be to the addressee at the address as it last appears in the official records of the Medical Staff. Electronic notifications will be sent to the address as it last appears in the official records of the Medical Staff.

16.7 CONFLICTS OF INTERESTS

16.7-1 Process

All nominees for election to a Medical Staff office or department chief, or appointment to the Medical Executive Committee or other Medical Staff committee chairpersons shall complete a Conflict of Interest form prior to election or appointment, and again annually when elected or appointed, to disclose those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could potentially result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff and Hospital.

16.7-2 Failure to Disclose

Candidates for election or appointment, and those who report annually, who fail to provide such a statement or who falsify statements may be disqualified from the Medical Staff office or department chief, or other appointed position. This determination will be made by the Medical Executive Committee.

16.8 CONFLICT MANAGEMENT – MEDICAL EXECUTIVE COMMITTEE AND MEDICAL STAFF

In the event of conflict between the Medical Executive Committee and the Medical Staff (as represented by written petition signed by at least thirty-three percent (33%) of the voting members of the Medical Staff) regarding a proposed or adopted bylaw, rule or policy, or other issue of significance to the Medical Staff, the Chief of Staff shall convene a meeting with the petitioners' representative(s). The foregoing petition shall include a designation of up to five members of the voting Medical Staff who shall serve as the petitioners' representative(s). The Medical Executive Committee shall be represented by an equal number of Medical Executive Committee members. The Medical Executive Committee's and the petitioners' representative(s) shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care at the hospital. Resolution at this level requires a majority vote of the Medical Executive Committee's representatives at the meeting and a majority vote of the petitioner's representatives. Unresolved differences shall be submitted to a vote of the Medical Staff, with at least a majority of voting members necessary to overrule the Medical Executive Committee's decision with respect to the proposed Rule, policy, or issue.

16.9 DISPUTES WITH THE BOARD OF TRUSTEES

In the event of a dispute between the Medical Staff and the Board of Trustees relating to the independent rights of the Medical Staff, as further described in California Business & Professions Code Section 2282.5, the following procedures shall apply.

a. Invoking the Dispute Resolution Process
   1. The Medical Executive Committee may invoke formal dispute resolution, upon its own initiative, or upon written request of twenty percent (25%) of the voting members of the active staff.
   2. In the event the Medical Executive Committee declines to invoke formal dispute resolution, such process shall be invoked upon written petition of fifty percent (50%) of the voting members of the active staff.

b. Dispute Resolution Forum
   1. The initial forum for dispute resolution shall be the Joint Conference Committee, which shall meet and confer as further described in Bylaws, Article XII, Section12.11.
   2. However, if dispute resolution is unsuccessful, a meet and confer will be conducted by a meeting of the full Medical Executive Committee and the full Board of Trustees. A neutral mediator acceptable to both the Board of Trustees and the Medical Executive Committee may be engaged to further assist in dispute resolution upon request of:
      a. At least a majority of the Medical Executive Committee plus one-third of the Board of Trustees; or
      b. At least a majority of the Board of Trustees plus one-third members of the Medical Executive Committee.
      c. The parties' representatives shall convene as early as possible, shall gather, and share relevant information, and shall work in good faith to manage and, it possible, resolve the conflict. If the parties are unable to resolve the dispute the Board of Trustees shall make its final determination giving great weight to the actions and recommendations of the Medical Executive Committee. Further, the Board of Trustees determination shall not be arbitrary or capricious and shall be in keeping with its legal responsibilities to act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the Hospital.

ARTICLE XVII

DUES

17.1 AMOUNT OF DUES

The Medical Executive Committee shall have the authority to establish dues for all Medical Staff members.

17.2 RESPONSIBILITY FOR PAYMENT

Dues shall be paid by all the Medical Staff members, except members on Leave of Absence as well as members of the Affiliate or Retired Staff. The Medical Executive Committee shall have the authority to waive the requirement of payment of dues for any individual member of the Medical Staff, as it may deem appropriate.

17.3 PAYMENT OF DUES

Dues shall be due and payable as part of the reappointment application and such related delinquencies shall be considered as part of the reappointment process.

17.4 EXPENDITURE OF FUNDS

Neither the Medical Staff, nor any officer or representative of the Medical Staff shall expend any dues or any other funds or resources on behalf of the Medical Staff, including the retention of any advisors, consultants, or counsel, without first obtaining the approval of the Medical Executive Committee.

ARTICLE XVIII

ADOPTION AND AMENDMENT OF BYLAWS

18.1 PROCEDURE

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

18.2 URGENT ACTION REQUIRING BYLAW CHANGE

Where urgent action is required to comply with law or regulation, the Medical Executive Committee is authorized to provisionally adopt a Bylaw and forward it to the Board of Trustees for approval and immediate implementation, subject to the following: If the Medical Staff did not receive prior notice of the proposed Bylaw, the Medical Staff shall be notified of the provisionally-adopted and approved Bylaw, and may, by petition signed by at least thirty-three percent (33%) of the voting members of the Medical Staff required for the Bylaw to be submitted for possible recall; provided, however, the approved Bylaw shall remain effective until such time as a superseding Rule meeting the requirements of the law or regulation that precipitated the initial urgency has been approved.

18.3 ADOPTION

These Medical Staff Bylaws may be adopted, amended, or repealed by an affirmative vote of the majority of the eligible voting members of the Medical Staff responding in a ballot, and will become effective when approved by the Board of Trustees. The procedure for distributing, returning, and counting ballots will be determined by the Medical Executive Committee; provided that a notice containing the existing bylaw language, if any, and the proposed changes will be sent to every Active Staff member at least thirty (30) days prior to the voting deadline.

Such notice may be written or electronic (email). Ballots may be counted by an electronic means, including by a contracted entity approved by the Medical Executive Committee. The voting deadline is thirty (30) days following the mailing or electronic delivery of the ballot. Ballots received after the voting deadline will not be counted.

ARTICLE XIX

REVIEW

The Bylaws shall be reviewed periodically to assure that the Medical Staff Bylaws, rules and regulations and policies, the Board of Trustees Bylaws and the hospital policies are compatible with each other and shall be compliant with current laws and regulations.