PROVIDENCE
Little Company of Mary
Medical Center
Torrance

PROFESSIONAL STAFF BYLAWS

Approval dates

Medical Executive Committee: 10/03/2017
Professional Staff: 11/29/2017
Board of Directors: 01/23/2018

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ARTICLE I

PREAMBLE, DEFINITIONS, NAME, AND PURPOSES

Section 1.1 Preamble

WHEREAS, PROVIDENCE LITTLE COMPANY OF MARY MEDICAL CENTER TORRANCE is a nonprofit corporation organized under the laws of the State of California; and

WHEREAS, its purpose is to serve as an acute general Hospital providing patient care, education and research; and

WHEREAS, it is recognized that the Professional Staff is responsible for the quality of medical care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital's Board of Directors, and that the cooperative efforts of the Professional Staff, the Chief Executive Officer and the Board of Directors are necessary to fulfill the obligations of the Hospital to the patients.

THEREFORE, the physicians, dentists, and podiatrists practicing in the Hospital hereby organize themselves into a Professional Staff in conformity with these Bylaws.

Section 1.2 Definitions

A. "Hospital" shall mean Providence Little Company of Mary Medical Center Torrance (includes all entities under the Hospital licensure, i.e., post-acute care, outpatient clinic, etc.).

B. The term "Board of Directors" means the Board of Directors of the Hospital or any delegate of the Board.

C. The term "Professional Staff" means all licensed physicians, licensed dentists and licensed podiatrists who are privileged to attend patients in the Hospital.

D. The term "Medical Executive Committee" means the Medical Executive Committee of the Professional Staff.

E. The term "Chief Executive Officer" means the individual appointed by the Board of Directors to act in its behalf in the overall management of the Hospital.

F. The term "practitioner" means a licensed physician, dentist, or podiatrist, as the context may require.

G. The term "member" means a member of the Professional Staff.

H. The term "year" or "calendar year" means the period from January to December.

I. The term ”investigation” means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a medical staff member or individual holding clinical privileges, and does not include activity of the Physicians’ Well Being Committee.

J. The term "in good standing" means a member is currently not under suspension for a disciplinary cause or reason, or serving with any limitation of voting or other prerogatives imposed by operation of the bylaws, rules and regulations or policy of the medical staff.

Section 1.3 Name

The name of this organization shall be the Professional Staff of Providence Little Company of Mary Medical Center Torrance.

Section 1.4 Purposes

The purposes of this organization are:

A. To strive to insure that all patients admitted to or treated in any of the facilities, departments or services of the Hospital shall receive the best possible care;

B. To strive to insure a high level of professional performance of all practitioners authorized to practice in the Hospital through the appropriate delineation of the clinical privileges that each practitioner may exercise in the Hospital and through an ongoing review and evaluation of each practitioner's performance in the Hospital;

C. To provide an appropriate educational setting that will maintain professional standards and that will lead to continuous advancement in professional knowledge and skill of all members;

D. To initiate and maintain Professional Staff Bylaws, Rules and Regulations for self-government of the Professional Staff; and

E. To provide a means whereby issues concerning the Professional Staff and the Hospital may be discussed by the Professional Staff with the Board of Directors and the Chief Executive Officer.

ARTICLE II

PROFESSIONAL STAFF MEMBERSHIP

Section 2.1 Policy

The Professional Staff of Little Company of Mary Hospital, by their adoption of these Bylaws, and the Board of Directors of the Hospital by their approval thereof, adopt as policy that membership on the Professional Staff of the Hospital shall be limited to those practitioners who are adjudged by the Medical Executive Committee and the Board of Directors to be qualified. See Article II of the Professional Staff General Rules and Regulations regarding Allied Health Professional Staff.

To the end of implementing this policy, only candidates who qualify under Section 2.2 will be considered for membership and those candidates who best meet the qualifications set forth in Section 2.3 will be appointed to the Staff.

Section 2.2 Qualifications for Consideration for Membership

A. Only physicians, dentists and podiatrists licensed to practice in the State of California, who are graduates of approved medical, dental or podiatric schools, who satisfy departmental membership criteria as outlined in each department's rules and regulations, who can document their background, experience, training and demonstrated competence, their adherence to the ethics of their profession, their good reputation, and their ability to work with others, and who can provide appropriate coverage for their practice, shall be qualified for consideration for membership. Physicians licensed by the State of California who are otherwise qualified for membership shall be entitled to such membership regardless of whether they hold either an M.D. or D.O. degree. No physician, dentist, or podiatrist shall be entitled to membership or to the exercise of any particular clinical privilege in the Hospital merely by virtue of the fact of licensure to practice medicine, dentistry, or podiatry in this, or in any other state, or membership in any professional organization, or the holding, in the past or present, of privileges at another hospital, or any contractual, membership, or employment relationship with this or any hospital or system or its subsidiaries or affiliates or any accountable care organization. Medical staff membership or clinical privileges shall not be revoked, denied, or otherwise infringed based on the member's professional or business interests. Neither the existence of an actual or potential conflict of interest, nor the disclosure thereof, shall affect a member's medical staff membership or clinical privileges.

B. Board Certification

1. As used herein, "Board Certified" refers to certification by a board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Podiatric Surgery, the American Board of Orthopedic Podiatric Medicine, the American Board of General Dentistry, the American

Board of Oral and Maxillofacial Surgery, National Board of Physicians and Surgeons, or any other specialty board or association with equivalent requirements approved by the Medical Board of California, the Osteopathic Medical Board of California, the Dental Board of California, or the California Board of Podiatric Medicine.

2. All Practitioners applying as initial applicants must be Board Certified in the primary specialty that they will practice at PLCMMCT. Practitioners who have completed their post-graduate training within the prior seven (7) years may fulfill this requirement by demonstrating that they are in the process of obtaining such Certification.

3. Furthermore, those practitioners who have been appointed to the professional staff after 1/1/2014 must remain Board Certified in order to be eligible for reappointment, or they will be deemed to have resigned their Membership and Clinical Privileges. Such automatic resignation shall not give rise to any procedural rights under these Bylaws.

4. Those Members who were in the process of obtaining Board Certification at the time of their initial appointment must remain in good standing in that process, and must obtain such Certification within seven (7) years of the completion of their post-graduate training, in order to be eligible for reappointment.

5. The Board Certification requirement does not apply to any professional staff member who was appointed to staff prior to 1/1/2014.

6. The Medical Executive Committee may grant exceptions to the Board Certification requirement, for certain medical specialties, based upon community need, at its sole discretion.

7. Failure to Meet Specific Minimum Requirements
Those members who were in the process of obtaining Board Certification at the time of their initial appointment, and who fail to remain in good standing in that process, or to obtain Board Certification within seven (7) years of the completion of their postgraduate training, will be deemed to have resigned their Membership and Clinical Privileges. Such automatic resignation shall not give rise to any procedural rights under these Bylaws.

C. Except for the Honorary Staff, the initial and ongoing responsibilities of each member include:

1. the provision of care for patients at the generally recognized level of quality and efficiency established by the Professional Staff and Hospital;

2. the examination is to be completed and documented by each physician, an oral maxillofacial surgeon, or other qualified licensed individual holding history and physical examination privileges in accordance with state law and these bylaws. No history and physical may be older than 30 days at the time of admission and must be in the chart within 24 hours of admission and prior to any procedure. The specific elements of a history and physical examination appear in the Professional Staff General Rules and Regulations.

3. responsibility within the member's area of professional competence for the continuous care and supervision of each patient for whom the member is providing services or arrange for suitable coverage consistent with the standards of the profession;

1. being available, in a timely manner, for patients in the member’s practice who present to the hospital for care.

2. compliance with the Professional Staff Bylaws, Professional Staff Rules and Regulations, Departmental Rules and Regulations, policies, all lawful standards including those related to patients’ rights, the Principles of Medical Ethics of the American Medical Association, the Code of Ethics of the American Dental Association or the Code of Ethics of the American Podiatry Association, whichever is applicable, the Ethical and Religious Directives for Catholic Health Care Services, and the "Guiding Principles for Physician-Hospital Relationships" of the California Medical Association;

3. compliance with all requirements set forth in these Professional Staff Bylaws including but not limited to those requiring attendance at meetings, maintenance of professional liability coverage, payment of Professional Staff dues, fines and refraining from the practice of division of fees;

4. the discharge of functions (Professional Staff, departmental, committee, and Hospital) including, but not limited to peer review, performance improvement activities, the protection of patient privacy and confidentiality, utilization review, proctoring (if eligible to proctor), provision of appropriate coverage for their practice, emergency service and Emergency Department back-up call, for which the member is responsible by virtue of category assignment, department requirement, appointment, election, exercise of privileges, prerogatives or other rights in the Hospital;

5. the preparation and completion in a timely fashion of the medical and other required records for all patients the member admits or in any way provides care to in the Hospital;

6. assistance in any educational programs for the Professional Staff, nurses and other personnel when so assigned;

7. treating each other and Hospital staff with respect, dignity and fairness. All forms of harassment are prohibited.

8. maintaining security of healthcare information. Professional Staff Members are assigned a unique login and password for accessing data. Under no circumstances are new or existing users allowed to inherit or use the login and password of another user or share this information with anyone else.

   Professional Staff Members with access to Providence data, systems, or devices are required to comply with Providence security policies and standards when utilizing Providence systems and devices or accessing Providence information

9. to notify the Medical Staff Office of all formal investigations and/or disciplinary action taken against their medical license or by another health center within seven (7) days of notification

C. No applicant shall be denied membership on the basis of sex, age, race, creed, color or national origin or disability for which reasonable accommodation can be provided, which does not preclude the member's practice within the scope of privileges requested.

D. Professional Liability Insurance: Each member (excluding Honorary Staff) granted clinical privileges shall maintain professional liability insurance in not less than the minimum amounts determined by the Medical Executive Committee. Practitioners shall carry professional liability insurance with an insurance carrier or risk retention group that is:

1. An admitted insurance carrier, as determined by the State of California Department of Insurance, with an A.M. Best rating (or equivalent rating system) of B+ or better; or

2. A non-admitted insurance carrier or risk retention group as long as the practitioner meets the following criteria: Annually, any physician whose professional liability insurance is provided through either a non-admitted insurance carrier or risk retention group must furnish to the Medical Staff Services Department a written statement from such risk retention group or non-admitted insurance carrier certifying to the following information:

   Non-Admitted Insurance Carriers
   a. An A.M. Best Rating (or equivalent) of B+ or better
   b. A positive Standard and Poor's Outlook (or equivalent)
   c. Confirmation that the non-admitted insurance carrier meets all applicable legal and regulatory requirements of the state in which such carrier is domiciled, and assurance that such carrier is not on such state insurance commissioner's supervision or watch list
   d. Meets National Association of Insurance Commissioners (NAIC) accreditation or equivalent requirements
   e. Meets financial solvency requirements of the state or country of domicile

   Risk Retention Groups
   a. Evidence of good standing with insurance commissioner's office in state or country of domicile
   b. Meets financial solvency requirements of the state or country of domicile
   c. No adverse financial information on risk retention group website (www.RRR.com)
   d. An A.M. Best Rating (or equivalent) of B+ or better
   e. A positive Standard and Poor's Outlook (or equivalent)

It is the responsibility of the medical staff member to furnish such information annually in a format satisfactory to the Hospital and medical staff. Additional criteria may be sought if the carrier is unable to provide the necessary certification as required above. Hospital and medical staff may elect to waive one or more of the above criteria based on evaluation and recommendations of the PH&S Office of Risk Management.

Required Coverage: The minimum amounts of coverage shall be determined by the Medical Executive Committee (see Medical Staff Services Department for amount). If any change in these limits occurs, the Medical Executive Committee shall designate when the change shall be implemented by the member. The insurance coverage shall apply to all procedures the member has privileges to perform in the Hospital.

Proof of Insurance: Proof of insurance coverage must be provided in the form of a copy of the current certificate/s of insurance, which shall be maintained in the Medical Staff Services Department. Information about insurance coverage must be provided at the time of appointment and reappointment and upon request.

At the time of initial appointment, reappointment, and upon request from the Professional Staff, each applicant or member must provide information on any professional liability claims filed against him or her, any malpractice claims reported to his or her insurance carrier, any letters of intent to sue he or she received, any claims pending, any judgment entered against him or her, and any settlement made where there was a monetary payment. In addition, the applicant or member must state whether he or she was denied professional liability insurance, had his or her policy canceled, had limitations placed on his or her scope of practice, or has been notified of any intent to deny, cancel, or limit coverage.

Reporting Changes: Each member shall report any reduction, restriction, cancellation, or termination of the required professional liability insurance or change in insurance carrier as soon as reasonably possible to the Professional Staff.

When a Professional Staff member with "claims made" insurance coverage terminates or changes his or her insurance coverage, he or she is required to obtain and provide to the Medical Staff Services Department proof of continuous insurance coverage through either (i) extended reporting (i.e. "tail") coverage, or (ii) prior acts coverage with his/her new policy.

Failure to Maintain Professional Liability Insurance: The automatic suspension procedure set forth in the Professional Staff Bylaws shall be followed in the event a member fails to maintain insurance in the required amount.

E. 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 or in contracts with a third party which contracts with this hospital.

Section 2.3 Conditions and Duration of Appointment

A. A report from the department chair as to each applicant's privileges requested shall be made to the Credentialing Committee. Following review of the applicant's file, the Credentialing Committee shall forward their recommendation for medical staff membership and clinical privileges to the Medical Executive Committee.

B. Initial appointments and reappointments to the Professional Staff shall be made by the Board of Directors. Appointments and reappointments to the Professional Staff shall not give rise to any vested right beyond the end of the period for which the member is appointed or reappointed. The Board of Directors shall act on appointments, or reappointments only after there has been a recommendation from the Professional Staff as provided in these Bylaws. In the event that the Professional Staff has failed to act on the appointment/reappointment or privileges of an applicant or member within the time period specified, the matter shall be referred to the Joint Conference Committee upon the written request of the applicant or the Chief Executive Officer.

C. Initial appointments shall be for a period of one (1) year and reappointments shall be for a period of two (2) years, unless otherwise specified by the Medical Executive Committee; under no circumstances can an appointment extend beyond two years.

D. Appointment to the Professional Staff shall confer on the appointee only such clinical privileges as have been granted by the Board of Directors on recommendation of the Professional Staff, in accordance with these Bylaws.

E. In addition to the acknowledgment required by Section 2.1, every application for Professional Staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every member's obligations to provide continuous care and supervision of patients and to abide by the Professional Staff Bylaws, Rules and Regulations, and policies.

F. As a condition of memership and previleges, a medical staff member shall continuously meet the requirements for professional conduct established in these bylaws. Non-members with privileges will be held to the same conduct requirements as members. Except as provided in these bylaws, no other codes or policy restricting or defining conduct apply to the medical staff and its members.

1. Acceptable Conduct

Acceptable medical staff member conduct is not restricted by these bylaws and includes, but is not limited to:

(a) advocacy on medical matters;
(b) making recommendations or criticism intended to improve care;
(c) exercising rights granted under the medical staff bylaws, rules and regulations, and policies;
(d) fulfilling duties of medical staff membership or leadership;
(e) engaging in legitimate business activities that may or may not compete with the hospital.

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 by a medical staff member against any individual involved with the hospital (e.g., against another medical staff member, house staff, hospital employee or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation.
(b) "Sexual harassment," defined as 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.
(c) Deliberate physical, visual or verbal intimidation or challenge, including disseminating threats or pushing, grabbing or striking another person involved in the hospital;
(d) Carrying a gun or other weapon in the hospital;
(e) Refusal or failure to comply with these member conduct requirements.

3. Medical Staff Conduct Complaint

All complaints or reports will be discussed and decisions made in executive session. 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 Chair and President of the Medical Staff, or to the medical staff officer designated by either the President or Medical Executive Committee. Complaints are shared with the subject member, who will be given the opportunity to respond in writing. The Department Chair, in consultation with the Chief of Staff shall refer the matter immediately to the Physicians' Well-being Committee for evaluation, and monitoring and treatment if needed, if there is any indication that the member's health is implicated and the conduct at issue can be addressed by the Physicians' Well-being Committee without jeopardizing quality care or patient safety. The Department Chair, in consultation with the Chief of Staff shall determine if the complaint or report is obviously specious and warrants no further action. If the Department Chair, in consultation with the President determines no action is warranted, the decision is reported at the next Medical Executive Committee. This decision may be discussed and acted upon at the request of any Medical

Executive Committee member, with the support of the majority of the Medical Executive Committee members present at that meeting. Complaints not referred to the Physicians' Well-being Committee or not dismissed by the Department Chair, in consultation with the Chief of Staff are referred to the appropriate department for peer review committee evaluation and investigation, if needed. The decision will be forwarded to the Medical Executive Committee. Any action taken shall be commensurate with the nature and severity of the conduct in question. If corrective action is decided by the Medical Executive Committee, the members will be afforded hearing rights per Article VIII. If the Medical Executive Committee decides no further action is necessary, the complaint will be closed and filed for up to two years and discarded thereafter.

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 President or any medical staff officer. The President shall forward the complaint or report to the appropriate hospital authority for action. Reports and complaints regarding hospital staff conduct will be tracked through the medical staff office, which will report results of such results and complaints to the Medical Executive Committee.

5. Abuse of Process
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.

Section 2.4 Informal Meeting with Unsuccessful Applicant

An unsuccessful applicant may request an informal meeting with the Chief Executive Officer, the President of the Professional Staff, officer in charge of the credentialing function as appointed by the President of the Professional Staff, and the chair of the department in which the applicant had requested privileges. A written request for the informal meeting must be made within thirty (30) days of the notice of non-selection. The meeting shall, if requested, be held within sixty (60) days after the notification of the applicant under Section 4.2 B. The meeting shall not constitute a hearing under Article VII, but shall be solely for the purpose of a constructive discussion with the applicant of the reasons for the denial of the application. If the applicant requests the meeting, the time during which the applicant may request judicial review under Section 7.3, shall be extended to thirty (30) days after the date of such meeting.

Section 2.5 Judicial Review of an Unsuccessful Applicant

An unsuccessful applicant shall be entitled to judicial review under the provisions of Article VII.

An applicant who has received a final adverse decision by the Board of Directors regarding appointment shall not be eligible to reapply to the Professional Staff for a period of at least one (1) year. Any such reapplication shall be processed and considered 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, or the unfavorable matters have been overcome by additional training, experience, or the like.

ARTICLE III

CATEGORIES OF THE PROFESSIONAL STAFF

Section 3.1 Professional Staff Categories

The Professional Staff shall be organized into Honorary, Active, Affiliate, Courtesy, Provisional and Limited **and Special Needs Consuslting** categories. All requests for change of Professional Staff category shall be approved by the Medical Executive Committee and the Board of Directors. Members will be reclassified based on compliance with criteria listed below. Members may not request reclassification to the Honorary Staff, but may be recommended for this category upon retirement from practice, by the Medical Executive Committee having fulfilled criteria listed below.

Section 3.2 Honorary Professional Staff

The Honorary Professional Staff shall consist of members who are not active in the Hospital and who are honored by emeritus positions. These may be members who have retired from active practice after unusual service to the Hospital or members who are of outstanding reputation, not necessarily residing in the community. Honorary staff members shall not be eligible to admit patients, to vote, hold office or to serve on standing committees, or attend department meetings.

Section 3.3 Active Professional Staff

The Active Professional Staff shall consist of members who have been on Staff for at least six (6) months, who have greater than 10 patient contacts a year, and who satisfy meeting attendance requirements of 2 meetings per most recent 12 month period being considered for current reappointment (may include department, sub-section, committee or Professional Staff meetings or medical staff approved , regularly scheduled series/RSS such as Cardiac Surgery Conference, Comprehensive Stroke Conference, Cancer Conference, Cardiac Cath Lab or High Reliability Organization conference). The meeting attendance requirement will be waived for 50 patient contacts or more. . A patient contact shall be defined as a history and physical, a consultation (dictated consultation report) or a procedure/surgery (inpatient and outpatient). Members of the Active Professional Staff shall be eligible to vote, hold office and serve on all committees of the Professional Staff.

Section 3.4 Affiliate Professional Staff

The Affiliate Professional Staff shall consist of members who have been on Staff for at least six (6) months, who do not wish to hold primary admitting, attending, or surgical privileges. They may co-admit with a physician member of the Active, Courtesy or Provisional staff, and be granted limited privileges for patient care. Affiliate Professional Staff members shall be appointed to a specific department. This staff category has NO meeting attendance requirements, and shall NOT be eligible to vote at Professional Staff meetings, participate in mail ballots, or hold office in the Professional Staff organization.

Section 3.5 Courtesy Professional Staff

The Courtesy Professional Staff shall consist of members who have been on Staff for at least six (6) months, who wish to attend private patients in the Hospital but who either do not use the Hospital frequently or do not comply with the meeting attendance requirements as outlined above under Section 3.3, Active Professional Staff. Courtesy Professional Staff members shall be appointed to a specific department shall not be eligible to vote at Professional Staff meetings, participate in mail ballots, or hold office in the Professional Staff organization.

Section 3.6 Provisional Professional Staff

A. All new applicants for membership shall initially be appointed to the Provisional Professional Staff and shall be subject to proctoring requirements unless otherwise noted. Provisional Professional Staff members shall remain on the Provisional Staff for a period of not less than six (6) months.

   Failure to fulfill the requirements of Provisional Staff status within one (1) year shall constitute a voluntary resignation by such Medical Staff member except upon a determination of good cause by the Medical Executive Committee.

   Provisional Professional Staff members shall not be eligible to vote, hold office, or serve on standing Professional Staff committees. Provisional Staff members shall attend department and medical staff meetings.

B. Each Provisional Staff member shall undergo a period of observation by proctors as described in Section 5.1 (C) and in the department rules and regulations and/or department privilege form. The observation shall be to evaluate the member's (1) proficiency in the exercise of clinical privileges initially granted and (2) overall eligibility for continued membership and advancement within Professional Staff categories. Observation of Provisional Staff members shall follow whatever frequency and format each department deems appropriate in order to adequately evaluate the member. This review will include but not be limited to concurrent or retrospective chart review, mandatory consultation and/or direct observation. Appropriate records shall be maintained in the member's file in the Medical

Staff Services Department.

C. The failure to complete the proctoring requirements without good cause (good cause being determined from time to time by the Medical Executive Committee) and to advance shall be deemed a resignation of Staff membership. If such failure to advance is due to a medical disciplinary cause or reason, such action shall be reported under Section 805 of the Business and Professions Code to the Medical Board of California, to the National Practitioner Data Bank and shall constitute grounds for a hearing under Article VII.

Section 3.7 Limited Professional Staff

A. The Limited Staff is a special category that consists of individuals who provide their services remotely via telemedicine, and are not physically at Providence Little Company of Mary Medical Center Torrance. Practitioners shall submit an application for membership and privileges and the application shall be processed and considered in the same manner as initial applicants. Only services recommended by the Medical Executive Committees of the Prodence Little Company of Mary Medical Center Torrance Medical Staff and of the remote site are authorized. Proctoring requirements shall also apply in accordance with departmental rules and regulations.

Section 3.8 The Special Needs Consulting Staff

The Special Needs Consulting Staff shall consist of members who act at Providence Little Company of Mary Medical Center only as consultants within their fields of special clinical competency by excerising only those clinical privileges that have been granted by the Board of Directors. They shall be considered for appointment or reappointment only by written invitation of the Medical Executive Committee and upon a determination by the Medical Ececutive Committee of a special need for their services to be available to patients of the Medical Center.

Special Needs Consulting Staff status may be administratively terminated by the Medical Executive Committee based upon a determination that such special need no longer exists. Uopn such a termination or denial of reappointment, a Special Needs Consulting Staff Member may be invited to apply for Provisional Staff on the Medical Staff if the member has the appropriate qualications. Such termination or denial of reappointment shall not provide the member with any rights pursuant to Article VII of these Bylaws.

The Special Needs Consulting Staff shall be appointed to a specific department. They shall not admit patients or serve as attending physicans for patients on Providence Little Company of Mary Medical Center.

Special Needs Consulting Staff members shall not be eligible to vote or hold office in this Medical Staff organization, but they shall be eligible to serve on committees, and to vote on matters before committees to which they have been appointed. They shall not be required to attend Medical Staff meetings or pay medical staff dues unless they are subject to medical records suspension fines, in which case they shall by required to pay the full amount of medical staff assessed.

Section 3.9 Fellowship Staff

The Fellowship Staff shall consist of members who are fellows, accepted to, and active, in a fellowship program approved by Providence Little Company of Mary Medical Center Torrance, and who can respond to their patients' needs in a timely and appropriate manner. Fellowship staff members shall be assigned to a specific department, but not eligible to vote or hold office in this Medical Staff organization. They shall not be required to pay medical staff dues. Fellowship membership ends with termination of the affiliation with such fellowship program.

Section 3.10 Voting Privileges and Committee Service

As outlined in each category description above, members of the Professional Staff may vote on matters within the scope of the member's licensure and may not serve on any committee where such service would not be within the scope of such licensure.

ARTICLE IV

PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Section 4.1 Application for Appointment and Reappointment

A. All applications for appointment or reappointment to the Professional Staff shall be in writing, shall be signed by the applicant or member and shall be submitted on a form prescribed by the Medical Executive Committee. The information provided shall be verified through primary sources. Secondary sources may be utilized if information from primary sources cannot be obtained.

The application shall require that the applicant provide detailed information concerning the applicant's professional qualifications and California and other state licensure, shall include the names of professional references including whenever possible practitioners in the same specialty and who can provide adequate information pertaining to the applicant's professional competence and ethical character, and shall include information as to the applicant's health status, whether the applicant's membership status and/or clinical privileges have ever been denied upon application, or after appointment, revoked, suspended, reduced, not renewed or voluntarily relinquished at any other hospital or institution, and as to whether the applicant has been denied admission to, or having been granted membership, has had that membership in any local, state or national professional societies suspended or revoked or the applicant's license to practice any profession or other registration in any jurisdiction has ever been voluntarily relinquished, successfully challenged or whether there are current challenges.

The application shall require that the member provide detailed information concerning the member's professional qualifications and California and other state licensure, and shall include information as to the member's health status, whether the member's membership status and/or clinical privileges have ever been denied upon application, or after appointment, revoked, suspended, reduced or not renewed or voluntarily relinquished at any other hospital or institution, and as to whether the member has been denied admission to, or having been granted membership, has had that membership in any local, state or national professional societies suspended or revoked or the member's license to practice any profession or other registration in any jurisdiction has ever been voluntarily relinquished, successfully challenged or whether there are current challenges.

B. Applicants for appointment and reappointment shall have the burden of producing adequate information for a proper evaluation of competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications. In order for the Medical Executive Committee to make a recommendation to the Board of Directors concerning an applicant for appointment or reappointment to the Professional Staff (or for clinical privileges under Article V), the Professional Staff must have in its possession adequate information for a conscientious evaluation of the applicant's training, experience and background as measured against the unique professional standards of this Hospital. Accordingly, the Professional Staff will not take action on an application that is not "complete."

1. An application for appointment, reappointment or new clinical privileges shall be deemed "incomplete," for purposes of sub-paragraph (c) below, unless and until:

   a. The applicant submits a written application, using the prescribed form, in which all of the requisite information is provided. All entries and attachments must be legible, understandable and substantively responsive on each point of inquiry;

   b. The applicant responds to all further requests from the Professional Staff, through its authorized representatives, for clarifying information or the submission of supplementary materials. If the practice of the applicant or member at another hospital or practice location is deemed relevant, the applicant or member shall have the burden of providing copies of patient records from such other hospital or location as requested. If the requested items or information or materials, such as reports or memoranda, are in the exclusive possession of another person or entity, the applicant shall take such measures as are necessary to obtain them or to arrange for them to be submitted to the Professional Staff directly by the source; and

   c. The applicant has assisted as necessary in the solicitation of written evaluations from those listed by the applicant as references and from other potential sources of relevant information. Such assistance may include the signing of a special release or similar document, as requested.

An applicant may be removed from consideration for staff membership if information requested from the applicant has not been received within sixty (60) days after it has been requested by the Medical Staff Services Department via certified mail, or other delivery mode, return receipt requested. Such applicant's application may, thereafter, be reconsidered only if all information therein which may change over time, including, but not limited to hospital reports and personal references have been re-submitted.

2. An application for new or additional privileges by a member of the Professional Staff, whether or not there is a prescribed form, shall not be complete unless and until:

   a. The applicant submits a written request for the privileges, supported by a complete description of the applicant's training, experience and other relevant qualifications, with documentation as appropriate.

   b. The applicant responds to any requests for additional information and materials as described above.

3. An application that is determined to be incomplete shall not qualify for a credentialing recommendation by any official or committee of the Professional Staff or by the Board of Directors, regardless of any assessment or determination that may have been made as to its completeness at an earlier stage in the process. Should the applicant fail to make the application complete after being given a reasonable opportunity to do so, the credentialing process will be terminated at the discretion of the Medical Executive Committee, after giving the applicant an opportunity to be heard, either in writing or at a meeting, as determined by the Medical Executive Committee. Termination of the credentialing process under this provision shall not constitute grounds for a hearing under Article VII.

   Until notice is received from the Board of Directors regarding final action on an application for appointment, reappointment or new clinical privileges, the applicant and reapplicant shall be responsible for keeping the application current and complete by informing the Professional Staff, in writing in the event that any information becomes available to the applicant that is at variance in any way with the information supplied by the applicant or member in the application or reappointment application. Failure to meet this responsibility will be grounds for denial of the application, nullification of an approval if granted, and/or immediate termination of Professional Staff membership and/or clinical privileges.

C. Applications that are deemed "complete" should be acted upon by the Medical Executive Committee within one hundred and eight (180) days. This time period requirement excludes applications where the burden to produce information has been placed on the applicant.

D. By applying for appointment or reappointment to the Professional Staff, each applicant and member thereby agrees:

   1. to attend Orientation and when requested appear for interviews in regard to the application or reappointment application;

   2. that the Hospital may consult with members of professional staffs of other hospitals with which the applicant or member has been associated and with others who may have information bearing on the applicant's or member's competence, character and ethical qualifications;

   3. to the Hospital's inspection of all records and documents that may be material to an evaluation of the applicant's or member's licensure, specific training, experience, professional qualifications, health status and competence to carry out the clinical privileges requested as well as the applicant's or member's moral and ethical qualifications for membership or continued membership; and

   4. to release from any liability all representatives of the Hospital and its Professional Staff for their acts performed in connection with evaluating the application or reappointment application and the credentials of the applicant or member, and to releases from liability all individuals and organizations who provide information to the Hospital concerning the applicant's or member's competence, ethics, character and other qualifications for membership and clinical privileges, including otherwise privileged or confidential information, so long as such actions are carried out in good faith. In addition to the general consent to disclose information contained in the application or reappointment application, the applicant or member shall, upon request, execute a specific

consent and release of liability directed to any person or institution if the Professional Staff deems it necessary to secure information concerning the applicant.

E. The application and reappointment application form shall include a statement that the applicant has received and read the Bylaws, Rules and Regulations of the Professional Staff and that the applicant or member agrees to be bound by the terms thereof if granted membership and clinical privileges, and to be bound by the terms thereof without regard to whether or not the applicant or member is granted membership and clinical privileges in all matters relating to consideration of the application or reappointment application.

F. Application for Appointment of Telemedicine Practitioners:

Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care by a practitioner at a distant site to patients located at an originating site. All practitioners who are responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the Hospital through one of the following mechanisms:

1. The Hospital may choose to fully privilege and credential the practitioner according to the Medical Staff credentialing and privileging process in these Bylaws.

2. The originating site (PLCMMCT) may choose to use the credentialing and privileging decision from the distant site (the Providence Health System site where the practitioner providing the professional service is located) to make a final privileging decision if:
   a) The distant site is a Joint Commission accredited facility
   b) The practitioner is privileged at the distant site for those services to be provided at the originating site
   c) The distant site provides the originating site with a current list of licensed independent practitioners' privileges
   d) The originating site has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement

Section 4.2 Appointment Process

A. In accordance with the procedures, the President of the Professional Staff shall forward to the Board of Directors all applications reviewed with all supporting documentation. The Medical Executive Committee shall make written recommendations to the Board of Directors concerning the appointment of each applicant. The Board of Directors shall act on the favorable recommendations of the Medical Executive Committee. Such recommendations shall include a delineation of the clinical privileges which the appointed practitioners may exercise.

B. All unsuccessful applicants shall be notified in writing promptly following the adoption of unfavorable recommendations by the Medical Executive Committee. The unsuccessful applicant shall also be notified of the availability of the meeting described in Section 2.5 and of the right to judicial review under these Bylaws.

In the event that an unsuccessful applicant who has been advised of non-appointment seeks a judicial review hearing under these Bylaws.

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Professional Staff for a period of at least one (1) year. Any such reapplication shall be processed and considered 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, or the unfavorable matters have been overcome by additional training, experience, or the like.

C. With respect to an applicant who was favorably recommended by the Medical Executive Committee, but whose application was rejected by the Board of Directors, the Board of Directors or its duly authorized committee shall act on the matter at its next regular meeting after all of the applicant's rights under Article VII have been exhausted or waived. The Board of Directors decision shall be conclusive, except that the Board of Directors may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons thereof, shall set a time limit not to exceed sixty (60) days within which a subsequent recommendation to the Board

of Directors shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation, and new evidence in the matter, if any, the Board of Directors shall make a decision either to appoint the applicant to the Staff or to reject the applicant for membership. All decisions to appoint shall include a delineation of the clinical privileges which the practitioner may exercise.

D. In reaching its decision, the Board of Directors shall give great weight to the actions of the Medical Executive Committee provided that no decision has been rendered in the matter by a Judicial Review Committee. In no event shall the Board of Directors act in an arbitrary or capricious manner. When the decision of the Board of Directors is final, it shall send notice of such decision through the Chief Executive Officer to the Secretary of the Professional Staff, to the President of the Professional Staff and the chair of the department concerned, and to the applicant.

Section 4.3 Reappointment Process

A. At least one hundred twenty (120) days prior to the commencement of the next reappointment period of the member, an application form for reappointment shall be sent to the member. The application for reappointment shall be completed and returned promptly. The verified application for reappointment shall be forwarded to the appropriate clinical department or sub-section chair for review and recommendations concerning reappointment of the member. The recommendations of the clinical department or sub-section chair shall be forwarded to the Credentialing Committee prior to the end of the member's current appointment period.

B. The Credentialing Committee shall review all pertinent information available on each member scheduled for reappointment, including the recommendation of the department chair in which the member has clinical privileges, for the purpose of determining its recommendations for reappointment to the Professional Staff and for the granting of clinical privileges for the ensuing period, and shall transmit its recommendations, in writing, to the Medical Executive Committee. Where non-reappointment or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

C. Each recommendation concerning the reappointment of a member and the clinical privileges to be granted upon reappointment shall be based upon such member's continued compliance with Section 2.2 (b), ongoing monitoring of information concerning the member's professional competence, clinical judgment and clinical and technical skills in the treatment of patients, health status, results of review obtained as part of Professional Staff monitoring functions including departmental monitoring and evaluation, surgical/procedure review, drug usage evaluation, blood usage review, medical record review, and the pharmacy and therapeutics review, the ethics and conduct of the member, attendance at required meetings and participation in Professional Staff affairs, compliance with the Professional Staff Bylaws, Rules and Regulations, policies/procedures, payment of all current or past professional staff dues and fines, cooperation with hospital personnel, relations with other members, and the general attitude of the member toward patients, the Hospital, and the public.

D. A member will be deemed to have resigned at the end of the current appointment term, if the member fails to return a completed reappointment application and all required attachments within thirty (30) days following receipt of a certified letter, which will be sent no later than sixty (60) days prior to the expiration of the current appointment. In the event membership terminates for the reason set forth herein, the procedures set forth in Article VII shall not apply following the date the initial reappointment application was mailed to the member.

E. The Medical Executive Committee shall make written recommendations to the Board of Directors concerning the reappointment, non-reappointment and clinical privileges of each member then scheduled for reappointment. Where non-reappointment is recommended, the reasons for such recommendation shall be stated and documented.

F. When the recommendation of the Medical Executive Committee is adverse to the member, either in respect to reappointment or clinical privileges, the Chief Executive Officer shall promptly so notify the member via certified mail, or other delivery mode, return receipt requested. No such adverse recommendation shall be forwarded to the Board of Directors until after the member has exercised or has been deemed to have waived, the right to a hearing as

provided in Article VII of these Bylaws.

G. At its next regular meeting, after receipt of the favorable recommendations, the Board of Directors shall act on the matter. Whenever the Board of Directors decision is contrary to a favorable recommendation of the Medical Executive Committee, the Board of Directors shall submit the matter to the Joint Conference Committee for review and recommendation and shall consider such recommendation before making its decision final. If in respect to either reappointment or clinical privileges, the Board of Directors' decision is adverse to the member who was favorably recommended by the Medical Executive Committee, the Chief Executive Officer shall promptly notify the member of such adverse decision via certified mail, or other delivery mode, return receipt requested, and such adverse decision shall be held in abeyance until the member has exercised, or has been deemed to have waived, the member's rights under Article VII of these Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

H. In reaching its decision, the Board of Directors shall give great weight to the actions of the Medical Executive Committee provided that no decision has been rendered in the matter by a Judicial Review Committee. In no event shall the Board of Directors act in an arbitrary or capricious manner. When the decision of the Board of Directors is final, it shall send notice of such decision through the Chief Executive Officer to the President of the Professional Staff and via certified mail, or other delivery mode, return receipt requested, to the member.

Section 4.4 Proctoring

Department specific rules and regulations, and privilege forms shall set forth for exact details regarding departmental proctoring requirements.

The results of the on-going Provisional Focused Professional Practice Evaluation (FPPE) Proctoring is submitted to the Physician Excellence Council at their monthly meeting.

Section 4.5 Leave of Absence

Any Active, Courtesy, or Affiliate member, in good standing, may take a leave of absence, after prviding the medical staff office notice in writing, for a period not to exceed the current membership term. Prior to the effective date of any leave of absence, the requesting member shall be provided with written disclosure of then-pending investigations, and may withdraw the request with no government report or other consequence.

The member shall be identify in writing the effective date of the leave of absence. It is the duty of the member to request reinstatement to the Professional Staff at least **30 days** prior to the conclusion of the leave. Should the member fail to request reinstatement prior to the end of the current membership, his/her membership shall lapse. During the period of the leave annual staff dues are to be paid.

The medical staff member shall submit a written summary of his or her professional activities during the leave. A medical staff member is also obligated to submit documented evidence of good physical and mental health sufficient to exercise privileges, and any other information reasonably requested by the Credentials Committee to enable its recommendation to the Medical Executive Committee regarding reinstatement. The Medical Executive Committee shall make a recommendation to the Board of Directors. Hearing and appeals rights consistent with these bylaws apply to denials of or restrictions upon reinstatement.

Section 4.6 Resignation

Any member may resign membership by submitting a resignation in writing to the chair of the member's clinical department identifying the effective date of resignation.

Section 4.7 Membership Criteria – Conviction

Notwithstanding any other provision of these Bylaws, an application or re-application for membership may be rejected on

a showing that the applicant or member has been convicted of a felony in this or any U.S. state or has pleaded guilty or nolo contendere or who has been convicted or pleaded guilty or nolo contendere with respect to any misdemeanor related to (i) controlled substances; (ii) illegal drugs; (iii) Medicare, MediCaid, or insurance fraud or abuse; (iv) violence against another, including sexual assault or abuse, or (v) any other illegal activity involving patients or otherwise substantially and adversely related to the qualifications, functions, and duties of the applicant or member.

The question as to whether a conviction is related to the qualifications, functions or duties, as defined in these Bylaws, of an applicant or member, shall be determined at the sole discretion of the Medical Executive Committee.

Section 4.8 Membership Criteria – Medicare/Medicaid or Public Program Action (Current, Pending, or Past)

Notwithstanding any other provision of these Bylaws, an application or re-application for membership will be rejected on a showing that the applicant or member is charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or has voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid or any public program or if action related to the above is pending. In addition, such action or pending action may be the basis of suspension or termination of the professional staff membership and/or privileges of a member.

The question of rejection of an application or re-application for any past action as described above shall be at the sole discretion of the Medical Executive Committee.

ARTICLE V

CLINICAL PRIVILEGES

Section 5.1 Clinical Privileges

A. Every member practicing at the Hospital by virtue of membership shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted consistent with these bylaws.

B. Every initial application for appointment to the Professional Staff shall contain a request for the specific clinical privileges desired by the applicant. The request for clinical privileges shall be evaluated by the appropriate clinical department chair who shall make a recommendation concerning privileges to the Medical Executive Committee. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence, references and other relevant information. The applicant shall have the burden of establishing such qualifications and competence for the clinical privileges requested. The requirements for completeness, as described in Section 4.1, sub-paragraph (b), shall apply to all applications for clinical privileges. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially institutions and health care settings where the applicant exercises clinical privileges.

C. Except as otherwise determined by the Medical Executive Committee, all initial appointees to the Professional Staff and all members granted new clinical privileges shall be subject to a period of proctoring. Each appointee or recipient of new clinical privileges shall be assigned to a department where performance of an appropriate number of cases established by the Medical Executive Committee, or department as a designee of the Medical Executive Committee, shall be observed by the chair of the department or the chair's designee during the period of proctoring specified in the department rules and regulations or privilege delineation form.

D. Periodic re-determination of clinical privileges and the increase or curtailment of privileges shall be based upon ongoing monitoring of care (relevant practitioner specific data and when available, compared to aggregate data), professional performance, judgment, clinical or technical skills, review of the records of patients treated in this or other hospitals, review of the records of the Professional Staff which document the member's experience, peer recommendations when deemed applicable, challenges to any licensure or registration, voluntary and involuntary relinquishment of any license or registration, voluntary or involuntary termination of medical staff membership, voluntary and involuntary limitation, reduction or loss of clinical privileges, involvement in a professional liability action, including final judgments and settlements, and documentation as to the member’s health status.

E. Clinical privileges granted to dentists shall be based on their training, experience and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the chair of the department of surgery. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services and shall be admitted by the attending dentist or oral surgeon. The dentist shall provide a dental history of the patient. A physician member shall be responsible for the admitting history and physical and for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

F. Clinical privileges granted to podiatrists shall be based on their training, experience and demonstrated competence and judgment. The scope and extent of surgical procedures that each podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges.

Section 5.2 Temporary Membership and Privileges

Temporary membership and privileges are allowed under two circumstances only: to address a patient care need or to finalize a pending application as set forth in this section.

Temporary membership and privileges shall be granted by the Chief Executive Officer, or his designee, upon the basis of information then available which may be reasonably relied upon as to the competence and ethical standing of the practitioner, and with the written concurrence of the department chair concerned and of the President of the Professional Staff.

A. Patient Care Needs

Care of Specific Patient: Temporary membership and clinical privileges may be granted upon completion of a medical staff application, and verifaction of current licensure and current competence, where good cause exists to allow a practitioner to provide care to a specific patient provided that the practitioner either has special expertise or otherwise can meet and important patient care need. Temporary privileges to fulfill an important patient care need can be granted to the same practitioner not more than twice during a calendar year and for no more than 60 days during a calendar year. Temporary privileges automatically terminate if the applicant's initial membership application is withdrawn.

B. Pending Application for Permanent Membership

Temporary membership and clinical privileges may be granted by the administrator upon recommendation of the President to applicants upon request while the application for membership and privileges are pending, based on

current licensure
relevant training or experience
current competence
ablitily to perform the clinical privileges requested
other criteria required by these medical staff bylaws
query and evaluation of any National Practitoner Data
Bank information
absence of current or previously successful challenge to licensure or registration,
absence of involuntary termination of medical staff
membership at any hospital or other entity,
absence of any involuntary limitation, reduction, denial or loss of clinical privileges

provided that the application has been completely verified, has been reviewed by the Credentialing Committee, raises no concerns and is awaiting approval by the Medical Executive Committee and Board of Directors. Such privileges shall not exceed one hundred and twenty (120) days.

C. General Conditions

1. If granted temporary privileges, the practitioner shall act under the supervision of the department chair to which the practitioner has been assigned, and shall ensure that the chair, or the chair's designee, is kept closely informed as to the applicant's activities within the hospital.

2. Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended under Articles VI and/or VII of these Bylaws or unless affirmatively renewed. As necessary, the appropriate department chair or designee shall assign a member of the medical staff to assume responsibility for the care of such practitioner's patient(s). The wishes of the patient shall be considered in the choice of a replacement medical staff member.

3. Requirements for proctoring and monitoring, including but not limited to those outlined in Section 5.1, shall be imposed on such terms as may be appropriate under the circumstances upon any practitioner granted temporary privileges after consultation with the departmental chair or the chair's designee.

4. All practitioners requesting or receiving temporary privileges shall be bound by the Bylaws and Rules and Regulations of the Professional Staff.

Section 5.3 Disaster Privileges

In an emergency, any member with clinical privileges may, without obtaining specific privileges to do so, provide any treatment or services within the scope of licensure to a patient in order to safe life or prevent serious harm. A disaster is an emergency that, due to its complexity, scope or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety or security functions.

When the disaster plan has been activated and there are insufficient Medical Staff members to meet patient needs, the Hospital Chief Executive Officer or his/her designee, President of Staff and the designated emergency medical care director (EMCD) have the authority to grant disaster privileges on a case by case basis to any volunteer practitioner (physicians, dentists, podiatrists and allied health professionals), to the degree permitted by his/her license and regardless of Department, Medical Staff status, or clinical privileges or lack of it, to do everything possible to save a patient from such danger, and said volunteer practitioner shall be assisted by Hospital personnel. To the extent possible, disaster privileges should be specialty specific to the volunteer practitioner and these may be assigned in any manner deemed appropriate by the granting authority.

Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following:

- Primary source verification of licensure, or
- A current picture identification card from a healthcare organization that clearly identifies professional designation, or
- Confirmation by a licensed independent practitioner currently privileged by the hospital, or
- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment or services in disaster circumstances, or
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized state or federal response organization or group, or
- A current license to practice

See Disaster Plan for mechanism to manage individuals who receive disaster privileges.

Section 5.4 Exclusive Privileges

Whenever the Hospital plans to issue a contract, exclusive or otherwise, to provide services delievered under clinical privileges, it informs the Medical Executive Committee as to which specialties and services will be affected. The Medical Executive Committee (or an ad hoc committee formed for this purpose) collects information from the members that would be affected, from the hospital administration, and from other interested parties, to make an imforned recommendation as to whether those services should be closed or discontinued, or provided through a contract, and, should a contract arrangement be recommended, what contract sources should be utilized. The actual terms of any contract and any financial information related to the contract, including but not limited to the remuneration to be paid to medical staff members under contract, are not relevant and therefore are neither disclosed to the Medical Executive Committee nor dicussed as part of this contracting evaluation process. Unless the recommendation is arbitrary or capricious, the board's action regarding the contract is consistent with the recommendation of the Medical Executive Committee.

ARTICLE VI

CORRECTIVE ACTION

Section 6.1 Procedure

A. Any person may provide information to the Professional 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 1) detrimental to patient safety or to the delivery of quality patient care within the hospital; 2) unethical; 3) contrary to these Bylaws and Rules/Regulations; or 4) below applicable professional standards, a request for an investigation or corrective action against such member may be requested by any officer of the Professional Staff, by the chair of any clinical department, by the chair of any standing committee of the Professional Staff, or by the Chief Executive Officer. Such requests shall be in writing, shall be made to the Medical Executive Committee, and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request.

B. Whenever the corrective action could be a reduction or suspension of clinical privileges, the Medical Executive Committee shall forward such request to the chair of the department wherein the member has such privileges who shall determine if the request warrants investigation. If warranted, the department shall notify the subject member that an investiagation has begun and that any resignation of membership or privileges will result in a National Practitioner Data Bank report, and promptly investigate the matter.

C. After investigation of the request for corrective action, the department shall close the investigation and make a report of its investigation to the Medical Executive Committee. Prior to the making of such report, the member against whom corrective action has been requested shall have an opportunity for an interview with the department. At such interview, the member shall be informed of the general nature of the charges, and shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in Article VII of these Bylaws with respect to hearings shall apply thereto. A record of such interview shall be made by the department and included with its report to the Medical Executive Committee.

D. At its next meeting following the receipt of a request for corrective action, or following receipt of a report from a department following the department's investigation of a request for corrective action, involving reduction or suspension of clinical privileges, the Medical Executive Committee shall take action upon the request. If the corrective action could involve a reduction or suspension of clinical privileges, or a suspension or expulsion from the Professional Staff, the affected member shall be permitted to make an appearance before the Medical Executive Committee prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such appearance shall be made by the Medical Executive Committee.

E. The action of the Medical Executive Committee on a request for corrective action may be to reject or modify the request for corrective action, to issue a warning, a letter of admonition, or a letter of reprimand, to impose terms of probation or to recommend a requirement for consultation, to recommend reduction, suspension or revocation of clinical privileges, to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained, or to recommend that the member's membership be suspended or revoked.

F. Any recommendation by the Medical Executive Committee resulting in actions listed in Section 7.3 (B) shall entitle the affected member to the procedural rights provided in Article VII of these Bylaws.

G. The President of the Professional Staff shall promptly notify the Chief Executive Officer in writing of all requests for corrective action received by the Medical Executive Committee and shall continue to keep the Chief Executive Officer fully informed of all action taken in connection therewith.

H. In those instances in which the Medical Executive Committee's failure to investigate or initiate disciplinary action is contrary to the weight of the evidence, the Board of Directors shall have the authority to direct the Medical Executive Committee to initiate an investigation or a disciplinary action, but only after consultation with the Medical Executive Committee. No such action shall be taken in an unreasonable manner.

In the event the Medical Executive Committee fails to take action in response to a direction from the Board of Directors, the Board of Directors shall have the authority to take action against a member. Such action shall only be taken after written notice to the Medical Executive Committee and shall fully comply with the procedures and rules

applicable to judicial review hearings as provided in Article VII of these Bylaws.

The Board of Directors and the Professional Staff shall act exclusively in the interest of maintaining and enhancing quality patient care.

Section 6.2 Summary Suspension

A. The President of the Professional Staff, the chair of a clinical department, or the Medical Executive Committee shall each have the authority to summarily suspend all or any portion of the clinical privileges of a member whenever the failure to take that action may result in an imminent danger to the health of any individual. Any such summary suspension shall become effective immediately upon imposition. The suspension shall be reviewed by the next meeting of the Medical Executive Committee, but in any event, within seven (7) days after the suspension.

B. A member whose clinical privileges have been summarily suspended shall be entitled to request an appearance before the next regular scheduled meeting of the Medical Executive Committee following such summary suspension, but in any event, within fourteen (14) days after the suspension. This appearance shall not constitute a hearing, shall be preliminary in nature and none of the procedural rules provided in these Bylaws with respect to hearings shall be applicable. A record of the appearance shall be made by the Medical Executive Committee.

C. The Medical Executive Committee may recommend modification, continuance or termination of the terms of the summary suspension. If, as a result of such appearance, the Medical Executive Committee does not recommend immediate termination of the summary suspension, the affected member shall be entitled to the procedural rights provided in Article VII of these Bylaws, but the terms of the summary suspension as sustained or as modified by the Medical Executive Committee shall remain in effect pending a final decision thereon by the Board of Directors.

D. Immediately upon the imposition of a summary suspension, the President of the Professional Staff or responsible department chair shall have authority to provide for alternative medical coverage for the patients of the suspended member still in the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative member.

E. When no person mentioned in Section 6.2 (A) is available to summarily suspend or restrict clinical privileges under circumstances specified in Section 6.2 (A), the Board of Directors, or its designee, may immediately suspend a member's clinical privileges if a failure to summarily suspend those privileges is likely to result in an imminent danger to the health of any individual, provided the Board of Directors has, before the suspension, made reasonable attempts to contact a person or committee authorized by Section 6.2 (A) of this Article to impose a summary suspension. A suspension by the Board of Directors which has not been ratified by the Medical Executive Committee within two working days, excluding weekends and holidays, after the suspension shall terminate automatically.

Section 6.3 Automatic Suspension

In the following instances, the member's privileges or membership may be suspended or limited as described, and a hearing, if requested, shall be limited to the question of whether the grounds for automatic suspension as set forth below have occurred.

Section 6.3.1 Licensure

A. Revocation, Suspension or Expiration: Whenever a member's license in this state is revoked, suspended or expires, professional staff membership and clinical privileges shall automatically be suspended as of the date such action becomes effective.
B. Restriction: Whenever a member's license in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the member has been granted at the hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date of such action becomes effective and throughout its term.
C. Probation: Whenever a member is placed on probation by the state licensing authority, membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

Section 6.3.2 Controlled Substances

A. Whenever a member's DEA certificate is revoked, limited, suspended, or has expired without evidence of renewal, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

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

Section 6.3.3 Professional Liability Insurance

Failure to maintain professional liability insurance shall be grounds for automatic suspension of a member's clinical privileges, and if within thirty (30) days after written notice of automatic suspension, the member does not provide evidence of required professional liability insurance, the member's membership and privileges shall be considered for termination by the Medical Executive Committee.

Section 6.3.4 Failure to Satisfy Special Attendance Requirement

A practitioner who fails to satisfy the requirements of Section 11.4 shall automatically be suspended from exercising all or such portion of his or her clinical privileges in accordance with the provisions of said Section 11.4.

Section 6.3.4 Medical Executive Committee Deliberation

As soon as practicable after action is taken or warranted as described in Section 6.3.1 (B), 6.3.1 (C), 6.3.2 (B), 6.3.3 and 6.3.4., the Medical Executive Committee shall convene to review and consider the facts, and may recommend any further corrective action as it may deem appropriate in accordance with these Bylaws.

ARTICLE VII

HEARING AND APPELLATE REVIEW PROCEDURE

Section 7.1 General Provisions

A. Exhaustion of Remedies
If adverse action described in Section 7.3 (B) is taken or recommended, the applicant or member must exhaust the remedies afforded by this Article VII before resorting to legal action.

B. Challenges to Rules

The hearings provided for in this Article shall not be utilized to make determinations as to the substantive validity of a Bylaw, rule, regulation or policy. Where the substantive validity of such Bylaw, rule, regulation or policy is the only issue and no report to the Medical Board of California under Business and Professions Code Section 805 can be made, the petitioner shall have a direct appeal and hearing, in the first instance before the Medical Executive Committee with an appeal to the Board of Directors. The hearing and appeal procedures shall be determined by the Medical Executive Committee and Board of Directors, respectively, and need not comply with the procedures for hearings contained in this Article VII. Such hearing and appeal procedures must be utilized prior to resorting to legal action.

Section 7.2 Definitions

Except as otherwise provided in these Bylaws, the following definitions shall apply under this Article VII:
A. Body whose decision prompted the hearing refers to the committee or body (which will generally consist of the Medical Executive Committee or the Board of Directors) which, pursuant to these Bylaws, rendered the decision which resulted in a hearing being requested.

B. Notice as used in this Article VII, shall be written communication sent via certified, or other delivery mode, return receipt requested.

C. Practitioner (for the purpose of this Article) refers to the applicant or member, as the case may be, who has requested a hearing pursuant this Article VII.

Section 7.3 Request for Hearing

A. Notice of Decision & Request for Hearing

1. In all cases in which the body or committee which, under these Bylaws has the authority to, and pursuant to this authority, has taken any of the actions constituting grounds for hearing as hereinafter set forth in Section 7.3(b) (Grounds for Hearing), the practitioner shall promptly be given notice. The notice shall state that such action, if adopted by the Board of Directors, be taken and reported to the Medical Board of California under Section 805 of the California Business and Professions Code.

2. The notice shall state that the practitioner shall have thirty (30) days following receipt of a notice of such action to file a written request for a hearing. Such request shall be delivered to the Chief Executive Officer either in person or via certified, or other delivery mode, return receipt requested.

3. The notice shall state that, in the event that the practitioner does not request a hearing within the time and in the manner described, the practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. Such recommendation or action shall thereupon immediately become the final recommendation of the Professional Staff to the Board of Directors.

The exception to the above is that, pursuant to Senate Bill 700 (effective January 1, 2011) a report is required to be filed with the Medical Board of California under Section 805.01 of the California Business and Professions Code within 15 days after a peer review body has recommended actions based on certain serious concerns, including:

1. Serious deviations from the standard of care involving death or serious bodily injury to patients;
2. The misuse of dangerous drugs or alcoholic beverages;
3. Excessive or abusive "prescribing, furnishing, or administering of controlled substances" and related acts;
4. Sexual misconduct with patients.

B. Grounds for Hearing

Any one or more of the following actions if taken for a medical disciplinary cause or reason shall constitute grounds for a hearing:

1. denial of membership~~;~~
2. denial of requested advancement in Professional Staff category;
3. denial of reappointment;
4. demotion to lower Staff category;
5. suspension of membership;
6. revocation of medical staff membership;
7. denial of requested privileges;
8. involuntary reduction in privileges;
9. suspension of clinical privileges;
10. termination of clinical privileges; and
11. involuntary imposition of significant consultation, special proctoring, or any other limitation on practice in the Hospital.

C. Notice of Charges

As a part of, or together with the notice of hearing, the Medical Executive Committee shall state in writing, in concise language, the acts or omissions with which the practitioner is charged, a list of charges referencing chart numbers under question, if appropriate, or a list of the reasons, acts or omissions which are the basis for the denial of the request of the practitioner.

D. Time and Place for Hearing

Upon receipt of a request for hearing, the Chief Executive Officer shall deliver such request to the Medical Executive Committee. The Medical Executive Committee shall, within thirty (30) days after receipt of such request schedule and arrange for a hearing. The Medical Executive Committee shall give notice to the practitioner of the time, place and date of the hearing, and the notice shall state that the practitioner may be represented by legal counsel at the hearing. The date of the commencement of the hearing shall be not less than thirty (30) days, from the date of the notice of the hearing, nor more than sixty (60) days from the date of receipt of the request by the Chief Executive Officer for a hearing; provided, however, that when the request is received from a practitioner who is under suspension which is then in effect, the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed thirty (30) days from the date of receipt of the request for hearing by the Chief Executive Officer.

E. 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 Active Professional Staff who shall gain no direct financial benefit from the outcome, and who have not acted as accuser, investigator, fact finder, initial decision maker, or otherwise have actively participated in the consideration of the matter involved at any previous level. Such appointment shall include designation of the chair. Knowledge of the matter involved shall not preclude a member from serving on the Judicial Review Committee. In the event that it is not possible to appoint a fully qualified Judicial Review Committee from the Active Professional Staff, the Medical Executive Committee may appoint qualified physicians from the Courtesy Professional Staff or physicians from outside the Professional Staff. The Committee, if feasible, shall include an individual practicing the same specialty as the practitioner.

F. Failure to Appear

Failure without good cause of the practitioner to appear and proceed at such a hearing, shall be deemed to constitute voluntary acceptance of the recommendations or actions involved which shall become final and effective immediately.

G. Continuances

Continuances shall be granted upon agreement of the parties or by the presiding officer only on a showing of good cause. The hearing shall be commenced within sixty (60) days after the receipt of the request for a hearing and the peer review process shall be completed within a reasonable time, unless the presiding officer issues a written decision finding that the practitioner failed to comply with the requirements of 7.3 (A) of this Article, or consented to the delay.

H. Decision of the Judicial Review Committee

Within ten (10) days after the final adjournment of the hearing (provided that in the event the practitioner is currently under suspension, this time shall be five (5) days,) the Judicial Review Committee shall render a decision which shall be accompanied by a report in writing which shall be delivered to the body whose decision prompted the hearing, together with a written explanation to the procedure for appeal of the decision.

The report shall contain findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. A copy of said decision shall be forwarded to the Board of Directors and a copy of the report and decision shall be delivered to the practitioner via registered or certified mail, or other delivery mode, return receipt requested, together with a written explanation or procedure for appeal of the decision.

I. The Appeal

The decision of the Judicial Review Committee shall be considered to be the final recommendation of the Medical Executive Committee to the Board of Directors unless it is appealed by the Medical Executive Committee as provided in Section 7.5.

Section 7.4 Hearing Procedure

A. Pre-Hearing Matters

1. If either side to the hearing requests in writing a list of witnesses, each party shall furnish to the other within ten (10) days after receipt of such request, a written list of the names and addresses of the individuals, so far as is reasonably known or anticipated, who are expected to give testimony or evidence in support of that party at the hearing. In addition, either side shall have the right to inspect and copy documents or other evidence relevant to the charges, and shall also have the right to receive at least (30) days prior to the hearing a copy of any documentary evidence relevant to charges which is reasonably necessary to enable that side to prepare for the hearing, including all evidence which was considered by the Medical Executive Committee in determining whether to proceed with the adverse action, any exculpatory evidence in the possession of the hospital or professional staff, all evidence which will be made available to the Judicial Review Committee and all evidence relevant to the charges which the practitioner has in his or her possession or control.

2. The failure by either party to provide the matters described in paragraphs (1) above at least ten (10) days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the practitioner under review.

3. The presiding officer (as defined below) shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process generally or justice requires. In so doing, the presiding officer shall consider:
   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; and
   d. any previous requests for access to information submitted or resisted by the parties to the same proceeding.

4. The practitioner shall be entitled to a reasonable opportunity to question and challenge the impartiality of Judicial Review Committee members and the hearing officer (if one has been appointed) prior to the introduction of evidence at the hearing. Challenges to the impartiality of any Judicial Review Committee member or the hearing officer shall be ruled on by the presiding officer.

5. It shall be the duty of the practitioner, and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the chair of the Judicial Review Committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible in order that decisions concerning such matters may be made in advance of the hearing by the presiding officer. Objections to any pre-hearing decisions may be succinctly made at the hearing.

B. Procedure at the Hearing

1. Personal Presence Mandatory. Under no circumstances shall the hearing be conducted without the personal presence of the practitioner unless the practitioner has waived such appearance.

2. Representation. The hearings provided for in these Bylaws are for the purpose of inter-professional resolution of matters bearing on professional conduct, professional competency, or character. The practitioner shall be entitled to representation by legal counsel in any phase of the hearing, should the practitioner so choose. In the absence of legal counsel, the practitioner shall be entitled to be accompanied by and represented at the hearing only by a person licensed to practice medicine in the State of California who is not also an attorney, and the Medical Executive Committee shall appoint a representative who is not an attorney to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions. The Medical Executive Committee shall not be represented by an attorney if the practitioner is not so represented. The practitioner as a condition of being represented by legal counsel at the hearing shall give written notice of such intent to the Medical Executive Committee at least thirty (30) days prior to the scheduled commencement of the hearing.

3. The Presiding Officer. The presiding officer at and prior to the hearing shall be the hearing officer or, if none has been appointed, the chair of the Judicial Review Committee. The hearing officer, if appointed, shall be the presiding officer from the date of appointment. The presiding officer shall act to insure that all participants in the hearing have a reasonable opportunity to be heard, to present all oral and documentary evidence, and that decorum is maintained, and shall be entitled to determine the order of procedure during the hearing. The

presiding officer shall have the authority and discretion, in accordance with these Bylaws, to make all rulings on questions which pertain to matters of law and to the admissibility of evidence, and all procedural disputes between the parties.

4. The Hearing Officer. At the request of the practitioner or the Judicial Review Committee, or on its own, the Medical Executive Committee may appoint a hearing officer who may be an attorney. An attorney regularly utilized by the Hospital, the practitioner, or the Professional Staff for legal advice regarding its affairs and activities shall not be eligible to serve as hearing officer. The hearing officer must not act as a prosecutor, as an advocate for the Hospital, Board of Directors, the Medical Executive Committee, the body whose action prompted the hearing, or the practitioner and shall have no financial benefit from the outcome. If requested by the Judicial Review Committee, the hearing officer may participate in the deliberation of such body and be a legal advisor to it, but shall not be entitled to vote.

5. Record of Hearing. The Judicial Review Committee shall maintain a record of the hearing by one of the following methods: a court reporter present to make a record of the hearing, a recording, or minutes of the proceedings.The Judicial Review Committee may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in the State of California.

6. Rights of Both Sides. During a hearing concerning a final proposed action from which reporting is required to be filed under Section 805, both parties shall have all of the following rights:
   a. To be provided with all information made available to the trier of fact.
   b. To have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable fees associated with the preparation thereof.
   c. To call, examine, and cross-examine witnesses.
   d. To present and rebut evidence determined by the presiding officer to be relevant.
   e. To submit a written statement at the close of the hearing.

7. Admissibility of Evidence. The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted by the presiding officer if it is the sort of evidence on which responsible persons are accustomed to rely on the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a memorandum of points and authorities, and the Judicial Review Committee may require such a memorandum to be filed following the close of the hearing. Any member of the Judicial Review Committee may interrogate any witness and the Judicial Review Committee may call additional witnesses if it deems it appropriate.

8. Official Notice. The presiding officer shall have the discretion to take official notice of any matters either technical or scientific, relating to the issues under consideration which could have been judicially noticed by the courts of this State. Participants in the hearing shall be informed of the matters to be officially noticed and they shall be noted in the record of the hearing. The practitioner shall have the opportunity to request that a matter be officially noticed or to refute the noticed matters by evidence or by written or oral presentation of authority. Reasonable or additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

9. Basis of Decision. The decision of the Judicial Review Committee shall be based on the evidence produced at the hearing. This evidence may consist of the following:
   a. oral testimony of witnesses;
   b. briefs, or memorandum of points and authorities presented in connection with the hearing;
   c. any material contained in the Professional Staff files regarding the practitioner;
   d. any and all applications, references, and accompanying documents;
   e. all officially noticed matters; and
   f. any other admissible evidence.

10. Burden of Proof. The burden of presenting evidence and proof during the hearing shall be as follows:
    The body whose decision prompted the hearing shall have the initial duty to present evidence which supports the charge or recommended action.

Initial applicants shall bear the burden of persuading the trier of fact 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 staff privileges, membership or employment. Initial applicants shall not be permitted to introduce information not produced during the application process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

Except as provided above for initial applicants, the body whose decision prompted the hearing shall bear the burden of persuading the trier of fact by a preponderance of the evidence that the action or recommendation is reasonable and warranted.

11. Adjournment and Conclusion. The presiding officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence, and any written argument permitted or required by the Judicial Review Committee, the hearing shall be closed.

The Judicial Review Committee shall thereupon, within the time specified in Section 7.3 (H), outside of the presence of any other person (except the hearing officer, if requested to be present during deliberations) conduct its deliberations and render a decision and accompanying report as provided by Section 7.3 (H).

Section 7.5 Appeal to the Board of Directors

A. Time for Appeal

Within 15 days after receipt of the decision of the Judicial Review Committee, either the practitioner or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the President of the Professional Staff, the Chief Medical Officer, and the other party in the hearing. If a request for appellate review is not requested within such period, that action or recommendation shall be affirmed by the Board of Directors as the final action if, in their opinion, it is supported by substantial evidence, following a fair procedure.

B. 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. The grounds for appeal from the hearing shall be: (a) substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice; and/or (b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 7.5(e).

C. Time, Place, and Notice

If an appellate review is to be conducted, the Appeal Board shall, within 30 days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place, and date of the appellate review. The date of appellate review shall not be less than 15 days, nor more than 60 days, from the date of such notice, 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 can reasonably be made. The time for appellate review may be extended by the Appeal Board for good cause.

D. Appeal Board

The Board of Directors may sit as the Appeal Board, or it may appoint an appeal board which shall be composed of not less than 3 members of the Board of Directors. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person did not take part in a prior hearing on the same matter. 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. The attorney selected by the Board of Directors shall not be the attorney that represented either party at the hearing before the Judicial Review Committee.

E. Appeal Procedure

The proceedings by the Appeal Board shall be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Review Committee, provided that the Appeal Board may accept additional oral or written evidence, subject to a foundational showing that such evidence is relevant to the appeal and could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence. Introduction of such evidence is subject to the same rights of cross-examination or confrontation provided at the Judicial Review hearing or 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 be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of his or her position on appeal, and to personally appear and make oral argument. The Appeal Board and/or its attorney shall determine the specific details for the appeal, including length of written submissions, oral arguments, and other appeal processes not specified in these Bylaws. After the conclusion of the appellate hearing, the Appeal Board may conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives.
The Appeal Board shall present to the Board of Directors its written recommendations as to whether the Board of Directors should affirm, modify, or reverse the Judicial Review Committee decision, or remand the matter to the Judicial Review Committee for further review and decision.

F. Decision

1. Except as provided in Section 7.5 (F-2), within 30 days after the conclusion of the appellate review proceedings, the Board of Directors shall render a final decision and shall affirm the decision of the Judicial Review Committee if the Judicial Review Committee's decision in their opinion is supported by substantial evidence, following a fair procedure.

2. Should the Board of Directors determine that the Judicial Review Committee decision is not supported by substantial evidence or did not involve a fair procedure, the Board may modify or reverse the decision of the Judicial Review Committee and may instead, or shall, where a fair procedure has not been afforded, remand the matter to the Judicial Review Committee for reconsideration, stating the purpose for the referral. If the matter is remanded to the Judicial Review Committee for further review and recommendation, the Committee shall promptly, as directed by the Board of Directors, conduct its review and make its recommendations to the Board of Directors.

3. The final decision of the Board of Directors shall be in writing and shall specify the reasons for the action taken.

G. 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.

ARTICLE VIII
OFFICERS

Section 8.1 Identification of Officers of the Professional Staff
The officers of the Professional Staff shall be a) the President, b) the President-Elect and c) the Secretary/Treasurer.

Section 8.2 Qualifications of Officers

Officers must be members of the Active Professional Staff, who have been on staff for at least 2 ½ years at the time of nomination and election and must remain members who are not subject to corrective or disciplinary action during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

Section 8.3 Nomination and Election of Officers

A. Nominations for officers of the Professional Staff shall be made by the Nominating Committee to the Medical

Executive Committee for approval. The names of the nominees shall be mailed to each member with a notice of the next Professional Staff meeting.

B. At the Professional Staff meeting, nominations from the floor shall be accepted subject to the written consent of the nominee.

C. If the nominees are running unopposed, the Professional Staff may accept the nominees with a verbal vote for approval at the same meeting. If the nominees are running opposed, ballots with copies of each nominee's conflict of interest statement shall be mailed out to each Active Staff member. There shall be no write–ins on the ballot. All ballots shall be counted by the President and Secretary of the Professional Staff 30 days after the ballots are mailed out.

A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the candidates receiving the highest number of votes. The results shall be presented to the Medical Executive Committee, Board of Directors and published in the physician newsletter.

Section 8.4 Term and Limitations of Office

All officers shall serve a two (2) year term or until their successor is elected and qualifies. Officers shall take office on the first day of January. Officers may be re-elected for additional consecutive terms.

Officers shall not concurrently serve in medical staff positions (officers or department chair) at more than one hospital.

Section 8.5 Vacancies in Office

Vacancies in office during the Professional Staff year, except for the Presidency, shall be filled by the Medical Executive Committee. If there is a vacancy in the office of the President, the President-Elect shall serve out the remaining term.

Section 8.6 Duties of Officers

A. President

The President shall serve as the chief administrative officer of the Professional Staff to:

1. act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern within the Hospital;
2. call, preside at, and be responsible for the agenda of all Professional Staff meetings;
3. serve as chair of the Medical Executive Committee;
4. serve as ex-officio member of all other Professional Staff committees without vote except the Nominating Committee;
5. be responsible for the enforcement of Professional Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Professional Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
6. appoint committee chairs for all standing, special, and multi-disciplinary Professional Staff committees except as otherwise provided in these Bylaws;
7. represent the views, policies, needs and grievances of the Professional Staff to the Board of Directors and to the Chief Executive Officer;
8. receive, and interpret the policies of the Board of Directors to the Professional Staff and report to the Board of Directors on the performance and maintenance of quality with respect to the Professional Staff's delegated responsibility to provide medical care;
9. be responsible for the educational activities of the Professional Staff; and,
10. be the individual responible for the organization and conduct of the Medical Staff, with whom the Governing Body shall directly consult on all matters related to the quality of medical care provided to patients at the Hospital and any other matters of mutual concern and, be the spokesman for the Professional Staff in its external professional and public relations.

B. President-Elect

The President-Elect shall, in the absence of the President, perform the duties assigned to the President, and shall otherwise perform such duties, i.e., performance improvement oversight, credentials review, as may be assigned by the President.

C. Secretary/Treasurer

The Secretary/Treasurer shall keep accurate and complete minutes of all Professional Staff meetings, call Professional Staff meetings on order of the President, attend to all correspondence, and perform such other duties as ordinarily pertain to the office including maintenance of all Professional Staff financial records, management of Professional Staff funds and financial reports to the Medical Executive Committee and perform such duties, i.e., performance improvement oversight, credentials review, etc. as may be assigned by the President. The Secretary/Treasurer shall chair the Credentialing Committee.

Section 8.7 Recall of Officers

Any Professional Staff officer whose election is subject to these Bylaws 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. Except as otherwise provided, recall of a Professional Staff officer may be initiated by the Medical Executive Committee or shall be initiated by a petition signed by at least one-third of the members of the Professional Staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds affirmative vote of the Professional Staff members eligible to vote for Professional Staff officers who actually cast votes at the special meeting in person or by mail ballot with a minimum of one hundred (100) votes for recall.

ARTICLE IX
CLINICAL DEPARTMENTS

Section 9.1 Organization of Clinical Departments

Each department shall be organized as a separate part of the Professional Staff and shall have a chair who shall be responsible for the overall supervision of the clinical work of the department. The Medical and Surgical Departments may be divided into clinical sections subject to the approval of the Medical Executive Committee.

Section 9.2 Departments

The Professional Staff shall be organized into the following clinical departments:

1. Anesthesiology and Peri-Operative Medicine
2. Emergency Medicine
3. Family Medicine
4. Medicine
5. Obstetrics and Gynecology
6. Pediatrics
7. Pathology
8. Radiology
9. Surgery

Section 9.3 Selection and Tenure of Department Chairs

Prior to the conclusion of the term (December), allowing sufficient time for the process to be completed by November, each department shall select a chair and vice chair as follows:

Appoint a nominating committee which shall be made up of between 3-5 members of the department. The nominating committee shall meet and report back to the department at its next meeting with the names of those members nominated for the offices of department chair and vice chair. Additional nominations may be submitted from the floor subject to consent from the nominee. If the nominees are running unopposed, the department may accept the nominees with a verbal vote for approval at the same meeting. If the nominees are running opposed, the vote will be conducted by written ballot at the following meeting. Absentee ballots may be cast in the Medical Staff Services Department up to the time of the meeting at which the ballots are to be counted. The nominee receiving a plurality of votes shall be elected and announced at the meeting at which ballots are counted.

Department Chairs and Vice Chairs must be members of the Active Professional Staff, certified by an appropriate specialty board or affirmatively establish comparable competence at the time of nomination and election and must remain members who are not subject to corrective or other disciplinary action during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

Department chairs and vice chairs shall serve for a term of two (2) years or until their successors are elected and qualify. Department chairs may be re-elected for additional consecutive terms.

Department chairs shall not concurrently serve in medical staff positions (officers or department chair) at more than one hospital.

Section 9.4 Functions of the Department Chairs

Each department chair shall have the following authority, duties, and responsibilities:

A. responsibility for all clinically related activities of the department, for the overall conduct of the department, preside over the departmental meetings (he or she may at the conclusion of the general business portion of the department meeting limit subsequent attendance), and report the activities of the departmental meetings to the Medical Executive Committee and to the President of the Professional Staff regarding all professional and administrative activities within the department unless otherwise provided by the hospital;
B. in the event of a significant or sensitive issue at year end concerning the department/committee or a member, the outgoing department/committee chair will inform the incoming department/committee chair of this matter for continuity and/or resolution of the situation.
C. transmit to the Credentialing Committee the department's recommendations concerning appointment, classification and clinical privileges for applicants and reappointment and clinical privileges for members;
D. transmit to the Physician Excellence Council the results of performance improvement activities and continued surveillance of the professional performance of all department members;
E. recommending to the Medical Executive Committee the criteria for clinical privileges that are relevant to the care provided in the department;
F. transmit to the Physician Excellence Council and the Medical Executive Committee the department's recommendations concerning corrective action with respect to practitioners with clinical privileges in his or her department and be responsible for implementation within the department of actions taken by the Physician Excellence Council and Medical Executive Committee;
G. participate in the administration of his or her department, including coordination and integration of interdepartmental and intradepartmental services and integration of the department or service into the primary functions of the organization;
H. develop and implement policies and procedures that guide and support the provision of care, treatment and services;
I. recommend sufficient number of qualified and competent persons to provide care, treatment and services;
J. determination of the qualifications and competence of department or service personnel, i.e., nurses, respiratory therapists, physical therapists, etc. who are not licensed independent practitioners and who provide patient care, treatment and services;
K. continuous assessment and improvement of the quality of care, treatment and services provided;
L. maintenance of quality control programs as appropriate;
M. orientation and continuing education of all members in the department or service;
N. assess and recommend to Administration off-site sources for needed patient care, treatment and services not provided by the department/service or the organization;
O. recommending space and other resources needed by the department or service;
P. assist in the preparation of such annual reports, including budgetary planning, pertaining to his or her department as may be requested by the Hospital Administration;
Q. perform such other duties commensurate with the office as may from time to time be reasonably requested by the President of the Professional Staff or by the Medical Executive Committee.

Section 9.5 Functions of Departments

A. Each department shall establish its own criteria, consistent with the policies of the Professional Staff, for the granting of clinical privileges and for the holding of office in the department.
B. Each department shall consider the initial request for new allied health professional category including evaluating and making recommendations regarding the need for and appropriateness of the performance of in-

hospital services by allied health professional (AHPs). Requests for additional categories of AHP shall be made by the professional staff member. Requests shall be in writing stating the specific category to be added and the reason(s) why an additional category of AHP is necessary and would be in the best interest of patient care in the Hospital. The request shall be considered by the Board of Directors based on the favorable recommendations of the medical staff department and Medical Executive Committee.

A request for a new category that is not approved by the medical staff department and/or the Medical Executive Committee or the Board of Directors may not be re-submitted for at least one (1) year from the date of the final decision to reject the request.

C. Each department shall establish its own rules and regulations subject to approval by the Medical Executive Committee and shall have a maximum degree of autonomy over the affairs of the department; provided,
D. however, that the Medical Executive Committee shall have ultimate authority over departmental and interdepartmental affairs which affect the Professional Staff and the Hospital as a whole.
E. Each department shall be responsible for the ongoing evaluation of the professional performance of its members by generally monitoring the quality of patient care and professional performance rendered by members with clinical privileges in the department through a planned and systematic process and by overseeing the effective conduct of patient care, evaluation, and monitoring functions of the department;
F. Each clinical department shall develop and implement departmental criteria for retrospective patient care review, ongoing monitoring of practice, credentials review and privileges delineation, orientation and continuing medical education, utilization review, and performance improvement;
G. Each department shall encourage the participation of all Professional Staff members in department continuing education programs and required meetings.
H. Each department may appoint sub-sections, as needed, to conduct department functions.

Section 9.6 Recall of Department Chairs

After election, removal of department chairs and vice-chairs from office may occur for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude, by a two-thirds vote of the medical executive committee and a two-thirds vote of the department members eligible to vote on departmental matters who cast votes.

Section 9.7 Assignment to Departments

The Medical Executive Committee shall, after consideration of the recommendations of the clinical departments and the Credentialing Committee, recommend initial departmental assignments for all members. No member shall be a member of more than one department but may have clinical privileges in more than one department. A member of the Department of Family Practice will be appointed as representative to the clinical departments in which family practitioners are granted privileges.

ARTICLE X
COMMITTEES

Section 10.1 Qualifications/Selection of Committee Chairs & Committee Composition/Voting

A. The President of the Professional Staff shall appoint the chair of each standing committee, subject to the approval of such appointments by the Medical Executive Committee. Committee Chairs shall be Active members, shall not be subject to disciplinary action at the time of appointment, and shall maintain such status throughout the term of appointment.

In addition, the President of the Professional Staff may invite other members to attend Medical Executive Committee meetings subject to approval by the Medical Executive Committee. These invited members shall not have a vote on the Medical Executive Committee and shall sign a confidentiality statement. Furthermore, a Palliative Care representative shall be an ex-officio member of the Medical Executive Committee, without vote.

Except, as otherwise provided in these Bylaws, each committee chair shall appoint the members of the committee to include enough representation from the prior year for continuity. Each committee chair shall also select a vice-chair to serve in the absence of the chair.

B. Only members shall vote at Professional Staff committees unless otherwise stipulated in these Bylaws.

Section 10.2 Medical Executive Committee (MEC)

A. Composition and Voting

This Committee may include physicians and other licensed independent practitioners. The Committee shall consist of the President, President-Elect, Secretary/Treasurer of the Professional Staff, the chair of each clinical department, the chair of each standing committee, the immediate Past President of the Professional Staff and three (3) Members-at-Large. The Providence Little Company of Mary Medical Center Torrance Chief Executive Officer, Chief Medical Officer, Chief Nursing Officer, and Ethics Committee Chair shall serve in a non-voting capacity.

Three (3) members-at large will be elected to the Medical Executive Committee every two (2) years by Active members of the Professional Staff. The nominations will be handled following the Bylaws for "Nomination and Election of Officers" (see Article VIII, Section 8.3). However, the ballot for members-at-large will be separate from that for the elected officers. The three nominees receiving the highest number of votes shall be elected to the seats. Each member-at-large will have one vote on the Medical Executive Committee and will be assigned a duty by the President of the Professional Staff.

In the event of a tie, a runoff election shall be held promptly between the two (2) or more candidates that have received the same number of votes. Those members at large shall be elected upon receiving a majority of the valid votes cast.

All appointed members of the Medical Executive Committee will be approved by majority vote of the elected members of the Medical Executive Committee at its first meeting in January. Appointed members of the Medical Executive Committee may be recalled by a majority of the voting members present at a duly constituted Professional Staff meeting.

B. Duties

Receive and act upon the reports and recommendations from Professional Staff committees, departments, services and ad-hoc committees.

Represent and act on behalf of the Professional Staff in the intervals between professional staff meetings, subject to such limitations as may be imposed by these Bylaws. This delegated authority may be expanded, restricted, or removed by implementing a change in the Bylaws that the medical staff may propose directly to the Board of Directors, as outlined in ARTICLE XVIII. AMENDMENTS.

Recommend to the Board of Directors all matters relating to appointments and reappointments, staff categorization, department/service assignments, delineation of clinical privileges, performance improvement, organized medical staff's structure, process used to review credentials and delineate privileges. In instances where there is doubt about an applicant's ability to perform the privileges requested, the Medical Executive Committee requests evaluations of staff members.

Fulfill the Professional Staff's accountability to the Board of Directors for the quality of the overall medical care rendered to the patients in the Hospital. This committee shall also receive and act on reports from the Physician Excellence Council which shall function as a performance improvement committee of the Medical Executive Committee.

Initiate and pursue corrective action when warranted in accordance with Professional Staff Bylaws provisions.

Professional Staff members of the Medical Executive Committee shall be actively involved in the accreditation process; this shall include participation in the hospital survey, and particularly in the final critique session.

The Medical Executive Committee shall meet and shall keep a permanent record of all proceedings. The Medical Executive Committee shall present at each meeting of the Professional Staff a report of important actions taken since the last meeting.

In addition to its other duties, the Medical Executive Committee shall have the following duties in connection with the selection of designated representatives of the Board of Directors of the Hospital from the Professional Staff. The bylaws

of the Hospital may provide from time to time that a specific number of the members of its Board of Directors will be members of the Professional Staff.

On each occasion when a new, or replacement designated representative of the Board of Directors of the Hospital from the Professional Staff is to be appointed to one of the designated Board of Director seats, the following procedure shall be utilized: The Board of Directors shall send to the Medical Executive Committee a list of at least three (3) candidates who are members of the Active Professional Staff. The Medical Executive Committee shall discuss each candidate and each member of the Medical Executive Committee shall select two (2) candidates. This vote shall be by secret ballot. The two candidates receiving the most votes shall be submitted to the Board of Directors. The Board of Directors shall select one candidate from the list of two who shall be appointed to the Board of Directors.

Yearly dues for Professional Staff membership and application processing fees shall be set by a majority vote of the Medical Executive Committee and use of these monies shall be the responsibility of the Medical Executive Committee.

On each occasion when a donation, over a specified amount to be determined by the Professional Staff, to the Hospital is being considered, a task force whose membership is decided by the MEC, shall be appointed to evaluate the donation and make a recommendation back to the MEC about the proposed donation. Additionally, a vote (simple majority) of the Active Staff members shall be required for any donation, over a specified amount to be determined by the Professional Staff, utilizing Professional Staff funds. The Medical Executive Committee is empowered to act on donation amounts of $5,000 or less.

The Medical Executive Committee shall have the responsibility to retain independent legal counsel where it deems appropriate.

Section 10.3 Credentialing Committee

A. Composition

The Credentialing Committee shall consist of a representative from each clinical department (chair or vice chair) and upon request may include the chairs of the medical or surgical sub-sections. The committee shall be chaired by the Secretary/Treasurer of the Professional Staff. The committee shall also include members of the hospital administrative team as deemed necessary. Credentialing Committee may meet in conjunction with Medical Executive Committee.

B. Duties

The committee shall administer the Professional Staff Allied Professional Staff selection process for initial applicants and reappointment process for reapplicants who have met all departmental, clinical criteria for reappointment set forth in these Bylaws. Those reappointments that have not met the departmental, clinical criteria for reappointment will be referred to the Physician Excellence Council.

The Credentialing Committee shall make recommendations to the Medical Executive Committee regarding the selection of initial applicants including clinical privileges and reappointment of members including clinical privileges.

Section 10.4 Physician Excellence Council

A. Composition

The Physician Excellence Committee shall be a multi-specialty committee consisting of the Director of Medical Education and the chairs or vice-chairs of the departments and other members of each department as appointed by the department chairperson. The council shall be chaired by the President-Elect of the Professional Staff. The council shall also include representatives from the Hospital's administrative and management staff to include the Chief Nursing Officer or his/her designee, the Director of Performance and Quality Improvement or his/her designee and the Chief Medical Officer.

B. Duties

The Council shall take a leadership role in the following:

Performance Improvement activities as outlined in the Organizational Plan for Performance Improvement including timely peer reviews, oversight of peer review process conducted within the departments, oversight and recommendation of

appropriate peer actions that will lead to improvement of quality of care, treatment, services and patient safety. (See OPPE and FPPE policies).

The Council shall make recommendations to the Medical Executive Committee regarding performance improvement activities and those reappointments that have not met department, clinical criteria for reappointment.

Section 10.5 Bylaws Committee

A. Composition

The Committee shall consist of at least 5 members representative of the clinical departments.

B. Duties

The Bylaws Committee shall be on call for consultation in reference to interpretation of the Bylaws and shall also act as adjudicator of parliamentary disputes. The Bylaws Committee shall review the Bylaws of the Professional Staff at least annually and recommend such changes as it may deem necessary or appropriate.

Section 10.6 Critical Care Committee

A. Composition
The Critical Care Committee shall consist of at least one representative from the Active Staff of each clinical department involved in critical patient care. The committee shall include nursing representatives from the critical care areas and a representative from Hospital administration in a non-voting status.

B. Duties

The areas of responsibility of this committee shall be as follows:
Establish and maintain criteria for admissions, transfer and discharge of patients from the critical care areas; approval of all policies, protocols, and pre-printed orders pertaining to the critical care areas; and review of patient charts pertaining to the critical care areas.

Section 10.7 Health Education Committee

A. Composition

The Health Education Committee shall consist of the chair, appointed by the President of the Professional Staff, the Director of Medical Education who shall serve as Chair of the committee, and representatives from each clinical department and Director(s) of Felowship Program.

B. Duties

This committee shall assist the Director of Medical Education in arranging regularly scheduled educational meetings for the Professional Staff, and review and approve health education programs arranged for the community at large by appropriate Hospital personnel. The Health Education Committee shall review the Medical Executive Committee approved Fellowship program(s). The committee shall be responsible for the Hospital Library and for marketing activities of the Hospital as they relate to the Professional Staff. The committee shall meet no less than quarterly.

C. Post-Graduate Education, Fellowship Program

All proposed fellowship shall be approved by the Medical Executive Committee and by the Board of Directors.

All approved fellowship shall have a designated Program Director who shall be a member of the Medical Staff and who is designated by the Medical Executive Committee.

The Program Director is accountable, and shall be responsible for the conduct of the program with an obligation for direct supervision of the fellow(s). The Fellowship Program shall be subject to the ongoing approval of the Medical Executive Committee.

All approved fellowships must include a contractual agreement between the fellow and sponsoring entity.

The Program Director, or designee, shall report to the Health Education Committee and Medical Executive Committee at least annually on the status of the Fellowship program.

Medical Staff Services, or designee, shall keep records regarding each Fellowship program.

Section 10.8 Infection Prevention/Blood Committee

A. Composition

The Infection Prevention/Blood Committee, shall have representation from the medical staff and all clinical departments; to include the Infection Prevention Manager, the Director of Pharmacy Services or designee and the Chief Nursing Officer. The latter three shall serve as voting members.

B. Duties

The Committee shall be responsible for the surveillance of Hospital infection potentials, the review and analysis of actual infections, the promotion of a preventative and corrective program to minimize infection hazards, and the supervision of infection control in all phases of the Hospital's activities, and for blood usage review.

Blood usage review includes developing proposed policies and procedures for, and continuously evaluating the appropriateness of blood and blood products usage, including the screening, distribution, handling and administration, and monitoring of blood components' effects on patients.

The Committee will evaluate such matters as are brought before it by the Professional Staff, the Administration, the Professional Staff departments, standing committees or members of the committee. All actions of the committee will be presented to the Medical Executive Committee for approval.

The Committee shall maintain a record of its proceeding and shall report thereon to the Medical Executive Committee.

C. Meetings

The committee shall meet as often as necessary at the call of its chair but at least quarterly.

Section 10.9 Joint Conference Committee

The Joint Conference Committee is a discussion committee of the Board of Directors. The Professional Staff members of the committee shall be the President of the Professional Staff and the past three Presidents of the Professional Staff who do not have a contractual or salaried relationship with the Hospital. The Board of Directors representatives will be the Chair of the Board of Directors, two members of the Board of Directors and the Chief Executive Officer.

The committee shall meet at the call of either the President of the Professional Staff or the Chair of the Board of Directors, who shall act as co-chairs of the committee. The President of the Professional Staff and the Chief Executive Officer shall be non-voting members of this committee.

The committee shall act as a liaison between the Board of Directors and the Professional Staff on all matters of mutual interest or concern, and shall make recommendations to the Medical Executive Committee on such matters that are referred to it by the Medical Executive Committee or the Board of Directors.

Section 10.10 Conflicts Resolution Committee

Within 15 days after receipt of the petition described in ARTICLE XVII. AMENDMENTS the Medical Executive Committee will appoint a Conflicts Resolution Committee to address the issues identified in the petition. Including but not limited to meeting with members of the medical staff who may have necessary input and gathering information

regarding the conflict, working with the parties to manage and, when possible, to resolve the conflict; and protect the safety and quality of patient care.

The Conflicts Resolution Committee voting members will include an equal number of members of the Medical Executive Committee and non-Medical Executive Committee members who were nominated in the Petition, and a non-voting Chair. The Conflicts Resolution Committee will discuss and attempt to resolve the conflict that was described in the petition. The Conflicts Resolution Committee Chair will report the results of the committee's efforts back to the Medical Executive not more than 30 days after the Conflicts Resolution Committee was appointed.

Unless a majority of the Conflicts Resolution Committee's voting members requests continuation of the Conflicts Resolution Committee's deliberations and the request is approved by the Medical Executive Committee, the Conflicts Resolution Committee will dissolve thirty (30) days after its Chair reported the results of the committee's efforts to the Medical Executive Committee. Under no circumstances will deliberations continue beyond 60 days after the Conflicts Resolution Committee members are appointed.

Section 10.11 Nominating Committee

A. Composition

The Nominating Committee shall consist of the five (5) past Presidents of the Professional Staff (each must hold current Active staff status), the current President, President-Elect, Secretary/Treasurer, and the elected department chairs of Family Medicine, Medicine, Obstetrics/Gynecology, Pediatrics, and Surgery. The chair of the committee will be the current President of the Professional Staff.

B. Duties

The committee shall select nominees for the three (3) members-at-large, the President-Elect, and the Secretary/Treasurer of the Professional Staff and shall present the nominees to the Medical Executive Committee for its approval prior to presenting the nominees slate to the Professional Staff (see Section 8.3 for details of the process).

Section 10.12 Nursing –Professional Staff Interdisciplinary Practice Committee

A. Composition

The Committee shall include, as a minimum, the Chief Nursing Officer, the Chief Medical Officer or designee, an equal number of physicians appointed by the Executive Committee of the medical staff, and registered nurses appointed by the Director of Nursing. Licensed or certified health professionals, other than registered nurses who are performing or will perform functions under standardized procedures, shall be included in the Committee.

B. Duties

The Nurse-Professional Staff Interdisciplinary Practice shall perform functions consistent with the requirements of law and regulation. The Committee shall routinely report pursuant to the Professional Staff General Rules and Regulations Article II.

The duties of the Committee shall include the following:

(a) evaluating and making recommendations regarding:

(1) the mechanism for evaluating the qualifications and credentials of AHPs who are eligible to apply for and provide in-hospital services with minimum qualification as outlined in Professional Staff General Rules and Regulations Article II, Section 2.1;

(2) the minimum standards of training, education, character, competence, and overall fitness of AHPs eligible to apply for the opportunity to perform in hospital services;

(3) identification of in-hospital services which may be performed by an AHP, or category of AHPs, as well as any applicable terms and conditions thereon; and

(4) the professional responsibilities of AHPs who have been determined eligible to perform in-hospital services.

(b) making recommendations regarding appropriate monitoring, supervision, and evaluation of AHPs who may be eligible to perform in-hospital services.

(c) evaluating and reporting whether in-hospital services proposed to be performed or actually performed by AHPs are consistent with the rendering of quality medical care and with the responsibilities of members of the medical staff.

(d) evaluating and reporting on the effectiveness of supervision requirements imposed upon AHPs who are rendering in-hospital services.

(e) periodically evaluating and reporting on the efficiency and effectiveness of in-hospital services performed by AHPs.

(f) The Committee shall establish provisions for securing recommendations regarding standardized procedures from Professional Staff members in the medical specialty, or clinical field of practice under review, and from persons in the appropriate non-medical category who practice in the clinical field or specialty under review.

Methods for the approval of standardized procedures shall be as follows:
Initial requests shall be referred to the clinical departments for consideration of approval. The departments shall review the request and if approved, the departments shall refer it to the committee who shall then review and make recommendations to the Board of Directors through the Medical Executive Committee. If the departments' recommendation is modified by the Committee, it shall be referred to the clinical departments for approval prior to submission to the Medical Executive Committee.

A standardized procedure can be approved only after it has been approved by the department involved and by an affirmative vote by the committee consisting of a majority of the Professional Staff members, and nursing members of the Committee present at the Committee meeting.

The committee shall also act to heighten awareness of the collaborative role of nurses and professional staff members, strengthen the professional relationship between nurses and professional staff members, enhance team building and encourage long term career opportunities for nurses at the Hospital. The committee shall survey professional staff members and nurses on an ongoing basis regarding professional relationships, foster the professional relationships of nurses and professional staff members in the Hospital, and define programs, time frames, and implementation plans to resolve issues identified in the surveys.

C. Meeting Frequency

The Committee shall meet as often as needed.

Section 10.13 Pharmacy and Therapeutics Committee

A. Composition

The Pharmacy and Therapeutics Committee shall have representation from the medical staff and all clinical departments; to include the Infection Prevention Manager or designee, the Director of Pharmacy Services or designee and the Chief Nursing Officer. The latter three shall serve as voting members.

B. Duties

Assist in the formulation of professional practices and policies regarding the continuing evaluation, appraisal, selection,

procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the hospital, including antibiotic usage.

With regard to drug review, Providence LCMMC-T and its providers delegate authority for formulary decision-making to the centralized PH&S Formulary Process, led by a representative PH&S formulary committee of experts in medicine, pharmacy, and nursing throughout the system and continuum of care, that ensures patients of Providence and its affiliates are provided with safe, high-quality, and affordable medications throughout the continuum of care.

The Committee will evaluate such matters as are brought before it by the Professional Staff, the Administration, the Professional Staff departments, standing committees or members of the committee. All actions of the committee will be presented to the Medical Executive Committee for approval.

The Committee shall maintain a record of its proceeding and shall report thereon to the Medical Executive Committee.

C. Meetings

The committee shall meet as often as necessary at the call of its chair but at least quarterly.

Section 10.14 Oncology Committee

A. Oncology Cancer Committee Authority

Providence Little Company of Mary Torrance's (PLCMMCT) Medical Executive Committee (MEC) gives authority to the Committee for goal setting, planning, initiating implementing, evaluating and improving all cancer-related activities in the program. Oncology Committee has oversight of Tumor Board and any other subcommittees that are generated to address issues that may include subject matter experts. Oncology Committee is responsible for keeping and maintaining PLCMMCT's comprehensive community hospital 3-year cancer program accreditation following the Commission on cancer (CoC) patient-centered standards and quality measures.

B. Duties

- Provide a high level of quality care coordination among medical disciplines, including physicians ranging from primary care providers to specialists in all oncology disciplines as well as input from other clinical and allied health professionals, including, nursing, social work, genetics, nutrition, rehabilitation, pharmacy, palliative care, radiation oncology, imaging, pastoral care and others.
- Provide for provision of treatment and survivorship plans, palliative care services, genetic services, navigation programs and psychosocial distress screening.
- Provide quality metrics as defined by the data collected by the cancer program's cancer registry, along with mechanisms in place to address deficiencies in performance.
- Provide ongoing monitoring that assess care, define and resolve barriers to high quality, and continuously improve care by using National Cancer Data Base (NCDB) quality tools.
- Utilize the CoC NCDB to collect, analyze, and report cancer program data at the Oncology Committee by annual updates on its' practice on numerous cancer sites via the Cancer Program Practice Profile reports (CP3R), which allows for auditing and updating of data.
- Utilizes the CoC NCDB quality data tool Rapid Quality Reporting System (RQRS), a real-time data collection program to assess hospital-level performance using quality of cancer care measures. The system tracks patients and include alerts to ensure patients receive proper care in the appropriate time.

Cancer patient management is conducted by a multidisciplinary team, including diagnosticians, pathologists, surgeons, radiation oncologists, and medical oncologists. All physicians involved in the evaluation and management of cancer patients, as well as those serving in are required physician positions on the Oncology Committee must be the following:

Board Certified; or in the process of becoming Board Certified and demonstrate ongoing cancer related education by earning 12 cancer-related continuing medical education (CME) hours each calendar year. A maximum of 6 of the 12 hours can be earned through educational activities offered by our facility; however, all 12 hours can be earned through educational activities that are external to our facility.

C. Composition

The care of patients with cancer requires a multidisciplinary approach and encompasses numerous physician and non-physician professionals. The committee responsible for program leadership is multidisciplinary and represents the full scope of cancer care and services.

The Oncology Committee must be chaired by a physician (of any specialty) and selected in accordance with these Medical Staff Bylaws.

Required Oncology Committee members must include at least one physician representing each of the diagnostic and treatment services. Other required members include representatives from each of the administrative, clinical, and supportive services available at the program. Committee and cancer program coordinators, who are responsible for specific areas of the cancer program, activity, are designated each calendar year. Each program assesses the scope of services offered and determines the need for additional Oncology committee members based on the major sites of cancer seen by the program:

Required physician members are:

Diagnostic Radiologist
Pathologist
Surgeon
Medical Oncologist
Radiation Oncologist
Cancer Liaison Physician
Palliative Care Physician
Required non-physician members are:

Cancer Program Administrator
Oncology Nurse
Social Worker
Certified Tumor Registrar (CTR)
Genetics Professional

Section 10.15 Post-Acute Care Committee

A. Composition

The committee shall consist of the medical directors and other members as appointed by the chair. The chair may appoint representatives from the Little Company of Mary Pavilion and Transitional Care, Home Care and Hospital as deemed appropriate.

B. Duties

The Committee's responsibilities shall include:
Utilization review, infection control and performance improvement activities at all post acute facilities of the Little Company Mary Hospital Continuum to include the Pavilion, Transitional Care Unit, Home Care, etc. The Committee may delegate utilization review and performance improvement matters to the medical directors;
Review and approval of policies, procedures, rules and regulations;
Ongoing peer review;
Assuring that members practicing at the post acute care sites are required to abide by applicable rules and regulations; and
Addressing any quality of care issues brought to the Committee by the medical directors.

C. Meeting Frequency

The Committee shall meet at least quarterly, and shall report to the Medical Executive Committee.

Section 10.16 Physicians' Well-Being Committee

A. Composition

The Physicians' Well Being Committee shall be comprised of not less than five (5) members of the Active Staff. All members, including the chair, shall be physicians. The committee may include appropriate consultants as needed. Except for the initial appointments, each member shall serve a term of three (3) years, and the terms shall be staggered as deemed appropriate by the Medical Executive Committee to achieve continuity. Insofar as possible, members of the committee shall not serve as active participants on other peer review or performance improvement committees while serving on this committee.

B. Duties and Confidentiality of Records

The committee's function shall be to aid the health and well being of members, thereby maintaining the quality and competence of the Professional Staff. The activities of the committee shall be confidential. In the event information received by the committee clearly demonstrates that the health or known impairment of a member poses a risk of harm to hospitalized patients or to the member, that information shall be referred to the President of the Professional Staff.

The committee shall be advisory to the Medical Executive Committee and such other appropriate Professional Staff committees as the Medical Executive Committee shall designate (See Professional Staff Rules and Regulations for additional details).

Section 10.17 Special Committees

Special committees may be appointed by the President of the Professional Staff as required to carry out the duties of the Professional Staff. Such committees shall confine their work to the purpose for which they were appointed and shall report to the President of the Professional Staff and the Medical Executive Committee. The powers of special committees shall be limited to the powers specified in the motion creating the committee.

10.18 Department Committees

10.17-1 Composition

Each department designated in Article IX may have a department committee consisting of not less than three (3) Active Staff members who shall be appointed by the department chairman. The department chairman may designate this committee to act on behalf of the department as a whole. The department chairman shall act as chairman of the department committee.

10.17-2 Duties

Each department committee shall assist the chairman of the department to carry out the functions described in Article IX.

10.17-3 Meetings

The department committee shall meet as often as deemed necessary.

ARTICLE XI
PROFESSIONAL STAFF MEETINGS

Section 11.1 Regular Meetings

The annual election meeting of the Professional Staff shall be held prior to the end of the calendar year. The agenda for such meetings shall include the election of officers and reports of the affairs of the Professional Staff. Written notice of the place, day and hour of the annual election meeting shall be electronically mailed to each member not less than fifteen 15 days prior to the meeting. Such notice shall include the nominees for election as officers of the Professional Staff. Regular Professional Staff meetings shall be held periodically as determined by the Medical Executive Committee to review the medical work performed at the Hospital and to transact other Professional Staff business. Additionally, all proposed Bylaws and Rules/Regulations revisions shall also be presented to the Professional Staff at regularly scheduled meetings of the Professional Staff, as a point of discussion only, prior to vote.

Section 11.2 Special Meetings

A. The President of the Professional Staff or the Medical Executive Committee may call a special meeting of the Professional Staff at any time. The President of the Professional Staff shall call a special meeting after receipt of a written request thereof from the Board of Directors or from not less than fifteen (15) members of the Active Professional Staff and stating the purpose for such meeting. The Medical Executive Committee shall designate the time and place of any special meeting.

B. Written or printed notice stating the place, day and hour of any special meeting of the Professional Staff shall be delivered, either personally or by mail, to each member not less than five (5) days prior to the date of such meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited postage prepaid, in the United States mail addressed to the member at the member's address as it appears on the records of the Professional Staff. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Section 11.3 Quorum

The presence of fifty (50) members of the Active Professional Staff at any regular or special meeting shall constitute a quorum.

Section 11.4 Attendance Requirements

Each member shall be required to satisfy meeting attendance requirements as specified for each category in accordance with Article III.

A. Special Attendance Requirement

A practitioner whose conduct or patient's clinical course of treatment is scheduled for discussion at a regular department or committee meeting shall be so notified. Whenever apparent or suspected deviation from standard clinical practice is involved, special notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting, a statement of issue involved and that the practitioner's appearance is mandatory.

Failure of a practitioner to appear at any meeting with respect to which he or she was given such special notice shall, unless excused by the Medical Executive Committee (or designated Council of Officers) upon a showing of good cause, result in an automatic suspension of the practitioner's clinical privileges or other disciplinary action as the Medical Executive Committee may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Medical Executive Committee (or designated Council of Officers).

Section 11.5 Agenda

A. Regular Meetings

The order of the agenda at any regular Professional Staff meeting shall be determined by the President of the Professional Staff.

B. Special Meetings

The agenda at special meetings shall be:

1. reading of the notice calling the meeting;
2. transaction of the business for which the meeting was called; and
3. adjournment

Section 11.6 Rules of Order

All regular and special meetings of the Professional Staff shall be governed by Roberts Rules of Order.

Section 11.7 Written Mail Ballot

Whenever these Bylaws require voting by written mail ballot, the mail ballots shall be returned in an unmarked envelope, which shall be placed inside a properly identified return envelope on which the Staff member has printed and signed his/her name. The Staff member's name shall be verified against the Professional Staff records.

All proposed Bylaws and Rules/Regulations revisions shall also be presented to the Professional Staff at regularly scheduled meetings of the Professional Staff, as a point of discussion only, prior to vote.

Section 11.8 Executive Sessions

At the call of its President, the medical staff may meet in executive session, with attendance restricted to medical staff members, a recording secretary, and such advisors or other attendees, as the President may specifically request to attend.

ARTICLE XII

COMMITTEE AND DEPARTMENT MEETINGS

Section 12.1 Regular Meetings

Committees may, by resolution, provide the time for holding regular meetings without notice. Clinical departments shall hold meetings to review and evaluate the clinical work of the department.

Section 12.2 Special Meetings

A special meeting of any committee or department may be called by or at the request of the chair thereof, by the President of the Professional Staff, or by one-third (1/3) of the committee or department members, but not less than two (2) members.

Section 12.3 Notice of Meetings

Written notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the committee or department not less than three (3) days before the time of such meeting, by the person or persons calling the meeting. The notice of the meeting shall be deemed delivered on the date it is sent to the member at the member's e-mail address as it appears on the individual's Professional Staff record. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

Section 12.4 Quorum

A quorum shall consist of one-third (33-1/3%) of the voting members of a Committee but in no event less than two (2) voting members.

The quorum for departments shall be defined in the department's rules and regulations.

Section 12.5 Manner of Action

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee or department. Action may be taken without a meeting by majority consent in writing signed by each member entitled to vote thereat, or by email, or other electronic and/or telephone means where permitted by the chair of the meeting on either an individual or group basis, so long as adequate precautions are in place to ensure authentication and security.

Section 12.6 Rights of Ex-Officio Members

Persons serving under these Bylaws as ex officio members of a committee shall have all rights and privileges of regular members except as otherwise provided in these Bylaws and except that they shall not be counted in determining the existence of a quorum.

Section 12.7 Minutes

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the vote taken on each matter. The minutes shall be signed by the recording secretary and copies thereof shall be made available to the attendants present at the next meeting for approval. A report of the action taken shall be forwarded to the Medical Executive Committee. Each committee and department shall maintain a permanent file of the minutes of each meeting.

Section 12.8 Attendance Requirements

See Categories of the Professional Staff, Article III.

Section 12.9 Executive Sessions

At the call of its chairman, any medical staff committee or department may meet in executive session, with attendance restricted to medical staff members, a recording secretary, and such advisors or other attendees as the chairman may specifically request to attend.

ARTICLE XIII

IMMUNITY FROM LIABILITY

The following shall be express conditions to any applicant's application or member's reapplication for, or any member's exercise of, clinical privileges at this hospital:

Any act, communication, report, recommendation, or disclosure, with respect to any such applicant or member, performed or made at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

Such privilege shall extend to members, the Board of Directors, the Chief Executive Officer and representatives thereof, and to third parties, who supply information to any of the foregoing authorized to receive, release, or act upon the same, and the term "third parties" shall mean both individuals and organizations from whom information has been requested by an authorized representative of the foregoing.

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

privileged in whole or in part.

Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to:

A. application for appointment and reappointment of membership and clinical privileges;
B. periodic reappraisals for reappointment or clinical privileges;
C. corrective action, including summary suspension;
D. hearings and appellate reviews;
E. medical care evaluations;
F. utilization reviews; and
G. other hospital, departmental, sub-section, or committee activities related to quality patient care and inter-professional conduct.

The acts, communications, report, recommendations and disclosures referred to in this Article may relate to an applicant's or member's professional qualifications, clinical competence, character, mental or emotional stability, physical condition (health status), ethics, or any other matter that might directly or indirectly have an effect on patient care.

In furtherance of the foregoing, each applicant or member shall upon request of the Hospital execute releases in accordance with the tenor and import of this Article in favor of the individuals and organizations specified above.

The consents, authorizations, releases, rights, privileges and immunities provided by any other provision of these Bylaws for the protection of members, appropriate Hospital officials and personnel and third parties, in connection with applications for initial appointments or reappointments, shall also be fully applicable to the activities and procedures covered by this Article.

ARTICLE XIV
CONFLICT OF INTEREST STATEMENT

Section 14.1 Conflict of Interest

Conflict of interest occurs when personal interests or activities influence or appear to influence actions and decisions. Professional Staff Members must avoid activities and relationships that may impair independent judgment and unbiased decision-making.

A Professional Staff Member is considered to have a conflict of interest when they, or any of their family members, or associates; receive financial or other significant benefit as a result of their position at Providence, have the opportunity to influence Providence business, administrative or other decisions in ways that could lead to personal gain or advantage, compete to the disadvantage of Providence, have a compensation agreement with Providence or have an ownership or investment in any entity with which Providence does business (refer to PROV-GOV-208 and any other conflict of interest specific policy that may be implemented by Providence and is applicable to Members). If any such conflict occurs, it is the Member's responsibility to disclose the conflict of interest to the Department Chair in writing.

Section 14.2 Committee Members

Elected or appointed, department or committee, Professional Staff Members shall use good faith to disclose material financial or personal interests that may potentially lead to a conflict. The Member must declare the conflict and must abstain from voting on the issues concerning the matter of conflict. The Medical Executive Committee (MEC) may take appropriate action when an elected or appointed, department or committee, Member fails to disclose the conflict.

Section 14.3 Department Chairs, Sub-Section Chairs, or Committee Chairs

Department Chairs, Sub-Section Chairs, or Committee Chairs shall have the duty to delegate review of applications for appointment, reappointment, clinical privileges, and/or questions that may arise to another member if the department/sub-section/committee chair has a conflict of interest with the individual under review, or could be reasonably perceived to be biased in the review process. It is acknowledged that in certain limited circumstances, the delegation of such review may not be practical -- for example, where a facility has a small medical staff. In such a case, the Department Chair, Sub-

Section Chair, or Committee Chair shall engage the facility Chief Executive Officer or Chief Medical Officer to act as an independent advisor assisting in the review.

Section 14.4 Failure to Properly Execute the Professional Staff Conflict of Interest Statement

The MEC may take appropriate action when a Department Chair, Sub-Section Chair, or Committee Chair fails to disclose the conflict and/or does not engage the Chief Executive Officer or Chief Medical Officer as required.

ARTICLE XV
GENERAL PROVISIONS

Section 15.1 Conflict Management: Under the following circumstances the Medical Executive Committee will initiate a conflict management process to address disagreement between members of the professional staff and the Medical Executive Committee about an issue relating to the professional staff's documents or functions, including but not limited to a proposal to adopt or amend the professional staff bylaws, rules and regulations or policies; or a proposal to remove some authority delegated to the Medical Executive Committee by the professional staff under these bylaws (by amending the bylaws).

Upon written petition signed by either:
A. At least 25% of the voting members of the professional staff, or
B. At least 2/3 of the voting members of any department or sub-section of the professional staff, or
C. Upon the Medical Executive Committee's own initiative at any time; or
D. As otherwise specified in these bylaws

A request to invoke the conflict management process must be submitted within any deadline specified in these bylaws;
A petition to initiate the conflict management process will designate two Active professional staff members to serve as representatives of the petitioners, describe the nature of the conflict, and state the reasons why the conflict management process will do all of the following:

A. Provide a reasonably timely, efficient, and meaningful opportunity for the parties to express their views;
B. Require good-faith participation by representatives of the parties, and
C. Provide for a written decision or recommendation by the Medical Executive Committee on the issues within a reasonable time, including an explanation of the Medical Executive Committee's rationale for its decision or recommendation.

At the Medical Executive Committee's discretion, the process for management of a conflict between the Medical Executive Committee and the professional staff members may include the involvement of a third party to facilitate or mediate the conflict management efforts.

The conflict management process described in this section will be a necessary prerequisite to any proposal to the Board of Directors by professional staff members for adoption or amendment of a bylaw, rules and regulations, provision, or policy not supported by the Medical Executive Committee, including (but not limited to) a proposed bylaws, amendment intended to remove from the Medical Executive Committee some authority that has been delegated to it by the professional staff.

Nothing in this Section is intended to prevent professional staff members from communicating with the Board of Directors about professional staff bylaws, rules and regulations, or policies; according to such procedures as the Board of Directors will specify.

Section 15.2 Unification/Disunification

A. Unification With Other Medical Staffs

The Medical Staff can be included in a included in a unified medical staff of any health system in which the Hospital participates only after:

1. Six months' prior written notice to all Medical Staff Members describing the proposed unification, setting forth its risks, benefits, and effects to the Medical Staff and its members:

2. The Medical Executive Committee concurs [based on favorable recommendations from two-thirds of all Departments reported to the Medical Executive Committee,] following review and study; and

3. No less than two-thirds of all Medical Staff Members with voting rights who hold clinical privileges to practice on-site at the hospital cast votes in favor of unifaction. The medical Execitve Committee shall determine whether the Medical Staff votes:

    a. At a special meeting called for the purpose,
    Or,
    b. Via confidential mail or electronic balloting.

If all these requirements are not met, the Medical Staff shall remain separate from any System unified hospital and continues as the Medical Staff of the Hospital.

If the Medical Staff votes to accept unification, these Medical staff Bylaws will remain in effect as to the Members, until the Medical Staff bylaws are amended or new Medical Staff Bylaws are adopted pursuant to the terms of these Bylaws.

B. Disunification From Other Medical Staffs

The Medical Staff shall disunify from any system-unified medical staff by vote to disunify by two-thirds of all Medical Staff Members with voting rights who hold clinical privileges to practice on-site at the hospital. The Medical Staff shall be the unique Medical Staff of the Hopsital effective immediately, operating under the Medical Staff Bylaws in effect prior to unification. Special election shall be called to elect officers, department chairs and other medical staff leadership immediately consistent with the Medical Staff Bylaws in effect immediately prior to unification.

C. Unification/Disunification Effect on Bylaws

1. A vote by the Medical Staff to accept a unified medical staff shall have no effect on the application of these Medical Staff Bylaws, which shall continue to govern this Medical Staff and be upheld by the Governing Body. Peer review and other activities of the Medical Staff and its Members shall continue to be governed by [name of state licensing the Hospital] law by which the Hospital is licensed.

2. Upon disunification, the Medical Staff Bylaws in effect the date of unification shall return to full force and effect.

ARTICLE XVI

RULES & REGULATIONS AND POLICIES & PROCEDURES

The Professional Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Board of Directors. These shall relate to the proper conduct of Professional Staff organizational activities as well as the level of practice that is to be required of each member. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular Professional Staff meeting at which a quorum is present and without previous notice or at any special Professional Staff meeting on notice, by a majority vote of the Active Professional Staff present. Such changes shall become effective when approved by the Board of Directors.

In the event the Medical Executive Committee receives documentation of an urgent need to amend the medical staff rules and regulations to comply with law or regulation, the Medical Executive Committee may adopt the necessary amendment provisionally and submit it to the Board of Directors for provisional approval, without prior notification of the medical staff.

Immediately following the Board of Director's provisional approval of such an urgent provisional amendment to the rules and regulations, the Medical Executive Committee will notify the professional staff, and offer an opportunity for any interested professional staff member to submit written comments to the Medical Executive Committee within 15 days of the date of the notice.

The amendment will become final at the end of the comment period if written opposition to the amendment has not been received by at least 25% of the Active professional staff members.

If written opposition to the amendment has been received by at least 25% of the Active professional staff members, then the Medical Executive Committee will implement the conflict management process set forth in Section 10.11 of these Bylaws, and may submit a revised amendment to the Board of Directors for approval if necessary.

Each clinical department shall adopt such rules and regulations as may be necessary for the proper conduct of the department. Such rules and regulations shall be a part of these Bylaws but amendments may be proposed at any departmental meeting. Such amendments shall become effective when approved by the Board of Directors, upon recommendation of the Medical Executive Committee.
Policies and Procedures shall be developed as necessary to implement more specifically the general principles found within these Bylaws and the Rules and Regulations, including those relating to the credentialing, privileging, focused review, corrective action, and fair hearing and appeal procedures. The Policies and Procedures may be adopted, amended, or repealed by majority vote of the Medical Executive Committee and subject to the approval of the Board of Directors and they shall not be inconsistent with the Professional Staff or Hospital Bylaws, Rules and Regulations, or other policies.

ARTICLE XVII

REVIEW

The hospital's legal counsel shall periodically review these bylaws to assure the bylaws, rules and regulations and policies do not conflict with the governing body bylaws or with current laws and regulations.

ARTICLE XVIII

AMENDMENTS

An amendment may be proposed in writing by any member and such proposed amendment shall be referred to the Bylaws Committee. If the Bylaws Committee recommends the adoption of the proposed amendment, such recommendation shall be referred to the Medical Executive Committee. If approved by the Medical Executive Committee, the following methods may be used:

These Bylaws may be amended by a two-thirds (2/3) affirmative vote of the Active Professional Staff members present at any regular or special meeting of the Professional Staff, provided that notice of such business is sent to all members not later than fifteen (15) days before such meeting. The notice shall include the exact wording of the proposed addition or amendment, if applicable, and the time and place of the meeting.

The Bylaws may also be amended by mail ballot utilizing the process outlined in Section 11.7 of these Bylaws and provided the ballot packet includes the exact wording of the proposed addition or amendment. The notice shall be mailed to all eligible voting members at least thirty (30) days before the closing date for submitting ballots. Approval by this method shall require affirmative vote of two-thirds (2/3) of the members who vote.

Additionally, all proposed Bylaws and Rules & Regulations to be amended by mail ballot shall also be presented to the Professional Staff at regularly scheduled meetings of the Professional Staff, as a point of discussion only, prior to vote.
In addition, the organized professional staff has the ability to adopt Professional Staff Bylaws, Rules and Regulations, and Policies and propose them directly to the Board of Directors, but only in accordance with the following procedure:

A. A proposal to amend the bylaws and rules may be initiated by submitting to the Medical Staff Services Department a petition signed by at least 25% of the Active professional staff members proposing a specific bylaws or rules

amendment or amendments (which will constitute notice of the proposed bylaws or rules amendment(s) to the Medical Executive Committee). Any such petition must identify two Active professional staff members, in good standing, who will serve as representatives and act on behalf of the petition signers in the process described below (including any conflict management processes).

B. Upon submission of such a petition, the Medical Executive Committee will determine whether it supports the proposed bylaws amendment(s) and if so,

1. The Medical Staff Services Department will arrange for a vote on the proposed bylaws or rules amendment(s) by the voting members of the Active professional staff according to the process described for voting on Medical Executive Committee proposed bylaws or rules amendments.

2. If the professional staff adopts the Medical Executive Committee supported proposed bylaws or rules amendment(s) by a vote of the professional staff conducted according to the process described above, then the proposed bylaws amendment(s) will be submitted to the Board of Directors for approval.

3. If the professional staff does not adopt the Medical Executive Committee supported proposed bylaws or rules amendment(s) will be deemed withdrawn.

C. If the Medical Executive Committee does not support the proposed bylaws amendment(s), the Medical Executive Committee will notify the designated representatives, in writing, and they will have 30 days from receipt of the notice to invoke the conflict management process described in these bylaws. If the conflict management process is not invoked within 30 days, it will be deemed waived and the proposed bylaws or rules amendment(s) will be deemed withdrawn.

1. If the conflict is not resolved by withdrawal of the proposed bylaws or rules amendment(s) as modified in the conflict management process, then the proposed bylaws or rules amendment(s) will be submitted (in original form or, if the originally proposed bylaws amendment(s) have been modified in the conflict management process, then as modified) to the professional staff for a vote. The proposed bylaws amendment(s) will be submitted to the Board of Directors if a majority of the Active professional staff members who are eligible to vote cast their ballots in favor of the proposed bylaws amendment(s).

2. A copy of the Medical Executive Committee's written statement of its decision and reasons issued at the conclusion of the conflict management process will be provided to the Board of Directors along with any proposed bylaws or rules amendment(s) after such process.

ARTICLE XIX

ADOPTION

Changes adopted by the Professional Staff shall become effective only after approval by the Board of Directors, which approval shall not be unreasonably withheld. If such approval of the Board of Directors Body is not given within ninety (90) days of receipt of such changes, the matter shall be submitted to the Joint Conference Committee for review and recommendation.

Upon adoption and approval as provided in this Article, in consideration of the mutual promises and agreements contained in these Bylaws, the Hospital and the Professional Staff, intending to be legally bound, agree that these Bylaws shall constitute part of the contractual relationship existing between the Hospital and the Professional Staff members, both individually and collectively.