

BYLAWS, RULES AND REGULATIONS OF THE MEDICAL STAFF

PREAMBLE

In recognition of their responsibilities for the quality of patient care, the physicians and psychologists at Langley Porter Psychiatric Hospital and Clinics at the University of California, San Francisco ("the Hospital") hereby organize themselves. This organization shall be in conformity with the Bylaws, Rules, and Regulations hereinafter stated, and is subject to the authority of The Regents of the University of California ("The Regents"). The Chancellor of the University of California, San Francisco represents The Regents in the governance of the Hospital. Consistent with University policies and procedures and actions of The Regents, the Chancellor shall otherwise govern all activities of the Hospital and the Chancellor may delegate his/her governance responsibilities for the Hospital to an appropriate designee. The Chancellor or his/her designee is hereinafter referred to as the Chancellor.

ARTICLE I

NAME

The name of this organization shall be the Medical Staff of Langley Porter Psychiatric Hospital and Clinics at the University of California, San Francisco, and is hereinafter referred to as the Medical Staff.

ARTICLE II

PURPOSE

The purposes of the Medical Staff shall be:

1. To ensure that all patients of the Hospital are treated with consideration and to ensure that access to care is not affected by race, color, sex, religion, national origin, age, disability or sexual orientation subject to state and federal laws and regulations.
2. To provide a means whereby problems of a medico-administrative nature may receive discussion and action.
3. To initiate and maintain Rules and Regulations for self-government.

4. To ensure that all Medical Staff members maintain the quality performance of their professional duties.
5. To integrate education and research programs of the University of California, San Francisco with clinical programs of the Hospital.

ARTICLE III

MEMBERSHIP

Section A. Eligibility and General Responsibilities of Membership

1. Except as permitted under Article III.A.8 and 9 below, only faculty members or employees in the Department of Psychiatry of the University of California, San Francisco School of Medicine shall be eligible for membership on the Medical Staff (hereinafter referred to as Members).
2. Members must be licensed or otherwise certified to practice in the State of California.
3. At the time of initial appointment or reappointment, Members must document their experience, background, training, health status, and ability to provide their patients with care at the generally recognized level of quality.
4. Members must adhere to the ethics of their profession, including refraining from fee-splitting or other inducements relating to patient referral.
5. Members must provide care to patients at the Hospital, patients referred by the UCSF Medical Center to the Langley Porter Consultation Liaison Service, and/or patients treated in Langley Porter Faculty Practices according to the principles established in these Bylaws, Rules and Regulations.
6. Membership shall not be denied on the basis of sex, race, creed, color, national origin, handicap, or sexual preference.
7. Membership for persons in a medico-administrative capacity shall be neither extended nor withdrawn based solely on administrative appointment, but shall be subject to the same terms of appointment and termination as otherwise provided in these Bylaws.
8. Appointment to the faculty of the School of Medicine, Department of Psychiatry, University of California, San Francisco, shall not automatically result in conferral of Medical Staff membership, nor shall appointment to the Medical Staff automatically result in a faculty appointment. Neither appointment to the Medical Staff nor the granting of privileges to perform specific procedures shall confer

entitlement to unrestricted use of the facilities of the Hospital or the resources thereof. Allocation of resources, including, but not limited to, patient beds shall be subject to administrative allocation pursuant to procedures established by authority of the Director of Clinical Services.

9. Individuals who are not members of the faculty of the University of California, San Francisco, or not otherwise employed by The Regents, must maintain professional liability insurance coverage with limits of coverage not less than those which may, from time to time, be established by The Regents, and with The Regents included as an additional insured.
10. Each Medical Staff member shall be willing and qualified to participate in the training of students, shall develop and maintain teaching skills essential to effective functioning in contact with students, and shall perform his/her responsibilities in such a way as to serve as an exemplary role model for the students and for the teaching programs of the Hospital.
11. Reappointment and continuation of privileges is subject to at least biennial review. This review may result in the expansion or reduction of privileges based upon criteria that include quality of patient care, quality of teaching, and utilization of the Hospital's resources.
12. Members of the Medical Staff agree to participate in the execution of Hospital functions. These are defined to include, but are not limited to, continuous performance improvement, peer review, utilization management, quality evaluation and related monitoring activities, on call and after-hours patient care responsibility, and in discharging such other functions as may be required from time to time.

Section B. Categories of Membership

1. Provisional

- a. All initial appointments to membership of any category of the Medical Staff shall be provisional for a period of six months. The Provisional Staff shall consist of psychiatrists, psychologists and allied health professionals who meet the qualifications specified for Attending, Courtesy or Allied Health Professional Staff except that they have not yet satisfactorily completed the proctoring requirements specified by the Hospital.
- b. Prerogatives: The prerogatives for Provisional Staff are as for Attending, Courtesy or Allied Health Professional Staff with the following limitations: The Provisional Staff are not eligible to hold office or vote. A Provisional Member shall be assigned to a service where his/her performance shall be proctored by the Chief of Service or another Member designated by the

President of the Medical Staff to determine the eligibility of such Provisional Member for Attending, Courtesy or Allied Health Professional Staff membership and for exercising the clinical privileges granted to them.

- c. Duration of Appointment: Provisional members receive an initial six month appointment after which regular appointment shall be reviewed in accordance with Article III.C.1.c. Provisional members are eligible for not more than two additional six month reappointments, or a maximum of eighteen months. If a member fails to advance to either Attending or Courtesy Staff within eighteen months following their initial appointment, he/she shall be terminated and such members shall be entitled to the procedural rights set forth in Article III.D.

2. Attending

- a. Attending Psychiatrist: Those physicians who are providing patient care or have direct responsibility for patient care through oversight of house officers, trainees, or students in their involvement with patients.

Prerogatives: They are eligible to vote and hold office and are expected to participate in the activities of the Medical Staff through membership on its committees and attendance at its meetings. They have admitting privileges to the Hospital.

Duration of Appointment: Appointments to the Attending Staff shall be for a two-year period unless terminated by other provisions of these Bylaws. Appointments shall be effective on the date signed by the Chancellor, and shall extend for a period of two years.

- b. Attending Clinical Psychologist: These are licensed clinical psychologists who are providing patient care or have responsibility for patient care through oversight of trainees in their involvement with patients.

Prerogatives: They are eligible to vote and hold office and are expected to participate in activities of the Medical Staff through membership on its committees and attendance at its meetings. They may admit patients to outpatient programs.

Duration of Appointment: Appointments to the Attending Staff shall be for a two-year period unless terminated by other provisions of these Bylaws. Appointments shall be effective on the date signed by the Chancellor, and shall extend for a period of two years.

3. Courtesy Staff

- a. Physicians who admit or clinical psychologists who treat 1-5 patients per year may apply for appointment to the Courtesy Staff. Members of the Courtesy Staff who have not been involved in patient care and who have not been involved in the clinical oversight of house officers for a period of two years shall automatically be transferred to Inactive Status. These physicians or clinical psychologists may reapply for active membership by completing a new application.
 - b. Prerogatives: They are not eligible to vote or hold office.
 - c. Duration of Appointment: Appointments to the Courtesy Staff shall be for a two-year period unless terminated by other provisions of these Bylaws. Appointments shall be effective on the date signed by the Chancellor, and shall extend for a period of two years.
4. Allied Health Professional Staff
- a. Individuals who meet the eligibility requirements described in Section C may be appointed to the Allied Health Professional (AHP) Staff. This category may include L.C.S.W.s, M.F.T.s , Nurse Practitioners and other health professionals deemed eligible by the Governing Body after recommendation and approval from the Credentials Committee and the Executive Committee of the Medical Staff. Upon appointment, Allied Health Professional Staff shall, as outlined in their job descriptions and to the extent approved by the Credentials Committee and the Executive Committee of the Medical Staff, be expected to:
 - (1) Exercise independent judgment within their areas of competence and as defined by licensure.
 - (2) Participate directly in the management of patients.
 - (3) Record initial evaluations and on-going treatment progress notes on patient charts
 - (4) Perform consultation, upon request.
 - b. Prerogatives: They are not eligible to vote or hold office. They may participate in the activities of the Medical Staff through membership on its committees and attendance at its meetings. They may be expected to attend and actively participate in the clinical meetings of their respective clinical services, to the extent permitted by the Chief of the Service. All decisions to appoint shall include a standardized procedure or delineation of clinical privileges that the applicant may exercise. In exercising such privileges, the applicant shall act under the supervision of the Chief of the Service to which he/she is assigned and shall be proctored and monitored

in accordance with UCSF Human Resources and/or clinical service guidelines.

- c. Limitations: None of the provisions for corrective action in Article III.D shall be applicable, in the event of any modification, suspension, restriction or termination of an AHP Staff Member's status. For AHPs who are University employees, the provisions of the University's applicable grievance procedure for such category of employee shall be followed. For AHPs who are independent contractors, the corrective action provisions of their respective service contract will be initiated by the Chair of the Credentials Committee.
- d. Duration of Appointment: Appointments to the Allied Health Professional Staff shall be for a two-year period unless terminated by other provisions of these Bylaws. Appointments shall be effective on the date signed by the Chancellor, and shall extend for a period of two years. Appointment to Allied Health Professional status is automatically terminated if employment or service contract is terminated.

5. Inactive Status

Attending or Courtesy members who have demonstrated an affiliation with the patient care, teaching, and research programs of the Hospital, but who have not been involved in patient care or clinical oversight for a period of two years shall be known as inactive members. Such members shall have no privileges or responsibilities. Inactive members shall automatically terminate their inactive staff membership at the end of two years.

6. Limitation of Perogatives: The prerogatives set forth under each staff category are general in nature and may be subject to limitation by special conditions attached to a practitioner's staff membership, by other sections of these Bylaws, by the Rules and Regulations of the Medical Staff, or by Hospital or governing body policies.

Section C. Procedure for Medical Staff Appointment

- 1. All initial appointments and reappointments shall be made by the Chancellor upon the recommendation of the Credentials Committee.
 - a. Applications for appointment to the Medical Staff shall be screened by the Chair, Department of Psychiatry ("the Chair"), who shall be responsible for verifying statements made by the Applicant, delineating the service privileges for which the Applicant shall qualify, and attesting to the health status of the Applicant.

- b. After review and investigation of the completed and signed application, Chair's recommendation and such other information as may be deemed pertinent (see Clinical Privileges Plan, #9, Section VII, D), the Credentials Committee will recommend approval or disapproval of the application.
 - c. Applications for reappointment to the Medical Staff shall also be based upon review of the clinical activities of the individual while a member of the Medical Staff as well as evidence of continuing currency in the Member's area of practice and shall be subject to expansion or reduction of clinical privileges.
2. In making application, the Applicant signifies willingness to appear for interviews; authorizes the Credentials Committee to consult with others who may have information bearing on competence or qualifications; and consents to examination of records that may be material to evaluation of competence and qualifications to carry out the clinical privileges requested, establishment of physical or mental health status, and assessment of professional ethical qualifications. The Applicant furthermore releases the Chair, the Credentials Committee, and its representatives from any liability for their acts performed in good faith and without malice in connection with evaluation of the application, and recognizes that the privileges accorded practitioners at the Hospital shall be considered a public record.
3. It shall be the responsibility of the Applicant to provide such documentation as may be required by the Credentials Committee in a form specified by the Committee. The Applicant shall have the burden of producing adequate information for evaluation of the application.
4. The Credentials Committee shall develop and maintain procedures for the timely review of applications and recommendations thereof (see Clinical Privileges Plan, #9, Section VII, D). However, the time for consideration and action by the Credentials Committee shall not exceed ninety (90) days from the time of receipt of the completed application. The decision to grant, limit or deny privileges or an existing privilege petitioned for renewal is communicated to the requesting practitioner within the current month or within 30 days.
5. A Medical Staff Member may request modification of clinical privileges at any time by written application to the Credentials Committee.

Section D. Termination or Suspension of Medical Staff Membership, Reduction of Clinical Privileges, and Other Corrective Action

1. Grounds for action:

- a. Noncompliance with Medical Staff Bylaws and Rules and Regulations. This shall include, but not be limited to, failure to disclose information pertinent to and necessary in the evaluation of a member's qualifications for appointment or reappointment to the Medical Staff.
- b. Violation of specific rules of the Hospital or this Medical Staff. This shall include, but not be limited to, failure to complete medical records, failure to adhere to approved admitting and discharge policies, or failure to discharge Attending staff responsibilities relative to consultation and call.
- c. Misconduct. This shall include, but not be limited to, violations as indicated in Section D.1.b above, abandonment of a patient, disruptive behavior, violation of the American Medical Association Principles of Ethics or the American Psychological Association's Business Code, or falsification of records.
- d. Care below applicable standards. This shall include, but not be limited to, incompetence, unprofessional conduct (as excluded from Section D.1.c above), failure to adhere to patient care policies of the Hospital, clinical performance below the standards of practice established by the Hospital, provision of suboptimal and/or substandard care, consistent misdiagnosis, and/or a demonstrated lack of clinical competence.
- e. Personality conflict. Inability to work in harmony with others or evidence of disruptive behavior may be cause for such action.

2. Procedures:

- a. Any person may provide information to an officer of the Medical Staff, the Director of Clinical Services, the Chair, or the Chancellor about the conduct, performance, or competence of its members. Any Member of the Active Medical Staff, the Director of Clinical Services, or the Chancellor may request the Executive Committee of the Medical Staff to institute action against a Medical Staff Member when there are grounds for action as set forth herein. Requests for corrective action shall be in writing to the Executive Committee of the Medical Staff and shall be supported by reference to specific activities or conduct constituting grounds for the request.
- b. Within 15 days of receipt of the request to institute corrective action, the Executive Committee of the Medical Staff shall assign the conduct of an investigation to the Credentials Committee. The Member shall be notified that an investigation is being conducted and may be given an opportunity

to provide information in a manner and upon such terms as the investigating body deems appropriate. The Member's failure without good cause to attend any investigating body committee meeting upon request shall constitute a waiver of his/her rights. Following full investigation, a report of findings and recommendations will be made to the Executive Committee of the Medical Staff within 30 days of receipt of the assignment. The Executive Committee of the Medical Staff may authorize extension of this time period for good cause.

- c. If a member or members of the Credentials Committee or the investigating body have a conflict of interest, such person(s) shall not sit on either committee when the corrective action issues are being discussed nor shall such person(s) vote or take an action, formal or informal, which may have a tendency to influence the decision for corrective action.
- d. Within five days of receipt of the report of findings and recommendations, the Credentials Committee shall notify the affected staff Member, furnish copies of the request for corrective action and the report of findings and recommendations, and offer him/her an opportunity to make an appearance before the Credentials Committee prior to taking adverse action against the affected staff Member. Neither this appearance nor the investigation referred to herein shall constitute a hearing. This appearance shall be at the next regularly scheduled meeting of the Credentials Committee, shall be preliminary in nature, and none of the procedural rules of the Bylaws with respect to hearings shall apply.
- e. The Credentials Committee may take any of the following actions on a request for corrective action after reviewing the findings and recommendations, giving the affected staff Member an opportunity to make an appearance as specified in this Article, and considering any past remedial action involving the same or similar acts or omissions:
 - (1) Determine no corrective action be taken and, if the Credentials Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the Member's file.
 - (2) Defer action for a reasonable time where circumstances warrant.
 - (3) Recommend the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring.

- (4) Recommend reduction, modification, suspension, or revocation of clinical privileges.
 - (5) Recommend reduction of membership status or limitation of any prerogatives directly related to the Member's delivery of patient care.
 - (6) Recommend suspension, revocation, or probation of Medical Staff membership.
 - (7) Take other appropriate action.
 - (8) Recommend to the Chancellor that an already-imposed summary suspension of privileges, as described in this Article, be terminated, modified, or sustained.
- f. Any action of the Credentials Committee which, pursuant to these provisions, constitutes grounds for a hearing shall entitle the affected Member to the procedural rights contained in Section E, Fair Hearing Plan.
- g. Despite the status of any investigation, the Credentials Committee shall at all times retain authority and discretion to take or recommend whatever action may be warranted by the circumstances, including summary suspension, termination of the investigation process, or other action.
- h. If the Executive Committee of the Medical Staff fails to investigate or initiate corrective action and the Chancellor determines that its failure to do so is contrary to the weight of the evidence then available, the Chancellor may, after consulting with the Executive Committee of the Medical Staff, direct the Executive Committee of the Medical Staff to investigate or initiate corrective action. If the Executive Committee of the Medical Staff fails to act after a directive from the Chancellor, the Chancellor may, in accordance with these Bylaws, after written notice to the Executive Committee of the Medical Staff, take action directly against a Medical Staff member. If the action is favorable to the practitioner, or if it constitutes an admonition, reprimand, or warning to the practitioner, it shall become effective as the final decision of the Chancellor.

3. Summary suspension:

- a. Any one of the following shall have the authority summarily to suspend or restrict all or part of the privileges and/or membership of a Medical Staff Member whenever the Member's conduct appears to require that immediate action is necessary to protect the best interest of the Hospital, to protect the life of any patient, or to reduce the likelihood of imminent danger to the health or safety of any individual: the Officer of the Medical Staff, the Executive Committee of the Medical Staff, the Chief of a Clinical Service, the Director of Clinical Services, and/or the Chancellor.
- b. A summary restriction or suspension shall be effective immediately upon imposition; however, a summary restriction or suspension imposed by the Chancellor must be ratified by the Executive Committee of the Medical Staff within two (2) working days of its imposition, excluding weekends and holidays, or it shall terminate automatically.
- c. Unless otherwise stated, a summary suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice of the suspension or restriction to the Member and the person or bodies set forth in the previous section. The summary suspension or restriction may be limited in duration and shall remain in effect for the period stated or, if unlimited in duration, until otherwise resolved. The President of the Medical Staff or responsible Chief of the Clinical Service, shall provide for alternative medical coverage for patient care with the wishes of the patients taken into consideration.
- d. A staff Member who has been summarily suspended or restricted shall be entitled to request a hearing on the matter according to procedural rights outlined in Section E, Fair Hearing Plan.
- e. In the event that the Credentials Committee determines that an investigation is warranted, it shall direct an investigation to be conducted immediately in accordance with these Bylaws. The summary suspension or restriction shall remain in effect until a final decision by the appropriate judicial or quasi-judicial body and all procedural rights contained in Section E have been exhausted.

4. Automatic suspension:

- a. Revocation and suspension. Whenever a Member's license or other legal credential authorizing practice in this state is revoked or suspended, Medical Staff membership and clinical privileges shall be revoked or suspended automatically as of the date such action becomes effective and throughout its term.

- b. Restriction. Whenever a Member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the Member has been granted at the Hospital which are within the scope of said limitation or restriction shall automatically be limited or restricted in a similar manner as of the date such action becomes effective and throughout its term.
- c. Probation. Whenever a Member is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.
- d. Failure to maintain professional liability insurance with limits of liability required by the University and naming The Regents of the University of California as an additional insured, with provision for notice to The Regents 30 days prior to cancellation or termination, shall constitute automatic suspension of all privileges and membership on the Medical Staff.
- e. The President of the Medical Staff and the Director of Clinical Services shall have the duty of enforcing all automatic suspensions.
- f. Whenever a Member's DEA certificate is revoked, limited, or suspended, the Member shall be divested automatically of the right to prescribe medications covered by the certificate as of the date such action becomes effective and throughout its term.

Section E Fair Hearing Plan

- 1. Request for hearing:
 - a. The hearing and appeals procedure is the administrative adjudicatory process for resolution of actions to be taken against Medical Staff Members. An aggrieved Medical Staff Member must follow the applicable procedures set forth in Section D prior to invoking the process set forth in Section E and must exhaust the remedies set forth in these Bylaws before resorting to legal action.
 - b. Notice of decision. In any case where action has been taken constituting grounds for hearing, as set forth in the subsection Grounds for Hearing (Section E.1.c), the Applicant or Medical Staff Member, as the case may be, shall be notified promptly by the President of the Medical Staff with a

written communication sent by certified or registered mail, return receipt requested. The Applicant or Member shall have 30 days following date of the mailing of the notice within which to request a hearing by a Hearing Committee, as defined in Section E.1.g, Hearing Committee. The Applicant or Member shall also be given a copy of Article III, Section E, Fair Hearing Plan. The request shall be made in writing and sent by certified or registered mail, return receipt requested, to the President of the Medical Staff. In the event the applicant or member does not request a hearing within 30 days following mailing of notice to him/her and in the manner described within this subsection, he/she shall be deemed to have accepted this action.

- c. Grounds for hearing. Any one or more of the following actions shall constitute grounds for a hearing:
- (1) Denial of application for Medical Staff membership.
 - (2) Denial of Medical Staff reappointment.
 - (3) Denial of promotion from probationary to regular status.
 - (4) Demotion to a lower staff category.
 - (5) Suspension or summary suspension from Medical Staff membership, except suspension resulting from action by the appropriate State of California examining board to suspend the license of a Medical Staff member, or his/her placement on probation.
 - (6) Revocation of Medical Staff membership, except expulsion resulting from action by the appropriate State of California examining board to revoke the license of a Medical Staff member.
 - (7) Denial of requested privileges (excluding temporary privileges).
 - (8) Involuntary reduction of privileges (excluding temporary privileges).
 - (9) Suspension or summary suspension of privileges (excluding temporary privileges).
 - (10) Termination of privileges (excluding temporary privileges).
- d. Time and place of hearing. Upon receipt of a request for a hearing, the President of the Medical Staff shall schedule a hearing and, within 15 days (but in no event less than ten days prior to the hearing) give written notice sent registered or certified mail, return receipt requested, to the Member of

the time, place, and date of the hearing. The date of commencement of the hearing shall be not less than five days, nor more than 90 days from the date of receipt of the request by the President of the Medical Staff for a hearing; however, when the request is received from a Member who is under summary suspension, the hearing shall be held as soon as arrangements may reasonably be made, but not to exceed 45 days from the date of receipt of the request.

- e. Notice of charges. As a part of, or together with, the notice of hearing, the Credentials Committee shall state in writing in concise language the acts or omissions with which the Medical Staff Member is charged, a list of charges to include medical record numbers, if applicable, or the reasons for the denial of the request of the Applicant or Medical Staff Member.
- f. Witnesses. Each party shall have the right to present witnesses. If either party by notice to the other requests a list of witnesses, the recipient, within ten days, shall furnish to the other a list in writing of the names and addresses of the individuals, so far as is then reasonably known, who will give testimony or evidence at the hearing. If a party fails to provide names and addresses of witnesses, the hearing officer in his/her discretion may preclude the testimony of witnesses whose names have not been disclosed. In any event, each party shall furnish to the other a written list of the names and addresses of the individuals.
- g. Hearing Committee. When a hearing is requested, the President of the Medical Staff shall appoint a Hearing Committee which shall be composed of not less than three members of the Attending Medical Staff who shall not have actively participated in the consideration of the matter involved at any previous level. The Hearing Committee shall consist of individuals who are not in direct economic competition with the Members or Applicant involved. The Hearing Committee shall nominate, from amongst its members, a Chairperson. Knowledge of the matter involved shall not preclude a member from serving on the Hearing Committee.
- h. Prehearing conduct. While neither side in a hearing shall have any right to discovery of documents or other evidence in advance of hearing, the hearing officer may confer with both sides to encourage an advance mutual exchange of documents which are relevant to the issues to be presented at the hearing. It shall be the duty of the Member and the Credentials Committee or its designee to exercise reasonable diligence in notifying the Chairperson of the Hearing Committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that the hearing officer may make prehearing decisions concerning such matters. Reconsideration of any prehearing decisions may be made at the hearing.

- i. Postponements and extensions. Postponements and extensions of time beyond the times expressly permitted in these Bylaws in connection with the hearing process may be requested by any party and may be permitted by the Hearing Committee or its Chairperson acting upon its behalf.
2. Hearing procedure:
- a. Failure to appear. If a person requesting the hearing fails to appear and proceed at such a hearing, this will constitute that person's voluntary acceptance of the recommendations or actions involved, and these recommendations or actions will become final and effective immediately.
 - b. Representation. The hearings provided for in these Bylaws are for the purpose of professional resolution of matters bearing on conduct or professional competency. Accordingly, the person requesting the hearings may be represented by the person or legal counsel of his/her choice. However, the person requesting the hearing must notify the Secretary of the Medical Staff, in writing, of his/her intention to be so represented no later than five days after submission of the request for a hearing.
 - c. The hearing officer. At the request of the person who requested the hearing, the Credentials Committee, the Hearing Committee, or on his/her own motion, the Chancellor, will appoint a hearing officer, who may be an attorney at law, to preside at the hearing. The hearing officer shall not act as a prosecuting officer nor as an advocate for the Hospital, Chancellor, or Credentials Committee. If requested by the Hearing Committee, he/she may participate in the deliberations of such body, but he/she shall not be entitled to vote. The Chairperson of the Committee shall be the hearing officer if the Chancellor has failed to appoint a hearing officer. The hearing officer shall act to provide that all participants in the hearing have a reasonable opportunity to be heard, to present all oral and documentary evidence, and to insure that decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or admissibility of evidence. If the hearing officer determines that either party in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary actions as seem warranted by the circumstances.
 - d. Record of hearing. The Hearing Committee shall maintain a record of the hearing by one of the following methods: a tape-recording or a shorthand reporter present to make a record of the hearing. The cost of shorthand reporting shall be borne by the party requesting same.

- e. Rights of both sides. At a hearing, both parties shall have the following rights: to call and examine witnesses, to introduce exhibits, to cross-examine any witness on any matter relevant to the issues, to impeach any witness, and to rebut any evidence. Both parties to the proceedings shall have a right to submit a written statement at the close of the hearing. The hearing shall be confidential and closed to the public.
- f. Admissibility of evidence. Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses and presentation of evidence need not apply to a hearing conducted under this Article. Any relevant evidence shall be admitted by the hearing officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a memorandum to be filed following the close of the hearing. The Hearing Committee may interrogate the witnesses or call additional witnesses if it deems it appropriate.
- g. Official notice. The hearing officer shall have the discretion to take official notice of any matters 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. Either party may request that a matter be officially noticed or 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.
- h. Basis of decision. The decision of the Hearing Committee shall be based only on the evidence admitted at the hearing. Hearsay alone shall not be used as a basis for a finding of fact.
- i. Burden of proof. At any hearing involving evidence or the receipt of closing written arguments, if requested, the hearing shall be closed. The Hearing Committee shall conduct any deliberations outside the presence of any other person unless the hearing officer is invited to participate in accordance with Section E.2.c.
- j. Decision of the Hearing Committee. Within 15 working days after the final adjournment of the hearing, the Hearing Committee shall render a final written decision which shall contain a concise statement of the reasons justifying the decision made. The decision shall be delivered to the Credentials Committee, the Executive Committee of the Medical Staff, the Director of Clinical Services, and the Chancellor. At the same time, a copy of the decision shall be delivered to the Applicant or Member who

requested the hearing by registered or certified mail, return receipt requested.

- k. Appeal. The decision of the Hearing Committee shall be final, subject only to the right of appeal as outlined in Section E.3.

3. Appeal:

- a. Time for requesting appeal. Within ten days after receipt of the decision of the Hearing Committee, either the person who requested the hearing or the Credentials Committee may request an appellate review by a Review Committee. This request shall be delivered either in person or by certified or registered mail, return receipt requested, to the Chancellor. If such appellate review is not requested within such period, the Hearing Committee's decision shall be final and effective immediately upon expiration of that ten-day period.
- 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:
 - (1) Substantial noncompliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice.
 - (2) The decision was not supported by substantial evidence based upon the hearing record.
 - (3) The decision is not sustainable in light of new evidence as may be permitted pursuant to Section E.3.e.
- c. Time, place and notice. In the event of any appeal to the Review Committee as set forth in the preceding subsection, the Chancellor shall, within 15 days after receipt of such notice of appeal, schedule and arrange for an appellate review if he/she determines that valid grounds exist for review. The Chancellor shall cause the Applicant or Member to be given notice of the time, place and date of the appellate review or that the request for appellate review is denied. The date of appellate review shall not be more than 30 days from the date of receipt of the request for appellate review; however, when a request for appellate review is from a Member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made. The time within which appellate review will be held may be extended by the Review Committee for good cause.

- d. Review Committee. A committee shall hear all appeals and shall be comprised of the Chancellor, the Dean of the School of Medicine, the Director of Clinical Services, and two additional Members from the Medical Staff who have not been involved in any aspect of the case to be heard and who are selected by the President of the Medical Staff. Knowledge of the matter involved shall not preclude any person from serving as a member of the Review Committee so long as that person did not take part in a prior investigation or hearing on the same matter. The Review Committee may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal.
- e. Review procedure. The proceeding by the Review Committee shall be in the nature of an appellate hearing based upon the record before the Hearing Committee provided that the Review Committee may accept new oral or written evidence, subject to a foundational showing that such evidence is not cumulative and could not have been made available to the Hearing Committee in the exercise of reasonable diligence. Presentation of such evidence shall be subject to the same rights of cross-examination or confrontation provided to the Hearing Committee. The Review Committee may remand the matter to the Hearing Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel in connection with the appeal, and to present a written statement in support of his/her position on appeal. In its sole discretion, the Review Committee may allow each party or representative to appear personally and make oral argument. The Review Committee may conduct deliberations outside the presence of the parties and their representatives.
- f. Final decision. Within ten days, or as soon thereafter as reasonably possible at the conclusion of the proceedings, the Review Committee shall render a final decision in writing and shall deliver copies to the parties and to the Executive Committee of the Medical Staff in person or by certified or registered mail, return receipt requested. The final decision of the Review Committee shall be effective immediately.

ARTICLE IV

CLINICAL PRIVILEGES

Section A. Requirements for Clinical Privileges

1. Every Member by virtue of Medical Staff membership shall be entitled to exercise only those clinical privileges specifically granted to him/her.

2. Every initial application for any category of staff appointment or application for reappointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated current competence and judgment, clinical performance, health, references, the documented results of patient care and other quality review and monitoring which the medical staff deems appropriate, and other relevant information, including an appraisal by the Hospital. The applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges he/she requests.
3. Periodic redetermination of clinical privileges and the increase or curtailment of same shall be based upon, review of the records of patients treated, review of Medical Staff documentation which provides information about the member's participation in the delivery of medical care, and the other factors described in Article III.C.

Section B. Temporary and Visiting Privileges

a. Visiting Privileges:

In circumstances in which patients or an academic program require the services of a provider who is not a member of the Medical Staff or Allied Health Staff, visiting privileges may be granted on a case by case basis to fulfill an important patient care need.

1. Visiting privileges do not include admitting privileges. No person shall receive more than two (2) privilege appointments and each privilege appointment shall be granted for 60 days. Providers with visiting privileges are not eligible to vote or hold office.

Visiting privileges may be granted after the applicant submits a complete visiting application and primary source verification of the following occurs by the Medical Staff Office:

- current licensure;
- relevant education and experience;
- current competence;
- ability to perform the privileges requested; and
- Other criteria listed in the Credentialing Policy and Procedures for visiting privileges.

b. Temporary Privileges

In circumstances in which a new applicant for Medical Staff or Allied Health Staff membership is waiting for approval by the Governing Body, temporary privileges may be granted for up to 90 days.

Temporary privileges may be granted after the applicant completes the Medical Staff membership application and primary source verification of the following occurs by the Medical Staff Office:

- Current licensure;
- Relevant education/training and experience;
- Current competence;
- Ability to perform the Privileges requested
- Other criteria listed in the Credentialing Policy and Procedures for Initial Appointments

c. General Conditions and Termination

- i. All requests for Visiting or Temporary privileges shall include a clinical rationale supporting the needed urgency of the privileges.
- ii. The results of the National Practitioner Data Bank and Medical Board of California queries have been obtained and evaluated.
- iii. The applicant has:
 - Filed a complete application with the Medical Staff office;
 - Demonstrated no current or previously successful challenge to licensure or registration exists;
 - Not been subject to voluntary/involuntary termination of medical staff membership at another organization; and
 - Not been subject to voluntary/involuntary limitation, reduction, denial, or loss of clinical privileges.
- iv. There is no right to visiting or temporary privileges. Accordingly, visiting or temporary privileges should not be granted unless the available information supports, with reasonable certainty, a favorable determination regarding the requesting applicant's qualifications, ability and judgment to exercise the privileges requested.
- v. If the available information is inconsistent or casts any reasonable doubts on the applicant's qualifications, action on the request may be deferred until the doubts have been satisfactorily resolved.
- vi. Visiting or Temporary privileges may be granted by the Department Chair, the President of the Medical Staff and the Credentials Committee Chair (or their designees) on the recommendation of the department chair where the privileges will be exercised.
- vii. A determination to grant visiting or temporary privileges shall not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff.

- viii. Providers granted visiting or temporary privileges shall be subject to the proctoring and supervision specified by the clinical department, or as described in these Bylaws, Rules and Regulations.
- ix. Visiting or Temporary privileges shall automatically terminate at the end of the designated period, unless affirmatively renewed, or earlier terminated, as provided in these Bylaws.
- x. Visiting or Temporary privileges may be terminated with or without cause at any time by the Department Chair, the President of the Medical Staff or the Credentials Committee Chair (or their designees). A person shall not be entitled to the procedural rights afforded by Bylaws Article III, Section J, Fair Hearing Plan.
- xi. Whenever visiting or temporary privileges are terminated, the appropriate department chair or, in the chair's absence, the President of the Medical Staff shall assign a member to assume responsibility for the care of the affected practitioner's patient(s).
- xii. All persons requesting or receiving visiting or temporary privileges shall be bound by the Bylaws and rules.

Section C. Disaster Privileges

- 1. Disaster Privileges may be granted when Langley Porter's emergency management plan has been activated and the organization is unable to handle the immediate patient needs. A medical disaster occurs when the destructive effects of natural or man-made forces overwhelm the ability of Langley Porter to meet the demand for health care services. Disaster privileges are granted pursuant to the Disaster Privileges Policy and Procedures.
- 2. If Disaster Privileges are granted, the provisions below apply.
 - a. Disaster Privileges may be granted by the Director of Administration, Director of Clinical Services, or their designees, based upon recommendation of the President of the Medical Staff, or in his or her absence, the recommendation of the responsible service director, upon presentation of any of the following:
 - (1) A current picture hospital identification card;
 - (2) A current license to practice and a valid picture ID issued by a state, federal or regulatory agency;
 - (3) Identification indicating that the practitioner is a member of a Disaster Medical Assistance Team (DMAT);

- (4) Identification indicating that the practitioner has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity;
 - (5) Presentation by current Langley Porter Psychiatric Hospital and Clinics or Medical Staff Member(s) with personal knowledge regarding the practitioner's identity.
3. Persons granted Disaster Privileges shall wear identification badges denoting their status as a DMAT member.
4. The Medical Staff office shall begin the process of verification of credentials and Privileges as soon as the immediate situation is under control, using a process identical to that described as Section C, Procedure for Medical Staff Appointment (except that the individual is permitted to begin rendering services immediately, as needed).
5. The responsible service chair shall arrange for appropriate concurrent or retrospective monitoring of the activities of practitioners granted Disaster Privileges. This must include one of the following as applicable – direct observation, record review or mentoring.
6. In the event of an emergency, any member of the Medical Staff [or any credentialed AHP] shall be permitted to do everything reasonably possible, within the scope of their licensure, to save the life of a patient or to save a patient from serious harm. The member [or AHP] shall promptly yield such care to a qualified member when one becomes available.

ARTICLE V

CLINICAL ORGANIZATION

Section A. Clinical Services

1. Purpose: the Hospital is an acute psychiatric hospital and all patients are admitted for treatment of psychiatric disorders. The Hospital consists of inpatient services for adults, and outpatient services for adults, children, and adolescents.
2. The Director of Clinical Services has full responsibility for the operation and management of the Hospital and is accountable for all professional and administrative activities. The Director of Clinical Services is responsible for: assessing needs on an ongoing basis; allocating resources; planning for changes in treatment services, training, and program evaluation; responding to community

needs, laws and regulations; coordinating the operations of the Hospital within the University of California, San Francisco system and external agencies; and negotiating all contractual agreements. She/he is responsible for monitoring the quality of patient care and professional performance rendered by individuals with clinical privileges who practice in the hospital and clinics; assuring that the quality and appropriateness of patient care provided within the Hospital are monitored and evaluated; recommending to the Medical Staff the criteria for clinical privileges in the Hospital; and recommending clinical privileges for each member of the Hospital. The Director of Clinical Services position is filled by the Chair, Department of Psychiatry, or by his/her appointee.

3. Clinical services at LPPH&C are organized into intensive services and outpatient services. Each is managed by a director who is responsible for the overall quality of the professional and administrative functions of the service. Each director is responsible to the Director of Clinical Services for the overall oversight of the clinical work and the administrative functions within his/her programs. The directors are appointed by the Director of Clinical Services and the Chair, Department of Psychiatry. The Directors are responsible for the following functions:
 - a. Plan, design, and implement the service goals to maintain high standards of clinical practice and administrative accountability.
 - b. Coordinate programs within the service to support the goals of the Hospital.
 - c. Review and approve the qualifications of and assign appropriate responsibilities to the various clinical and administrative personnel under span of control.
 - d. Ensure, the protection of patient rights, including informed consent, and the adherence to the Hospital procedures.
 - e. Assess the competence of new members of the Medical Staff. Make recommendations regarding clinical privileges based on evaluations of current clinical performance of physicians or psychologists under his/her oversight.
 - f. Functions as the medical staff leader for his/her programs in utilization management activities.
 - g. Actively participates in the Hospital's performance improvement activities
4. Each inpatient and outpatient treatment program is managed by a Chief of Service, a qualified professional who shall be responsible to the Director of

Clinical Services for the overall oversight of the clinical work within his/her unit or program. The Chiefs of Services are appointed by the Director of Clinical Services and the Chair, Department of Psychiatry. The Chief of Service is responsible for the following functions:

- a. Plan, design, and implement the program's goals to maintain high standards of clinical practice
- b. Determine the number of appropriately qualified clinical, administrative, and support staff necessary to meet the clinical service needs of the program.
- c. Ensure that the selection, evaluation, advancement, and termination of staff members are carried out in accordance with Hospital and University policies.
- d. Review and approve the qualifications of and assign appropriate responsibilities to the various clinical and administrative personnel who are part of the program.
- e. Ensure that clinical responsibilities assigned to members of the treatment team are appropriate and in keeping with their established, approved clinical privileges and recognized competence and abilities.
- f. Ensure, on behalf of all patients in the program, the protection of patient rights, including informed consent, and the adherence to the Hospital procedures.
- g. Ensure the development and implementation of individualized treatment plans for all patients of the program and that appropriate documentation is included in the patient's record.
- h. Ensure, prior to implementation, review of the rationale, justification, and necessity of the use of special treatment procedures such as restraint and seclusion.
- i. Serve as a member of the Executive Committee of the Medical Staff, as appointed.
- j. Serve as a proctor to assess the competence of new members of the Medical Staff, and to make recommendations regarding clinical privileges based on evaluations of current clinical performance of physicians or psychologists under his/her oversight.
- k. Assume responsibility for oversight of house staff and other professional trainees assigned to the service or program.

- I. Function as the service leader in utilization management activities for assigned clinical staff.
 - m. Actively participate in the Hospital's performance improvement activities.
4. The Hospital treatment programs are:
 - a. Inpatient and Partial Hospitalization Services (adult)
 - b. Outpatient Services (child, adolescent, adult)
 - c. Detailed description of programs in Policy 100

Section B. Department Chair

1. The Department of Psychiatry ("the Department") shall have a chair who shall serve as Chair of the Department of Psychiatry in the School of Medicine.
2. The Department chair shall be an active Medical Staff member certified by an appropriate specialty board in at least one of the clinical areas covered by the Department or shall satisfy the Credentials Committee of equivalent competence, and shall be willing and able to discharge faithfully the functions of his or her office.
3. The Department chair shall have the following duties and responsibilities, subject to the authority of the Chancellor and The Regents to:
 - Maintain membership on the Medical Staff
 - Supervise and evaluate all clinically related activities of the department
 - Supervise and evaluate all administratively related activities of the department, unless otherwise provided by the hospital
 - Administer and implement these Bylaws, Rules, and Regulations within the Department to continually survey the professional performance of all individuals in the department who have delineated clinical privileges
 - Recommend to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department
 - Screen all Departmental applications for clinical privileges and make recommendations for clinical privileging to the Credentials Committee. Provide applicant evaluations in accordance with the provisions of these Bylaws for all appointments and reappointments. No appointment or re-appointment shall be made without a recommendation of the chair.

- Assure that Members of the Department practice within the limits of privileges assigned to them and in accordance with the Medical Staff Bylaws and Rules and Regulations as well as the applicable sections of Title 22 of the California Code of Regulations, Conditions of Participation of the health Care Financing Administration and guidelines set forth by the Joint Commission of Accreditation of Healthcare Organizations.
- Promptly report the failure of any Medical Staff member to discharge patient care responsibilities in accordance with the standard practice within the community and these Bylaws, Rules and Regulations, and recommend appropriate disciplinary actions.
- Assume or assign patient care responsibilities on behalf of any Member of the Department who shall be unable to carry out same by virtue of disciplinary action, illness, or other causes.
- Receive information and take action on, as may be appropriate, issues of quality of care and professional standards regarding Members of the Department.
- Assess and recommend to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization
- Coordinate and integrate interdepartmental and intradepartmental services
- Develop and implement policies and procedures that guide and support the provision of care, treatment, and services
- Assure that there is adequate coverage of the services provided by the Department. Coverage includes assessment and assignment of a sufficient number of qualified and competent persons to provide care, treatment, and services. Appropriate back-up and on-call services shall also be provided. The Chair shall inform the President of the Medical Staff and/or the Director of Clinical Services of coverage deficiencies or inability to provide services.
- Determine the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services
- Continually assess and improve the quality of care, treatment, and services
- Establish and maintain quality control programs to evaluate the quality of care, as appropriate
- Assure adequate orientation and continuous education to all persons in the department or service
- Recommend space and other resources needed by the department or service.

4. The Chair is appointed by the Chancellor upon recommendation of the Dean and is reviewed at five-year intervals.

ARTICLE VI

OFFICERS OF THE MEDICAL STAFF

Section A. Officers and Their Duties

1. President. The President shall be responsible for:
 - a. Calling, preparing the agenda for, and presiding over meetings of the Executive Committee of the Medical Staff and Medical Staff.
 - b. Appointing Chairs and members of the Medical Staff committees, and appointing proctors.
 - c. Establishing and disbanding special committees of the Medical Staff, subject to approval of the Executive Committee of the Medical Staff.
 - d. Serving as an ex-officio member of all Medical Staff committees.
 - e. Representing the views, policies, needs, and grievances of the Medical Staff to the Director of Clinical Services, the Chancellor, and The Regents, and representing the Medical Staff for the purpose of receiving and acting upon policies of the University of California, San Francisco and its School of Medicine.
 - f. Representing the Medical Staff for the purpose of receiving and acting upon policies of the Hospital.
 - g. Reporting on a regular periodic basis to the Executive Committee of the Medical Staff on the performance and quality of delegated responsibilities for the provision of patient care services.
 - h. Reporting on a regular periodic basis to the Chancellor and The Regents on the performance and quality of delegated responsibilities for the provision of patient care services.
 - i. Representing the Medical Staff in external professional and public relations.

- j. Participating in the Fair Hearing Plan as indicated in Article III.E.
2. President Elect. The President Elect shall succeed the President following his/her two-year term. The President Elect shall function in place of the President, if the President is absent. The President Elect shall chair the Quality Council (Committee of the Whole).
 3. Secretary. The Secretary shall be responsible for:
 - a. Maintaining accurate and permanent records of all meetings of the Medical Staff, Executive Committee of the Medical Staff, and Medical Staff committees.
 - b. Handling all Medical Staff correspondence.
 - c. Serving or assigning a representative to serve as an ex-officio member of all Medical Staff committees.
 - d. Establishing systems for the gathering, maintaining, and reporting of Medical Staff information required by government agencies and other external parties.
 - e. The duties of the Secretary shall be performed by the Director of Clinical Services or his/her designee.

Section B. Election and Tenure of Officers

1. The President and President Elect shall be Members of the Attending Staff at the time of nomination and election and must retain membership during their terms of office. Failure to maintain such status shall create a vacancy in the office.
2. The President and President Elect shall serve two-year terms beginning on January 1 and ending on December 31, or shall serve until a successor is elected.
3. Nominations for the office of President Elect shall be made by the Executive Committee of the Medical Staff and announced at a meeting of the Medical Staff. Further nominations may be made from the floor.
4. Voting shall be conducted by secret mail ballot with election by a plurality of the votes cast.
5. After serving in office, the President Elect shall succeed to the office of President. Should the President leave office before expiration of the term, the President Elect shall complete the remaining portion of the term as well as the succeeding

term as President. If the President Elect leaves office prior to expiration of the term, a successor will be nominated and elected as provided in Section B.3 and 4 above.

6. The Director of Clinical Services shall serve as permanent Secretary of the Medical Staff.
7. Officers may be removed for failure to perform duties and responsibilities as outlined under Section A of this Article (VI.A). Officers may be removed from office by a two-thirds vote of the Executive Committee of the Medical Staff, or by a two-thirds vote at any annual or special meeting of the Medical Staff.

ARTICLE VII

EXECUTIVE COMMITTEE OF THE MEDICAL STAFF

Section A. Membership

1. The Executive Committee of the Medical Staff shall consist of the following members:
 - a. The Secretary.
The Director of Clinical Services or his/her designee attends each meeting of the Executive Committee of the Medical Staff.
 - b. The President and President Elect.
 - c. The Director of Ambulatory Services.
 - d. The Director of Intensive Services.
 - e. The Director of Pharmacy.
 - f. The Director of Patient Care Services.
 - g. The Department Chair.
2. A quorum shall consist of five members, three of whom are Attending Medical Staff members.
3. Any member of the Medical Staff actively practicing in the hospital is eligible for membership on the Executive Committee

Section B. Duties of the Executive Committee of the Medical Staff

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

1. To establish Rules and Regulations for the functions of the Medical Staff consistent with the purposes delineated in these Bylaws.
2. To coordinate the activities and general policies of the various services and to be responsible for the quality of patient care provided by them.
3. To establish such committees as may be necessary to govern clinical activities at the Hospital.
4. To review, approve, and act on recommendations of the committees of the Medical Staff.
5. To act for the Medical Staff as a whole under such limitations as may be imposed by the Medical Staff.
6. Is empowered to act for the Medical Staff in the intervals between Medical Staff meetings.
7. To support the strategic initiatives and objectives of the Hospital.
8. To assure conformity, where indicated, with external licensure, certification, and accreditation requirements.
9. To review the credentials of applicants for medical staff membership and delineated clinical privileges.
10. To make recommendations regarding the mechanism designed to review credentials and delineate individual clinical privileges to the governing body.
11. Make recommendations for medical staff membership and delineated privileges to the governing body.
12. To organize the Medical Staff's performance improvement activities and establish a mechanism designed to conduct, evaluate, and revise such activities.
13. Develop the mechanism by which Medical Staff membership may be terminated
14. Create the mechanism designed for use in fair hearing procedures.

Section C. Meetings of the Executive Committee of the Medical Staff

1. The Executive Committee of the Medical Staff shall meet monthly and shall hold such additional meetings, at the call of the President or any three members, as may be necessary for the conduct of its business.
2. A permanent record shall be kept of the minutes of all meetings, and a report of Committee actions shall be made annually to the Medical Staff at a quarterly meeting.

ARTICLE VIII

COMMITTEES OF THE MEDICAL STAFF

Section A. Membership

Except as otherwise noted below, and with the approval of the Executive Committee of the Medical Staff and the Chancellor, the President shall appoint a chair and members for all committees and subcommittees of the Medical Staff. Each shall be composed of at least three Members of the Medical Staff and such additional Members and nonmembers as may be appropriate.

Section B. Meetings

Standing committees and subcommittees of the Medical Staff shall meet monthly, and additionally as necessary to conduct their business. A written record of these meetings shall be maintained and provided to the Executive Committee of the Medical Staff and the Chancellor. Unless otherwise specified, at least two of the active Medical Staff members of a committee shall constitute a quorum. Persons serving as ex-officio members of a committee shall have all rights and privileges of regular members except that they shall not be counted in determining the existence of a quorum and shall not be eligible to vote unless so designated in these Bylaws.

Special committees of the Medical Staff shall meet as necessary to conduct their business and shall report to the Executive Committee of the Medical Staff.

Section C. Authority and Responsibility

All committees shall enjoy the authority and responsibility defined in these Bylaws subject to the authority of the Executive Committee of the Medical Staff and the Chancellor and shall carry out these responsibilities and other duties assigned to them by the President.

The Medical Staff of the Hospital is a small group. To reflect the size of the organization the committee structure is organized into four standing committees.

Section D. Standing Committees

1. Executive Committee of the Medical Staff

This committee, in addition to duties outlined in Article VII.B, is responsible for oversight of all functions of the Medical Staff and for preparation of a slate of nominees for officers of the Medical Staff as follows:

- a. Nominating Function. The Committee nominates one candidate biennially for President Elect of the Medical Staff and presents this name at a quarterly meeting of the Medical Staff.

2. Quality Council

The Quality Council is responsible for the following Medical Staff functions: medical records; pharmacy and therapeutics; utilization management; infection control; risk issues and safety-related practices; and performance improvement activities. On a scheduled basis, the Council reviews and evaluates data and findings from these functions. The Council also considers patient satisfaction data and patient/family complaints. The Quality Council shall function as the LPPH&C Committee of the Whole and shall regularly report its findings to the Executive Committee of the Medical Staff and to the LPPH&C Leadership Committee.

- a. The Quality Council shall specifically review goals and objectives of the organization as well as significant sources of data which include but are not limited to: findings of continuous monitoring activities; feedback from patients and families, the community, and other customers; regulatory findings and requirements; strategic planning; and program evaluation information.
- b. Performance Improvement Function: The Quality Council shall monitor and evaluate, objectively and systematically, the quality and appropriateness of patient care in order to pursue opportunities to improve patient care, to resolve identified problems, and to evaluate the effectiveness of the scope of practice of the organization. The Council shall be responsible for the coordination of the overall performance improvement plan and program, and shall evaluate the actions of the organization in its implementation of the performance improvement plan.
- c. Utilization Management Function: The Quality Council shall be responsible for establishing utilization management standards and monitoring professional performance in order to assess the appropriateness of patient admission to the Hospital and continued care therein, and the appropriateness of services rendered on an ambulatory basis. The

Council shall monitor and evaluate the effectiveness and efficiency of the use of health care resources in providing patient care.

- d. **Medical Records Function:** The Quality Council shall be responsible for the form and content of medical records and shall approve the format of all materials filed therein. The committee shall appraise the quality of patient records, assuring that they meet necessary standards of patient care, usefulness, and historical validity, shall assure that all records reflect accurate documentation of medical events, and shall establish standards for the content and timely completion of records.
- e. **Pharmacy and Therapeutics Function:** The Quality Council shall establish or adopt a formulary, develop guidelines for the control and distribution of investigational drugs, and shall consider general problems of pharmacological therapeutics throughout the Hospital.
- f. **Infection Control Function:** The Quality Council shall examine all Hospital infections and shall establish proper precautions for the care of the Hospital's patients with communicable diseases. The Committee shall establish a program of environmental surveillance throughout the Hospital.
- g. **Risk Management Function:** The Quality Council shall review risk management activities for trends which may indicate practices which pose a potential for exposure. The Council shall recommend actions to be taken which may include: referral to the Executive Committee of the Medical Staff, Service Chiefs, and Discipline Directors; or drafting policy and procedure.
- h. **Safety Function:** The Quality Council shall function as the Environment of Care (EC) Committee and establish a safety program that includes risk assessment, hazard surveillance, collection/review/monitoring of safety activities and incident data, safety training and performance improvement measures for the seven areas of safety, security, fire prevention, emergency management, hazardous materials and waste, medical equipment and utilities. The Council shall evaluate the effectiveness of the seven EC program areas on an annual basis.
- i. The Quality Council shall report to the Executive Committee of the Medical Staff and to the LPPH&C Leadership Committee.

3. Credentials Committee

The Credentials Committee shall be responsible for recommending appointments and reappointments to the Medical Staff, delineating staff privileges, and applying corrective actions where indicated.

4. Peer Review Committee

- a. The Peer Review Committee shall meet at least monthly. This committee shall be responsible for monitoring and evaluating on a continual basis, the conduct, utilization, documentation and performance of its members to ensure quality and appropriateness of patient services and the clinical performance of each clinically privileged individual at LPPH&C. Minutes of these meetings shall be sent to the Executive Committee of the Medical Staff. These minutes shall document individual and aggregate review of clinical care and shall include:
 - (1) individual patient care monitoring;
 - (2) review of patient care incidents;
 - (3) other clinical care problems brought to the Committee's attention.
- b. The Peer Review Committee's evaluation shall be used by the Credentialing Committee for determining recommendations for reappointment of medical staff members, or the renewal or revision of individual clinical privileges. The Peer Review Committee shall receive minutes from committees and workgroups for review of the full range of clinical activities. The composition shall be determined annually by the Executive Committee of the Medical Staff to reflect the range of clinical services at LPPH&C.
- c. Minutes of its proceedings shall be maintained as privileged. The committee shall submit minutes of its meetings to the Executive Committee of the Medical Staff.

5. Well-Being Committee

- a. A primary obligation of any organized Medical Staff is to assure that the care provided to patients by its members is consistent with acceptable standards of quality and safety. The mental and physical health of those who provide care can be a significant factor in the failure to meet acceptable standards. The purpose of the Well-Being Committee is to support the Medical Staff in the education, identification, evaluation and monitoring of Medical Staff members who may be comprised in some way due to physical, mental or chemical dependency issues and/or behavioral problems. The Well Being Committee also assists the Medical Staff in the provision of education to its members about illness and impairment recognition.

Through the provision of preventive, supportive responses to the individual, the Medical Staff is able to meet its obligation to limit potential

risk to patient safety in a manner which makes its resources available to Members in the interests of maximizing Medical Staff Member health and preventing professional failure.

The University of California has adopted a policy which recognizes drug and alcohol dependence as treatable problems and which commits the University to offer services for employees and students with dependency problems. In accordance with this policy, the Hospital Medical Staff commits itself to the early recognition of potential disability on the part of its members and to the provision of supportive responses when problems are identified. The Medical Staff is furthermore committed to assuring that all such support, referrals, and other responses made to potentially disabled Medical Staff Members shall be as confidential as the investigative process allows, unless it has been demonstrated that the health or impairment of the Member poses a risk of harm to patients or staff.

- b. The Well-Being Committee strives to achieve this purpose through facilitation of treatment for, prevention of, and intervention in Medical Staff member impairment or potential impairment caused by chemical dependency, medical or behavioral problems.
- c. Policy and procedures shall be developed and implemented to confidentially manage Medical Staff member well-being matters which may affect patient care delivery and for which assistance to the Medical Staff member may be appropriate and necessary. The Well-Being Committee operates as a peer review committee and its activities and proceedings are protected under federal and state peer review statutory privileges and protections, including but not limited to those provided pursuant to California Evidence Code 1156.
- d. The Well-Being Committee commits to a non-punitive process that encompasses the following elements:
 - The education of medical staff members and hospital staff regarding recognition of potential impairment on the part of its members.
 - A confidential environment for self-referral to the Well-Being Committee by a medical staff member, as well as referral to the committee by other organization staff regarding medical staff colleagues.
 - Evaluation of the credibility of a complaint, allegation or concern.
 - Facilitation of referral of the affected medical staff member to the

appropriate professional internal and external resources for evaluation, diagnosis and treatment of the condition or concern.

- Maintenance of confidentiality of the medical staff member-, except under the following circumstances:
 - as limited by law or ethical obligation
 - when the health and safety of a patient is threatened; or
 - as may be necessary to obtain information to evaluate the credibility of a third party concern
 - complaint, allegation or concern which is brought to the committee.

- — Monitoring the affected medical staff member and the safety of patients until the rehabilitation or any required monitoring process is complete and periodically thereafter, if required.

•

- Reporting to medical staff leadership instances in which a Medical Staff Member fails to complete the required treatment program.

~~Reporting to medical staff leadership instances in which a Medical Staff Member fails to complete the required treatment program.~~

- Reporting to the President of the Medical Staff instances when there is evidence that the mental or physical impairment, chemical dependency or behavioral problem of the member is posing a risk of harm to patients or staff.

- e. In cases where a member has been diagnosed with a problem of chemical dependency, received treatment, and now has a Medical Staff appointment, it is the policy of the Medical Staff that lack of total abstinence is an indication for immediate investigation.
- f. The Well-Being committee will meet at the direction of the President of the Medical Staff or as required in managing a referred affected medical staff member through the investigative, evaluation and monitoring processes.
- g. The Well-Being committee is comprised of at least three Medical Staff members and Legal Affairs (ex officio). The Chair of the Well-Being Committee is a physician.

6. Ethics Committee

- a. The Director of Clinical Services appoints a member of the LPPH&C Medical staff to serve as a member of the UCSF Medical Center Ethics

Committee. This member is the liaison between the UCSF Ethics Committee and the LPPH&C Medical Staff. Ethical questions which arise at LPPH&C are directed to the designated liaison for discussion as part of the regular agenda of the UCSF Ethics committee.

- b. This committee is available for ethical consultations. The UCSF Ethics Committee meets regularly to identify and discuss issues involving medical ethics, to convene consultations to assist in resolution of clinical ethical dilemmas, to make recommendations about their resolution to the President of the LPPH&C Medical Staff and to educate its members and the hospital community on issues relating to medical ethics.
- c. The purpose of the Ethics committee is to provide guidance for the resolution of specific ethical dilemmas arising from direct patient care. The Ethics Committee provides consultative services to all clinical departments of UCSF.

Section E. Special Committees

With the concurrence of the Executive Committee of the Medical Staff, the President shall appoint such special committees as may be necessary for the proper functioning of the Medical Staff. The appointment of such special committees shall be reviewed annually.

ARTICLE IX

MEETINGS

Section A. Quarterly Meetings

The Medical Staff shall meet at least quarterly, with thirty days' advance notice to the voting membership.

Section B. Special Meetings

With thirty days' advance notice to the voting membership, the President may call a special meeting of the Medical Staff and with such advance notice shall call a special meeting at the written request of any ten voting Members of the Medical Staff.

Section C. Attendance at Meetings

Unless excused by the President or Chair of the Department, each Member is expected to attend one half of all Medical Staff meetings held each year. For the conduct of business at a special meeting, a simple majority of members of the Attending Staff with voting privileges shall constitute a quorum.

ARTICLE X

RULES AND REGULATIONS

The Executive Committee of the Medical Staff shall adopt such Rules and Regulations as may be necessary to assure the proper conduct of Medical Staff business. Such Rules and Regulations shall be consistent with these Bylaws, and may be amended by a majority vote of those present at any meeting of the Executive Committee of the Medical Staff.

ARTICLE XI

AMENDMENT OF BYLAWS

Section A. Amendment Procedure

The Bylaws may be amended at any Quarterly or Special Meeting of the Medical Staff provided that thirty days' advance written notice of the proposed amendments is given to the voting membership. Amendments shall require an affirmative vote of a majority of the Members present and eligible to vote and approval of the Chancellor.

Section B. Interim Amendment of Bylaws

The Bylaws may be temporarily amended by a majority affirmative vote at a regular or special meeting of the Executive Committee of the Medical Staff. Such temporary amendments shall be submitted to the Medical Staff at the next Quarterly or Special Meeting at which time they shall either be affirmed or disbanded according to the voting procedure described in Section A of this Article. Review of these Bylaws, Rules, and Regulations shall occur at least once every two (2) years and revisions made as may be necessary and appropriate.

The Executive Committee of the Medical Staff shall have the power to adopt such amendments to the Bylaws as are, in its judgment, technical modifications or clarifications, reorganization or renumbering of existing Bylaws, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression, or inaccurate cross-references. Such amendments shall be effective immediately, and shall be permanent if not disapproved by the Chancellor within 90 days after adoption by the Executive Committee of the Medical Staff. The action to amend may be taken by

motion and acted upon in the same manner as any other motion before the Executive Committee of the Medical Staff. Such approved amendments shall be communicated in writing to the Medical Staff at the next Quarterly Meeting, or sooner if deemed necessary by the Executive Committee of the Medical Staff or the Chancellor.