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PREAMBLE

In recognition of their responsibilities for the quality of patient care, the physicians, dentists, and other health care professionals at UCSF Medical Center (the "Medical Center"), 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 have delegated authority for the governance of the Medical Center to the Chancellor of the University of California, San Francisco. Consistent with University policies and procedures and actions of The Regents, the Chancellor shall otherwise govern all activities of the Medical Center.

DEFINITIONS

1. **ALLIED HEALTH PROFESSIONAL ("AHP")** means an individual, other than a licensed physician, dentist, clinical psychologist, or podiatrist, who provides direct patient care services in the Medical Center under a defined degree of supervision by a Medical Staff Member who has been granted clinical privileges. AHPs exercise judgment within the areas of documented professional competence and consistent with the applicable State Practice Act. AHPs are designated by the Governing Body to be credentialed through the Medical Staff Organization and provide patient care pursuant to approved standardized procedures and/or job descriptions, as defined in these Bylaws and related policies and procedures. The Governing Body periodically determines the categories of individuals eligible for clinical privileges as an AHP. Allied Health Professionals are not eligible for Medical Staff membership.
2. **CHANCELLOR** means the Chancellor of the University of California, San Francisco ("UCSF").
3. **CHIEF EXECUTIVE OFFICER ("CEO")** means the person appointed by the Governing Body to serve as Chief Executive Officer of UCSF Medical Center or his or her designee.
4. **CHIEF MEDICAL OFFICER ("CMO")** means a Practitioner appointed by the Governing Body (or designee) to serve as a liaison between the Medical Staff and the administration.
5. **CHIEF OF CLINICAL SERVICE or SERVICE CHIEF or CHIEF OF SERVICE** shall mean the individual who is responsible for administration and oversight of their respective clinical service at the Medical Center pursuant to the provisions of Article IV, Section B.
6. **COMPLETE APPLICATION** shall mean an application for either initial appointment or reappointment to the Medical Staff, or an application for clinical privileges that has been determined by the applicable Service Chief, the Credentials Committee, the Executive Medical Board ("EMB") and/or the Governing Body to meet the requirements of these Bylaws and related policies and procedures. Specifically, to be complete the application must be submitted on a form approved by the EMB and Governing Body, and include all required supporting documentation and verifications of information, and any additional information needed to perform the required review of qualifications and competence of the applicant.
7. **DATE OF RECEIPT** means the date any Notice or other communication was delivered personally; or if such Notice or communication was sent by mail, it shall mean 72 hours after the Notice or communication was deposited, postage prepaid, in the United States mail.
8. **EX OFFICIO** means service by virtue of office or position held. An Ex Officio appointment is with vote unless specified otherwise.

9. EXECUTIVE MEDICAL BOARD (“EMB”) means the Executive Committee of the Medical Staff.
10. GOVERNANCE ADVISORY COUNCIL means the group that has been established by the Chancellor to facilitate governance of UCSF Medical Center.
11. GOVERNING BODY means The Regents of the University of California and any Governing Body committee or individual, including the Chancellor, authorized to act on behalf of the Governing Body.
12. HOUSESTAFF means post-medical graduates and clinical fellows who are pursuing a defined course of study (ACGME-approved) at the UCSF under the supervision of faculty at the Medical Center.
13. MEDICAL CENTER means UCSF Medical Center, UCSF Medical Center at Mount Zion and their ambulatory practices.
14. MEDICAL STAFF means the organizational component of the Medical Center that includes all physicians (M.D. or D.O.), dentists, clinical psychologists, and podiatrists who have been granted recognition as Members pursuant to these Bylaws.
15. MEDICAL STAFF YEAR means the period from July 1 through June 30.
16. MEMBER means any Practitioner who has been appointed to the Medical Staff.
17. NOTICE means a written communication delivered personally to the addressee or sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the Medical Staff or the Medical Center.
18. PHYSICIAN means an individual with a M.D. or D.O. degree who is currently licensed to practice medicine in California.
19. PRACTITIONER means, unless otherwise expressly limited, any currently licensed physician (M.D. or D.O.), dentist, clinical psychologist, or podiatrist.
20. PRESIDENT means the person who has been elected by the Medical Staff to act on their behalf.
21. PRESIDENT-ELECT means the person who shall become the president after the President’s term concludes and who has been elected by the Medical Staff.
22. PRIVILEGES means the permission granted to a Medical Staff Member to render specific patient services.
23. RULES refer to the Medical Staff Rules adopted in accordance with these Bylaws unless specified otherwise.
24. SCHOOL OF MEDICINE means UCSF School of Medicine.
25. STANDARDIZED PROCEDURES means the scope of services approved by the Committee on Interdisciplinary Practice and EMB granted to an AHP to render specific patient care in multidisciplinary settings.

26. THE REGENTS means The Regents of the University of California pursuant to Article IX, section 9 of the California Constitution.
27. UCSF MEDICAL GROUP (“Medical Group”) means the UCSF provider organization consisting of salaried faculty at UCSF or other Medical Group approved health care providers.

ARTICLE I: NAME

The name of this organization shall be the Medical Staff of UCSF Medical Center, and is hereinafter referred to as the Medical Staff.

ARTICLE II: PREROGATIVES AND PURPOSE

The prerogatives and purposes of the Medical Staff Organization shall be:

1. Provide a system for Medical Staff self-governance and accountability to the Governing Body for patient care, whereby patients treated in the Medical Center shall receive the level of care consistent with the generally recognized standards of the profession.
2. To ensure that all patients of the Medical Center receive care and consideration and to ensure that access to care is not affected on the basis of race, color, national origin, religion, sex, physical or mental disability, age, disabled veterans or veterans of the Vietnam era, or medical condition, ancestry, marital status, citizenship, sexual orientation or gender identity (see UCSF Non-discrimination policy at <http://www.aaco.ucsf.edu/nondispol.htm>) or by source of payment, subject to state and federal laws and regulations.
3. To provide a means whereby problems of a medico-administrative nature may receive discussion and action.
4. To initiate and maintain Bylaws, Rules and Regulations for self-governance.
5. To ensure that all Medical Staff members maintain quality in their performance of professional duties through the appropriate delineation of clinical privileges that he/she may exercise in the Medical Center.
6. To foster education and research programs of the University of California in an integrated manner with the clinical programs of the Medical Center.

ARTICLE III: MEMBERSHIP AND/OR CLINICAL PRIVILEGES

Section A: Eligibility and General Responsibilities of Membership and/or Clinical Privileges

1. **Eligibility:** Membership on the Medical Staff and/or granting of clinical privileges shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these bylaws, rules and regulations, and applicable Medical Center policies. Appointment to the medical staff shall confer on the member only such privileges and prerogatives as have been recommended by the Medical Staff and granted by the Governing Body in accordance with these bylaws. No practitioner shall admit or provide services

to patients in the Medical Center unless he is a member of the staff or has been granted privileges in accordance with the procedures set forth in these bylaws.

- a. Members of the Medical Staff must be licensed or otherwise certified to practice in the State of California or be specifically exempt from such requirements.
- b. Members of the Medical Staff must have a Federal DEA number or furnishing license if prescribing controlled substances.
- c. New and Reappointment of Attending Physician applicants to the Medical Staff must meet the following requirements:
 - Completion of residency program approved by the Accreditation Council for Graduate Medical Education (or verifiable equivalent non-U.S. training*) that includes complete training in the specialty or subspecialty for which the Practitioner is applying for credentials.

And

- Current board certification (or verifiable equivalent*) and/or Certificate of Added Qualification (CAQ), in the specialty that the applicant will practice (as applicable to the privileges requested)

Practitioners with a time-limited board certification or CAQ are required to maintain current board certification, if available, and/or CAQ within the specialty for which they primarily practice. In fields such as Medicine and Pediatrics, in which there is general training followed by subspecialty training, individuals may retain basic privileges in their general field if they maintain active board certification in their subspecialty.

Or

- Entry into the examination process of the appropriate specialty board.

The practitioner must be board certified within six (6) years following completion of his/her residency or fellowship. An applicant to the Medical Staff who is within one-year of completing the appropriate ACGME accredited training program is expected to enter the examination process at the time of application to ensure compliance with the Board Certification requirements in the time frame required.

Because a Practitioner is required to become Board Certified within six (6) years following completion of his or her residency, the termination of the Practitioner's Clinical Privileges and membership on the Medical Staff because of his or her failure to become board certified as required by this Section, shall not entitle a Practitioner to the procedural hearing and appellate review rights provided for in the Fair Hearing Plan, except as to the sole question of whether such board certification was obtained in a timely manner.

Exceptions:

Exceptions to the requirement for Board Certification and CAQ must be substantiated by appropriate

medical education and training, extraordinary experience and reputation, and additional evidence of current competency endorsed by the Department Chair/Chief of the Clinical Service and presented in writing, for consideration by the Executive Medical Board through the Credentials Committee.

Equivalency:

Equivalency shall include, but not be limited to board certification or equivalency of certification from another country and shall be determined by the Department Chair/ Chief of the Clinical Service to which the applicant seeks appointment and confirmed by the Credentials Committee.

- d. Practitioners must document their experience, background, training, health status, and their ability to provide their patients with care at the generally recognized level of quality. Practitioners must also document their adherence to the ethics of their profession, including refraining from fee splitting or other inducements relating to patient referral.
 - e. No individual who is currently excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid, is eligible or qualified for Medical Staff membership.
 - f. Membership shall not be denied on the basis of race, color, national origin, religion, sex, age, veterans of the Vietnam era, ancestry, marital status, citizenship, sexual orientation or gender identity or the types of procedures (e.g. abortions) or the types of patients (e.g. Medicaid) in which the practitioner specializes.
 - g. Appointment to the faculty of the School of Medicine or the School of Dentistry, 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. Absence of a faculty appointment shall not disqualify a person from Medical Staff membership.
 - h. Neither appointment to the Medical Staff or the granting of Privileges to perform specific procedures shall confer entitlement to unrestricted use of the facilities of the Medical Center or the resources thereof. Allocation of resources, including, but not limited to, patient beds and operating room time, shall be subject to administrative allocation pursuant to procedures established by authority of the Chief Executive Officer of the Medical Center, or the CEO's delegate in consultation with the appropriate Chief of Service.
 - i. Each Medical Staff member granted Privileges at the Medical Center shall maintain in force professional liability insurance in not less than the minimum amounts, if any, as from time to time may be determined by, and with an insurance carrier acceptable to, the University, and provide evidence satisfactory to the Executive Medical Board, of conforming coverage.
 - j. 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.
2. **Waiver of Qualifications:** Insofar as is consistent with applicable laws, the Governing Body has the discretion to deem an applicant to have satisfied a qualification, upon recommendation of the Executive Medical Board, if it determines that the applicant has demonstrated he or she has

substantially comparable qualifications and that this waiver is necessary to serve the best interests of the patients and of the Medical Center. There is no obligation to grant any such waiver, and applicants have no right to have a waiver considered and/or granted. An applicant who is denied waiver or consideration of a waiver shall not be entitled to any hearing and appeal rights under these Bylaws.

3. General Responsibilities of Membership

- a. Members must provide for continuous care to patients at the Medical Center according to the principles established in these Bylaws, Rules and Regulations.
- b. Members agree to know these Bylaws, Rules and Regulations and be bound by them.
- c. Only members of the Medical Staff shall have the privilege of managing treatment of patients at the Medical Center.
- d. 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 Medical Center.
- e. Reappointment and continuation of Privileges is subject to at least biennial review and may be based upon criteria that includes quality of patient care, quality of teaching, and utilization of the Medical Center's resources.
- f. The requirements for completing and documenting medical histories and physical examinations are outlined in the Rules & Regulations, Section Three Subsection I. The medical history and physical examination are completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with state law and the requirements of the Rules & Regulations.

Section B: Categories of Membership

1. Medical Staff:

- a. Attending Staff

Definition: Physicians, dentists, podiatrists, or clinical psychologists who are involved in patient care and/or in the supervision of students or house officers in their involvement with patient care or contact must be members of the Attending Staff. Members of the Attending Staff who have not been involved in patient care at the Medical Center and who have not been involved in the clinical supervision of students or house officers at the Medical Center for a period of two (2) years shall automatically be transferred to Inactive Status.

Prerogatives and Responsibilities: Members of the Attending Staff 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.

- b. Affiliate Staff

Definition: Affiliate Staff shall consist of those physicians who were formerly on the Medical Staff at UCSF/Mount Zion Medical Center prior to December 31, 1999, who have not completed full training in their specialty and/or do not meet board certification or eligibility for board examination, but who, nonetheless, appear likely to provide a distinct benefit to the Medical Center, the Medical Staff, and patients. The Affiliate Staff category shall expire automatically upon the cessation of medical staff privileges of the last Affiliate Staff Member who qualifies under this section.

Prerogatives and Responsibilities: Affiliate Staff members may advise UCSF attending physician(s), may assist in surgery and write progress notes, depending on their training and experience; however, they may not admit patients. Affiliate Staff shall not supervise trainees. Members of the Affiliate Staff are not eligible to vote or to hold office except as otherwise provided in these Bylaws but they are expected to participate in continuing education activities and in the activities of the Medical Staff through membership on committees and attendance at its meetings.

c. Courtesy Staff:

Definition: Physicians, dentists, podiatrists, or clinical psychologists who admit five (5) or fewer patients per year or devote less than 150 hours per year to patient care activities at UCSF Medical Center may apply for appointment to the Courtesy Staff. Members of the Courtesy Staff who have not been involved in patient care at the Medical Center and/or who have not been involved in the clinical supervision of students or house officers for a period of two (2) years shall automatically be transferred to Inactive Status.

Prerogatives and Responsibilities: Such members may not vote or hold office and are not required to participate in Medical Staff affairs.

Section C: Allied Health Professionals (AHPs)

1. **Definition:** Only AHPs in approved categories (see *Credentialing Policy and Procedures*) who are employed or contracted by the Medical Center, School of Medicine, or UCSF Medical Group are eligible to apply for Allied Health Staff. Applications (initial and renewal) shall be submitted and processed in the same manner as the processes used for members of the Medical Staff, unless otherwise specified in the Credentialing Policy and Procedures. Appointment to the Allied Health staff is automatically terminated if employment or service contract is terminated.
2. **Prerogatives and Responsibilities:** AHPs shall provide services pursuant to approved standardized procedures and/or job descriptions delineated by the Service and granted by the Governing Body. Supervision requirements shall be specifically defined on any applicable Standardized Procedures and/or job descriptions. AHPs are not members of the medical staff and are not eligible to hold office or vote but may participate in the activities of the Medical Staff and may be appointed to committees with voting privileges if specified at the time of committee appointment. No AHP may admit patients to the Hospital. Upon appointment and to the extent approved by the Committee on Interdisciplinary Practice (CIDP), Credentials Committee, Executive Medical Board and Governing Body, AHPs shall be expected to:
 - a. Meet the qualifications outlined in their Standardized Procedures and/or job descriptions;
 - b. Exercise independent judgment within their areas of competence, provided that a physician who is a current member in good standing of the Active Medical Staff shall retain the

- ultimate responsibility for the patient's care;
 - c. Participate directly in the management of patients;;
 - d. May write orders;;
 - e. Record reports and progress notes on patient charts;
 - f. Perform consultation, upon request.
3. Corrective Action: Employed AHPs are subject to corrective action processes pursuant to Medical Center Human Resources policies and procedures. Contracted AHPs are subject to corrective action processes described within the terms of their service contract.

Section D: Inactive Status

Medical Staff or Allied Health Professional Staff who resign or who have not been involved in patient care or clinical supervision for a period of two (2) years shall be classified as "inactive". Inactive practitioners have no membership status or clinical privileges. Practitioners or AHPs who are inactive may reapply for membership and/or clinical privileges as an initial applicant, provided that they meet all qualifications as defined in these Bylaws, Rules and Regulations.

Section E: Leave of Absence

Members must request a leave of absence for any anticipated leave that exceeds six (6) months. Members must request the leave of absence from their Service Chief, which must be approved by the EMB. The request for a leave of absence must state the reason for the leave and the specific period of time, which may not exceed two (2) years. During the period of leave, the member shall not exercise privileges at the Medical Center, and membership rights and responsibilities shall be inactive. The time period for consideration of reappointment shall be stayed during the leave of absence.

At least 30 days prior to termination of the leave, or at any earlier time, the member may request reinstatement of his or her privileges and prerogatives by submitting a request to the Service Chief who shall promptly forward the request to the Credentials Committee and to the EMB via the Medical Staff Services Department. The member shall submit a written summary of his or her relevant clinical activities during the leave. The EMB, upon receipt of the request, shall recommend to the Governing Body whether to approve the member's request for reinstatement of privileges and prerogatives. Reinstatement at the end of the leave must be approved in accordance with the standards and procedures set forth in the requirements for reappointment review.

Section F: Procedure for Appointment

1. **Application:** A separate credentials file shall be maintained for each applicant for Staff membership or clinical privileges. Each application for Staff appointment, reappointment, and/or clinical privileges shall be in writing, submitted on the prescribed form, and signed by the applicant. When an individual is applying for initial appointment or is initially requesting clinical privileges, he/she shall be provided an application form when he/she is deemed eligible to apply, and shall also be given access to these Bylaws, the Medical Staff Rules and Regulations, and applicable Medical Center policies. At least four (4) months prior to expiration of the current term of membership or clinical privileges for an individual who is a member of the Medical Staff

or who currently holds clinical privileges, the individual should be sent a notice of the impending expiration and an application for reappointment and/or renewal of privileges.

An applicant who does not meet the basic qualifications as outlined in these Bylaws and related policies and procedures is ineligible to apply for membership or AHP status, and the application shall not be accepted for review. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in the Fair Hearing Plan.

Failure to File Reappointment Application: Failure without good cause to file a complete application for reappointment at least 45 days prior to expiration of his/her current appointment shall result in the automatic termination of membership, privileges or standardized procedures of the Member or AHP at the end of the current appointment. The member or AHP shall be deemed to have resigned and the member or AHP shall not be entitled to any hearing or review.

2. **Burden on Applicant:** The applicant for appointment, reappointment, and/or clinical privileges shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for membership or clinical privileges. Neither the Medical Staff nor the Governing Body shall have any obligation to review or consider any application until it is complete, as defined in these Bylaws. The applicant shall provide accurate, up-to-date information on the application form, and shall be responsible for ensuring that all supporting information and verifications are provided, as requested. It shall be the responsibility of the applicant to ensure that any required information from his/her training programs, peer references, or other facilities are submitted directly to the Medical Staff Services Department by such sources. The applicant shall be responsible for resolving any doubts regarding the application. If during the processing of the application the Medical Center or the Medical Staff or any committee or representative thereof, determines that additional information or verification, or an interview with the applicant is needed, further processing of the application may be stayed and the application may not be considered complete until such additional information or verification is received, or the interview is conducted. The Credentials Committee, EMB or the Governing Body may request that the applicant appear for an interview with regard to the application. The Medical Staff Services Department shall notify the applicant of the specific information being requested, the time frame within which a response is required, and the effect on the application if the information is not received timely. Failure to provide a complete application, as defined in these Bylaws, within six months after being provided with an application form for appointment, reappointment or clinical privileges, or failure to appear for any requested interview, shall be deemed a voluntary withdrawal from the application process. Voluntary withdrawal from the application process shall not be considered an adverse action, and shall not entitle the applicant to exercise procedural rights outlined in these Bylaws in the event of such withdrawal. The Medical Staff Services Department shall provide notice to an individual regarding his/her withdrawal from the application process due to lack of requested information or failure to appear for an interview. The complete application form shall include accurate and complete disclosure with regard to the following queries:

- Whether the applicant's professional license or controlled substance registration (DEA, state or local), in any jurisdiction, has ever been disciplined, restricted, revoked, suspended, or surrendered, or whether such action is currently pending, or whether the applicant has voluntarily or involuntarily relinquished such licensure or registration in any jurisdiction;
- Whether the applicant has had any voluntary or involuntary termination of Medical Staff

membership, or voluntary or involuntary limitation, reduction, loss, or denial of clinical privileges at another Hospital;

- Whether the applicant has had any notification of, or any involvement in a professional liability action, including any final judgments or settlements involving the applicant; and,
- Whether the applicant has ever been subject to a criminal conviction, or whether any such action is pending.
- A statement from the applicant that his/her health status is such that he/she has the ability to perform the clinical privileges that he/she is requesting.
- A statement from the applicant that he/she has had access to and read the current Medical Staff Bylaws, Rules and Regulations, and policies and agrees to be bound by them, including any future Bylaws, Rules and Regulations and policies which may be duly adopted;
- A pledge from the applicant to provide continuous care to his/her patients.
- A statement from the applicant consenting to the release and inspection of all records or other documents that may be material to an evaluation of his/her professional qualifications, including all health information and medical records necessary to verify the applicant's health status and a statement providing immunity and release from civil liability for all individuals requesting or providing information relative to the applicant's professional qualifications or background, or evaluating and making judgments regarding such qualifications or background.

The applicant agrees that the Medical Center and the Medical Staff may share information with a representative or agent of the UCSF Medical Center, UCSF School of Medicine, and the UCSF Medical Group, including information obtained from other sources, and releases each person and each entity who received information and each person and each entity who disclosed information from any and all liability, including any claims of violations of any federal or state law, including the laws forbidding restraints of trade that may arise from the sharing of information. Applicant agrees that the Medical Center and the Medical Staff may seek information from other sources regarding voluntary or involuntary limitation of privileges or loss of licensure elsewhere. Applicant also agrees that UCSF Medical Center, UCSF School of Medicine, and the UCSF Medical Group may act upon such information.

- 3. Verification Process:** Upon the receipt of a complete application form, the Medical Staff Services Department shall arrange to verify the qualifications and obtain supporting information relative to the application. The Medical Staff Services Department shall consult primary sources of information about the applicant's credentials, where feasible. Verification may be made by a letter or computer printout obtained from the primary source or it may be verbally or electronically transmitted (e.g., telephone, facsimile, email, Internet) information when the means of transmittal is directly from the primary source to the Medical Center and the verification is documented. If the primary source has designated another organization as its agent in providing information to verify credentials, the Medical Center may use this other organization as the designated equivalent source. The Medical Staff Services Department shall promptly notify the applicant of any problems in obtaining required information. Any action on an application shall be withheld until the application is completed; meaning that all information has been provided and verified, as defined in these Bylaws. The Credentialing Policy and Procedure shall identify all information that will be verified.

4. **Application Processing:** After verification is accomplished and the application is fully complete it shall be reviewed and processed as follows:
- a. Service Report: The Medical Staff Services Department shall make available the application and all supporting materials to the Chief of each Service in which the applicant seeks privileges, and request the documented evaluation and recommendations as to the staff category (in the case of applicants for Staff membership), the Service to be assigned, the clinical privileges to be granted, and any concerns regarding the clinical privileges requested. In the event that the applicant is the Service Chief, the President of the Staff shall designate an alternate to make the evaluation and recommendations. Following the Service Chief(s)' evaluation and recommendations, the report shall then be transmitted to the Credentials Committee. The time frame for completion of the Service report(s) shall be within 30 days of receipt of a complete application.
 - b. Credentials Committee Report: The Credentials Committee shall review the application, supporting materials, the report of the Service Chief and any such other available information as may be relevant to the applicant's qualifications. The Credentials Committee shall prepare a written report and recommendations for the EMB as to Staff appointment and staff category (in the case of applicants for Staff membership), the Service to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. In the event there are any adverse recommendations, the reasons shall be stated. The time frame for completion of the Credentials Committee action shall be at the next regular meeting of the committee following receipt of the Service report, to be within 30 days.
 - c. Medical Executive Committee Recommendation: The EMB shall receive the reports and recommendations of the Service Chief and the Credentials Committee, and any such other available information as may be relevant to the applicant's qualifications. The EMB shall prepare a written report and recommendations for the Governing Body as to Staff appointment and staff category in the case of applicants for Staff membership, the Service to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. In the event there are any adverse recommendations, the reasons shall be stated. The time frame for the EMB to make a recommendation to the Governing Body shall be at the next regular meeting of the committee following receipt of the Credentials Committee report, to be within 30 days.
 - d. Effect of EMB Recommendation
 - Deferral: The EMB may defer making a recommendation where the deferral is not solely for the purpose of causing delay. A decision by the EMB to defer the application for further consideration shall state the reasons for deferral, provide direction for further investigation, and state time limits for such further investigation. As soon as practical after the deferral, such decision to defer the application shall be followed with a subsequent favorable or adverse recommendation. The EMB may delegate the responsibility for further consideration to the Credentials Committee or Service Chief as deemed appropriate.
 - Favorable Recommendation: When the recommendation is completely favorable, the application shall be forwarded promptly to the Governing Body for action at the Governing Body's next regular meeting.

- Adverse Recommendation: If the recommendation of the EMB is adverse as defined in the Fair Hearing Section of these Bylaws, Article III, Section J, the President of Staff shall promptly notify the applicant. Such notice shall contain the information prescribed in the Fair Hearing section of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in the Fair Hearing Plan and the recommendation need not be transmitted to the Governing Body until after the applicant has exercised or waived such rights.
- e. Governing Body Action: Unless subject to the provisions of the fair hearing and appeal provisions in these Bylaws, the Governing Body shall act on the application at its next regular meeting following receipt of the recommendation from the EMB. The action of the Governing Body shall be taken within 30 days after receiving a recommendation from the EMB.

If the Governing Body adopts the recommendation of the EMB, it shall become the final action of the Medical Center.

If the Governing Body does not adopt the recommendation of the EMB, the Governing Body may either refer the matter back to the EMB with instructions for further review and recommendation and a time frame for responding to the Governing Body or the Governing Body may take unilateral action. If the matter is referred back to the EMB, the EMB shall review the matter and shall forward its recommendation to the Governing Body. If the Governing Body adopts the recommendation of the EMB, it shall become the final action of the Medical Center.

If the action of the Governing Body is adverse to the applicant, the CEO or designee shall promptly send written notice to the applicant. Such notice shall contain the information prescribed in the Fair Hearing Plan of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in the Fair Hearing Plan of these Bylaws, and the adverse decision of the Governing Body shall not become final until after the applicant has exercised or waived such rights. At its next regular meeting, after all of the applicant's hearing and appeal rights under these Bylaws have been exhausted or waived, the Governing Body shall take final action.

All decisions to appoint shall include a delineation of clinical privileges, the assignment of a staff category and Service assignment, and any applicable conditions placed on the appointment or clinical privileges. The applicant shall be so notified within 60 days of the Governing Body's decision.

Subject to any applicable provisions of the Fair Hearing Plan, notice of the Governing Body's final decision shall be given in writing through the Medical Staff Services Department to the applicant. In the event a hearing and/or appeal was held, provisions detailed in the Fair Hearing Plan shall govern notice of the Governing Body's final decision.

Section G: Term of Appointment

1. Appointments shall be for a two-year term unless terminated by other provisions of these Bylaws. Appointments shall be effective on approval by the Governing Body, and shall extend for a period of two (2) years.

2. Initial appointments or the granting of new privileges shall be proctored for a period of twelve (12) months.
3. Reappointments will be for a period of not more than 24 months.

Section H: Privileges

1. Delineation of Privileges in General:

- a. **Exercise of Privileges:** Except as otherwise provided in these Bylaws or the Rules, every Practitioner or Allied Health Professional providing direct clinical services at this Medical Center shall be entitled to exercise only those Privileges specifically granted to him or her.
- b. **Requests:** Each application for appointment and reappointment to the Medical Staff must contain a request for the specific Privileges desired by the applicant. A request for a modification of Privileges must be supported by documentation of training and/or experience supportive of the request.
- c. **Basis for Privilege Determination:** Requests for Privileges shall be evaluated on the basis of the Practitioner's education, training, experience, demonstrated professional competence and judgment, health status, clinical performance, the documented results of patient care and other performance improvement review and monitoring, performance of a sufficient number of procedures each year to develop and maintain the Practitioner's skills and knowledge and compliance with any specific criteria applicable to the Privileges. Privilege determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a Practitioner exercises Privileges.

2. Visiting and Temporary 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.

Visiting privileges do not include admitting privileges. No person shall receive more than two (2) privilege appointments annually 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 60 days (the timeframe allowed pursuant to the National Committee on Quality Assurance (NCQA) credentialing standards).

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 Chief Executive Officer, 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 Chief of Staff, the responsible department chair, or the Chief Executive Officer (or designee) after conferring with the Chief of Staff or the responsible department chair. 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.
- d. Disaster Privileges
- i. Disaster Privileges may be granted when the Medical Center'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 the Medical Center to meet the demand for health care services. Disaster privileges are granted pursuant to the Disaster Privileges Policy and Procedures.
<http://manuals.ucsfmedicalcenter.org/AdminManual/IndividualPolicies/DisasterPrivilegesPolicy.pdf>
 - ii. 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.

3. Focused Professional Practice Evaluation (FPPE)

a. General Proctoring Requirements

- i. Except as otherwise determined by the Executive Medical Board and Governing Body,

all initial appointees to the Medical Staff and all members granted new Privileges shall be subject to a period of proctoring in accordance with standards and procedures defined by each Service and documented on delineations of clinical privileges. In addition, Members may be required to be proctored as a condition of renewal of Privileges (for example, when a Member requests renewal of a Privilege that has been performed so infrequently that it is difficult to assess the Member's current competence in that area.) Proctoring may also be implemented whenever the Executive Medical Board determines that additional information is needed to assess a Practitioner's performance. Proctoring is not normally imposed as a form of discipline but rather to assess competency. It should be imposed only for such period (or number of cases) as is reasonably necessary to enable such assessment. A Member shall be entitled to the procedural rights described in the Fair Hearing Plan only when and if proctoring is imposed as a form of discipline for a medical disciplinary cause or reason.

- ii. During proctoring, the Practitioner must demonstrate that he/she is qualified to exercise the Privileges that were granted.
- b. Completion of Proctoring: Proctoring shall be deemed successfully completed when the Practitioner completes the required number of proctored cases within the time frame established in the Bylaws or as required by the Chief of Service and the Practitioner's professional performance in the cases met the standard of care of the Medical Center.
- c. Effect of Failure to Complete Proctoring
- i. Failure to Complete Necessary Volume: Any member who fails to complete the required number of proctored cases within the time frame established in the Bylaws or at the time privileges were provisionally granted shall be deemed to have voluntarily withdrawn his or her request for membership (or relevant Privileges), and he or she shall not be afforded the procedural rights provided in the Fair Hearing Plan. However, the clinical service has the discretion to extend the time for completion of proctoring in appropriate cases subject to ratification by the Executive Medical Board. The inability to obtain such an extension shall not give rise to procedural rights described in the Fair Hearing Plan.
 - ii. Failure to Satisfactorily Complete Proctoring: If a Practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring, he or she may be terminated (or the relevant Privileges may be revoked) and he or she shall be afforded the procedural rights as provided in the Fair Hearing Plan.
 - ii. The failure to complete proctoring for any specific Privilege shall not, by itself, preclude advancement. If advancement is approved prior to completion of proctoring, the proctoring will continue for the specified Privileges. The specific Privileges may be voluntarily relinquished or terminated if proctoring is not completed thereafter within a reasonable time.

4. Ongoing Professional Practice Evaluation:

UCSF will conduct ongoing evaluation of each practitioner's professional performance. Individual departments will monitor and review trends and outliers through the departmental quality review process and through information provided on the Quality and Safety Dashboard at least every six (6) months. This process not only allows any potential problems with a practitioner's performance to be identified and resolved as soon as possible, but also fosters a

more efficient, evidence-based privilege renewal process.

The ongoing professional practice evaluation allows the organization to identify professional practice trends that impact on quality of care and patient safety. Such identification may require intervention by the organized medical staff. The information used in the ongoing professional practice evaluation may be acquired through the following:

- Periodic chart review
- Direct observation
- Quality and Safety Dashboard data
- Monitoring of diagnostic and treatment techniques
- Departmental Quality Review process
- Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel. Relevant information obtained from the ongoing professional practice evaluation is integrated into performance improvement activities. These activities adhere to the organization's policies or procedures intended to preserve any confidentiality or legal privilege of information established by applicable law.

If there is uncertainty regarding the practitioner's professional performance, the organized medical staff should follow the course of action defined in the medical staff bylaws for further evaluation of the practitioner. (i.e. Adhoc review process)

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

1. Grounds for Action:

- a. Non-compliance 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 Medical Center 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 responsibilities relative to consultation and call.
- c. Misconduct -- This shall include, but not be limited to, violations as indicated in I.1.b above, abandonment of a patient, disruptive behavior, unethical behavior, or falsification of records.
- d. Care Below Applicable Standards -- This shall include, but not be limited to, incompetence, unprofessional conduct (as excluded from I.1.c above), failure to adhere to patient care policies of the Medical Center, clinical performance below the standards of practice established by the clinical service, provision of sub-optimal and/or sub-standard care, substantial or consistent misdiagnosis, and/or a demonstrated lack of clinical competence.
- e. Personality Conflict -- Continuous inability to work in harmony with others or evidence of disruptive behavior or conduct detrimental to patient care may be cause for such action.
- f. Improper use of Medical Center resources.

2. Procedures:

- a. Any person may provide information to an officer of the Medical Staff, the Chief Executive Officer of the Medical Center, the Chief Medical Officer, or the Chancellor, about the conduct, performance, or competence of its members. When such information about a member of his/her service comes to the attention of the Chief(s) of Service, he/she may review and investigate the matter, either directly or by delegation. If the Chief(s) of Service thereafter concludes that there appear to be grounds for corrective action, he/she must submit a request for such action in accordance with this subsection; however, such prior investigation by the service is not a precondition for making a request for corrective action. Any member of the Active Medical Staff, the Chief Executive Officer of the Medical Center, the Chief Medical Officer, or the Chancellor, may request the Executive Medical Board 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 Medical Board and shall be supported by reference to specific activities or conduct constituting grounds for the request.
- b. Within fifteen (15) days of receipt of the request to institute corrective action, the President of the Medical Staff shall assign the conduct of an investigation to the Credentials Committee, or a standing or ad hoc committee of the Medical Staff, or a standing or ad hoc committee of the clinical service; provided, however, that if there is a conflict or if the President of the Medical Staff is for any reason unable to so assign, the head of the Credentials Committee shall have the responsibility to assign the matter to the appropriate 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 shall be offered an opportunity to make an appearance before the 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 committee, shall be preliminary in nature, and none of the procedural rules of the Bylaws with respect to hearings shall apply. Following full investigation, a report of findings and recommendations will be made to the President of the Medical Staff within thirty (30) days of receipt of the assignment. The President 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 (5) days of receipt of the report of findings and recommendations, the President of the Medical Staff shall notify the affected staff member in writing and shall furnish him/her with copies of the request for corrective action and the report of findings and recommendations.
- e. The President of the Medical Staff shall forward the committee's report of findings and recommendations to the Executive Medical Board for consideration at its next regularly scheduled meeting. The Executive Medical Board 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 that no corrective action be taken and, if the Executive Medical Board determines there was no credible evidence for the complaint in the first instance, removing any adverse information related to the request for corrective action 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 which, pursuant to these provisions constitutes grounds for a hearing, shall entitle the affected staff member to the procedural rights contained in Section J, Fair Hearing Plan. Except for summary suspensions, any adverse recommendation shall be held in abeyance until the member has waived or exercised his/her rights under Article III, Section J.
- g. Despite the status of any investigation, at all times the Executive Medical Board shall 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 Medical Board 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 Medical Board, direct the Executive Medical Board to investigate or initiate corrective action. If the Executive Medical Board fails to act after a directive from the Chancellor, the Chancellor may, in accordance with these Bylaws, after written notice to the Executive Medical Board, take action directly against a Medical Staff member. If the action is favorable to the practitioner, or 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 individuals shall have the authority to summarily suspend or restrict all or part of the Privileges and/or membership of a Medical Staff member whenever the member's conduct requires that immediate action be taken to protect the life of any patient or to reduce the likelihood of imminent danger to the health or safety of any individual or to prevent the disruption of the Medical Center: Officer of the Medical Staff, Executive

Medical Board, the Chief of a Clinical Service, the Chief Executive Officer of the Medical Center, the Chief Medical Officer and the Chancellor or Chancellor's designee.

- b. If the persons or body designated above fail, under the foregoing circumstances, to restrict or suspend a Medical Staff member's membership, or all or any portion of his/her clinical Privileges, the Chancellor, or the Chancellor's designee, may, when necessary to protect the life of any patient or to reduce the likelihood of imminent danger to the health or safety of any individual, after reasonable attempts to contact the Executive Medical Board, immediately restrict or suspend the Medical Staff member's membership or all or any portion of his/her clinical Privileges. A summary restriction or suspension shall be effective immediately upon imposition, provided, however, that a summary restriction or suspension imposed by the Chancellor, or the Chancellor's designee, must be ratified by the Executive Medical Board within two (2) working days of its imposition, excluding weekends and holidays, or it shall terminate automatically. Unless otherwise stated, a summary suspension shall become effective immediately upon imposition.
- c. 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 J, Fair Hearing Plan.
- e. In the event that, following a summary suspension, the Credentials Committee or Executive Medical Board 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 J have been exhausted. Unless a postponement is concurred in by the affected staff member and the President of the Medical Staff, any hearing after investigation shall begin as soon as possible but no longer than forty-five (45) days from the date of imposition of the summary suspension.

4. Automatic Suspension:

- a. The President of the Medical Staff and the Chief Executive Officer of the Medical Center shall have the duty of enforcing all automatic suspensions. A member's Medical Staff membership shall be automatically revoked or suspended in the following circumstances:
 - (1) 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.
 - (2) 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 Medical Center 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.

- (3) Probation -- Whenever a member is placed on probation by the applicable licensing or certifying authority, his/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.
- (4) 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.
- (5) 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.
- (6) Failure or refusal to complete medical records in accordance with applicable Medical Center and legal requirements after notice to the member of incomplete records. When a member has accumulated more than ninety (90) suspension days in twelve (12) consecutive months, he or she shall be deemed automatically and voluntarily terminated from the Medical Staff. A member who has been so terminated may not reapply for membership until one (1) year from the effective date of the termination, and his or her reapplication shall be considered as if it were an initial application.
- (7) Medicare/Medicaid Number – If a practitioner is excluded, for any period of time, from participation in a federal health care program, including but not limited to Medicare and Medicaid, then such practitioner's privileges, including admitting privileges to provide services to or to order or prescribe any items, medications or services for any federal health care beneficiary, shall immediately and automatically be revoked. Once such practitioner's participating provider status is fully restored and in good standing, then the practitioner may apply for reinstatement of full privileges, which reinstatement shall be at the discretion of the EMB. Such revocation of privileges does not preclude further corrective action from being initiated.

A practitioner is required to advise the President of Staff and the Chief Executive Officer in writing immediately upon any exclusion, suspension, or change in status of the practitioner's participating provider status in a federal health care program or any investigation by a governmental agency relating to the practitioner's participation in a federal health care program of care of a federal health care beneficiary. Failure to do so shall be grounds for corrective action.

- (8) Testing and Immunization Requirements – All Medical Staff and Allied Health Professional members are required to comply with all Infection Control testing and immunization requirements upon initial application and annually thereafter for selected requirements. Failure or refusal to comply with these requirements after notice to the member of non-compliance will result in withdrawal of initial application or administrative suspension of current privileges until such requirements have been met. Refer to Rules and Regulations, Section Two Subsection II – Infection Control and Communicable Diseases

- b. No hearing rights. Automatic suspension shall not constitute grounds for a hearing.
- c. Reinstatement. Except as otherwise provided herein, the President of the Medical Staff may reinstate the member when the reason for the automatic suspension no longer exists. If the member's appointment to the Medical Staff has expired during the term of the automatic suspension and he/she is seeking reappointment, the President of the Medical Staff may, in accordance with these Bylaws, Rules and Regulations grant him/her Visiting Privileges for a period not to exceed the period ending with action on the application for reappointment.

5. No Right to Duplicative Hearings:

If a Member's membership or participation in the Medical Staff is denied, terminated or limited based on Medical Staff's independent determination that cause for discipline exists, Member shall be entitled to request notice and a hearing in accordance with the procedures set forth herein; provided, however, that in no event shall Member be entitled to more than one hearing related to allegations based on the same set of facts that were used as the basis for a hearing in the UCSF School of Medicine or UCSF Medical Group. If the Member has had a hearing pursuant to UCSF Medical Group's Bylaws or pursuant to the applicable policies and procedures of UCSF's School of Medicine, the decision(s) in those action(s) shall be adopted as final by the Medical Staff and the Member shall have no further or additional right to a hearing under the Medical Staff Bylaws. Any allegation regarding failure to comply with UCSF's billing rules shall be forwarded to UCSF's Corporate Compliance Officer and/or the Office of the General Counsel for resolution in accordance with UCSF's Corporate Compliance Program.

Section J: 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 F, Termination or Suspension of Medical Staff Membership, Reduction of Clinical Privileges, and Other Corrective Action, prior to invoking the process set forth in Section J, Fair Hearing Plan, and must exhaust the remedies set forth in these Bylaws before resorting to legal action.
- b. Notice of Charges -- In any case where action has been taken constituting grounds for hearing, as set forth in G.l.c., Grounds for Hearing, 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. Such notice shall inform the practitioner: (a) of the recommendation or action; (b) the reasons therefore; (c) that such action or recommended action, if adopted, shall be taken and reported to the Medical Board of California and/or National Practitioner Data Bank, if required by law; (d) that he/she has a right to request a hearing within thirty (30) days; and (e) of his/her rights with respect to such hearing. The applicant or member shall have thirty (30) days following date of the mailing of the notice within which to request a hearing by a Hearing Committee, as defined in subsection f of this Article. The applicant or member shall also be given a copy of Article III, Section J, Fair Hearing Plan. The request for a hearing 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 thirty (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 or reappointment.
 - (2) Denial, revocation, suspension, restriction, or involuntary reduction of Medical Staff Privileges.
 - (3) Denial of requested advancement of Medical Staff membership.
 - (4) Demotion to a lower staff category.
 - (5) Involuntary imposition of significant consultation or proctoring requirements (excluding proctoring incidental to provisional staff status, or the granting of new Privileges, or imposed because of insufficient activity, or proctoring or consultation that does not restrict the Practitioner's Privileges).
 - (6) Summary suspension of Medical Staff membership and/or Privileges during the pendency of corrective action and hearings and appeals procedures.
 - (7) Any other disciplinary action or recommendation that must be reported to the Medical Board of California.
 - (8) Suspension or summary suspension of Privileges (excluding Visiting Privileges).
- d. Time and Place of Hearing. Within fifteen (15) days of a request for a hearing, the President of the Medical Staff shall schedule a hearing and give written notice, delivered in person or 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 thirty (30) days, nor more than sixty (60) days from the date of receipt of the request by the President of the Medical Staff for a hearing unless the member who requested the hearing voluntarily waives the minimum time limit and requests a shorter waiting period in writing, and the Hearing Committee, or its Chair acting on its behalf, concurs. The date of commencement of the hearing shall not be more than sixty (60) days from the date of receipt by the President of the Medical Staff of the request for a hearing unless extended by the Hearing Committee or its Chair; provided, however, that when the request is received from a member who is under summary suspension, the hearing shall be scheduled to commence on a date not more than forty-five (45) days from the date of receipt of the request.
- e. 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, at least fifteen (15) days prior to the hearing, 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.

- f. **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 (3) 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, who have not acted as an accuser, investigator, fact finder or initial decision maker in the same matter, and shall include, where feasible, an individual practicing the same specialty as the affected member or initial applicant. The Hearing Committee shall nominate, from amongst its members, a Chair. A Hearing Officer may be appointed pursuant to Section 2 (c) below. Knowledge of the matter involved shall not preclude a member from serving on the Hearing Committee.
- g. **Pre-Hearing Conduct.** While neither side in a hearing shall have any right to discovery of documents or other evidence in advance of hearing, both parties shall exchange all documents that they intend to offer at least fifteen (15) days prior to the commencement of the hearing. Failure to disclose the identity of a witness or to produce copies of all documents expected to be produced at least fifteen (15) days prior to the commencement of the hearing shall constitute good cause for a continuance. No documentary evidence or witnesses shall be admitted or allowed to testify at the hearing unless the documents or names of witnesses were exchanged prior to the hearing as set forth herein; provided, that the Hearing Officer, in his/her discretion, may allow said evidence or testimony if it could not have been reasonably discovered and made available to the other party prior to the hearing. The parties shall notify each other as soon as they become aware of the relevance or participation of such additional documents or witnesses. 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 or the applicant and the President of the Medical Staff, or his/her designee, to exercise reasonable diligence in notifying the Chair 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 pre-hearing decisions concerning such matters. Reconsideration of any pre-hearing decisions may be made at the hearing.
- h. **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 Chair, 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 inter-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 President of the Medical Staff, in writing, of his/her intention to be so represented no later than ten (10) days after submission of the request for a hearing. If the affected member or applicant is represented by an attorney, the body whose recommendation prompted the

- hearing may also be represented by an attorney from the Office of the General Counsel, but the body whose recommendation prompted the hearing may not be represented by an attorney if the affected member or applicant is not. The Hearing Officer shall determine the role of attorneys and may eject any attorney whose activities at the hearing, in his or her judgment, disrupt the proceedings. When attorneys are not allowed, both parties may be represented at the hearing by a member of the Medical Staff licensed in California who is not also an attorney. Postponements and extensions of time beyond those expressly stated herein shall be granted on agreement of the parties, or by the Hearing Officer, on a showing of good cause.
- c. **The Hearing Officer.** The Hearing Committee may 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 Medical Staff, Medical Center or the Chancellor and shall gain no direct financial benefit from the outcome. 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 Chair of the Committee shall be the hearing officer if the Hearing Committee has chosen not to appoint a hearing officer and he/she shall be entitled to vote. The hearing officer shall act to assure 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. **Voir Dire:** The affected member or initial applicant shall have the right to a reasonable opportunity to voir dire the Hearing Committee and any Hearing Officer, and the right to challenge the impartiality of any committee member or Hearing Officer. Challenges to the impartiality of any committee member or Hearing Officer shall be ruled on by the presiding officer who shall be the Hearing Officer if one has been selected.
 - e. **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. Access to the records of the Hearing Committee shall be limited to the President of the Medical Staff, the Credentials Committee or the committee assigned to conduct the investigation. The records shall be maintained by the Medical Staff Services Department. The affected member or applicant may have a copy of the hearing record upon payment of reasonable charges associated with preparation of the copy.
 - f. **Rights of Both Sides.** At a hearing, both parties shall have the following rights: to inspect and copy, at their own expense, any documentary information that either party has under his/her control that is relevant to the charges, as soon as practicable after receipt of the request for hearing; to be present; to call and examine witnesses; to introduce exhibits; to cross-examine any witness on any matter relevant to the issues; to impeach any witness; to be provided with all information made available to the Hearing Committee; and to rebut any evidence. The failure by either party to provide access to information within fifteen (15) days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to individually identifiable licentiates other than the affected member or initial applicant under review. The Hearing Officer or presiding officer shall consider and rule upon any request for access to information, and may impose any

safeguards that the protection of the peer review process and justice require. If the affected member or applicant does not testify on his/her own behalf, he/she may be called and examined as if under cross-examination. 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.

- g. Continuances. Continuances shall be granted upon agreement of the parties or upon a showing a good cause.
- h. 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. The body whose recommendation prompted the hearing may object to the introduction of evidence that was not produced by the Petitioner during the appointment, reappointment, Privilege delineation or correction action process. The Presiding Officer shall bar such evidence unless the Petitioner proves that he or she previously acted diligently and could not have previously produced it. The Hearing Committee may interrogate the witnesses or call additional witnesses if it deems it appropriate. When ruling upon requests for access to information and the relevancy thereof, the Hearing Officer or presiding officer shall consider the following:
 - (1) Whether the information sought may be introduced to defend or support the charges.
 - (2) The exculpatory or inculpatory nature of the information sought, if any.
 - (3) The burden imposed on the party in possession of the information sought, if access is granted.
 - (4) Any previous requests for access to information submitted or resisted by the parties to the same proceeding.
 - (5) Initial applicants shall not be permitted to introduce evidence not produced upon the request of the Medical Center during the application process unless the initial applicant establishes that the information would not have been produced previously in the exercise of reasonable diligence.
- i. 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.
- j. 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.

- k. **Burden of Proof.** Initial applicants shall bear the burden of persuading the Hearing Committee by a preponderance of the evidence of their qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubt concerning their current qualifications for staff Privileges, membership, or employment. Initial applicants shall be responsible for going forward with their evidence first.

Except as provided above for initial applicants, the body whose action resulted in the charges being brought shall bear the burden of persuading the Hearing Committee by a preponderance of the evidence that the action or recommendation is reasonable and warranted and said body shall be responsible for going forward with the evidence first.

- l. **Adjournment and Conclusions.** The hearing 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 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 J.2.c.
- m. **Decision of the Hearing Committee.** Within fifteen (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 include findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the decision. The decision shall be delivered to the Credentials Committee, the Executive Medical Board, the Chief Executive Officer of the Medical Center, and the Chancellor. At the same time, a copy of the decision shall be delivered to the applicant or member who requested the hearing either in person or by registered or certified mail, return receipt requested.
- n. **Appeal.** The decision of the Hearing Committee shall be final, subject only to the right of appeal as outlined in section G.3. of this Article.

3. Appeal:

- a. **Time for Requesting Appeal.** Within twenty (20) days after receipt of the decision of the Hearing Committee, either party 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 twenty-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 non-compliance 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 J.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 fifteen (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, or his/her designee, 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 thirty (30) days from the date of receipt of the request for appellate review; provided, however, that 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 be comprised of the Chancellor or the Chancellor's designee 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 review, 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. The parties shall have the right to appear and to respond. The Review Committee may conduct deliberations outside the presence of the parties and their representatives.
- f. **Final Decision.** Within fifteen (15) 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 Medical Board in person or by certified or registered mail, return receipt requested. The final decision of the Review Committee shall be effective immediately.

Section K: Waiting Period after Adverse Action

1. Who is Affected

- a. A waiting period of 24 months shall apply to the following Practitioners:
 - (1) An Applicant who:
 - Has received a final adverse decision regarding appointment; or

- Withdrew his or her application or request for membership or Privileges following an adverse recommendation by the Executive Medical Board or the Governing Body.

(2) A former member who:

- Has received a final adverse decision resulting in termination of Medical Staff membership and/or Privileges; or
- Resigned from the Medical Staff or relinquished Privileges while an investigation was pending or following the Executive Medical Board or the Governing Body issuing an adverse recommendation;

(3) A Member who has received a final adverse decision resulting in:

- Termination or restriction of his or her Privileges; or
- Denial of his or her request for additional Privileges.

- b. Ordinarily the waiting period shall be 24 months; however, for Practitioners whose adverse action included a specified period or conditions of retraining or additional experience, the Executive Medical Board may exercise its discretion to allow earlier reapplication upon completion of the specified conditions. Similarly, the Executive Medical Board may exercise its discretion, with approval of the Governing Body, to waive the 24-month period in other circumstances where it reasonably appears, by objective measures, that changed circumstances warrant earlier consideration of an application.
- c. An action is considered adverse only if it is based on the type of occurrences which might give rise to corrective action. An action is not considered adverse if it is based upon reasons that do not pertain to medical or ethical conduct, such as actions based on a failure to maintain a practice in the area (which can be cured by a move), or to maintain professional liability insurance (which can be cured by obtaining the insurance).

2. Date When the Action Becomes Final

The action is considered final on the latest date on which the application or request was withdrawn, a Member's resignation became effective, or upon completion of (a) all Medical Staff and Medical Center hearings and appellate reviews and (b) all judicial proceedings pertinent to the action served within 2 years after the completion of the Medical Center proceedings.

3. Effect of the Waiting Period

Except as otherwise allowed (per Article III.H.1.b), Practitioners subject to waiting periods cannot reapply for Medical Staff membership or the Privileges affected by the adverse action for at least 24 months after the action became final. After the waiting period, the Practitioner may reapply. The application will be processed like an initial application or request, plus the Practitioner shall document that the basis for the adverse action no longer exists, that he or she has corrected any problems that prompted the adverse action, and/or he or she has complied with any specific training or other conditions that were imposed.

ARTICLE IV: CLINICAL ORGANIZATION

Section A: Clinical Services

1. The Medical Staff shall be organized into the clinical services detailed below. Each Member of the Medical Staff must belong to at least one of the following services:

Anesthesia	Ophthalmology
Dentistry	Orthopaedic Surgery
Dermatology	Otolaryngology
Emergency Medicine	Pathology
Family & Community Medicine	Pediatrics
Laboratory Medicine	Psychiatry
Medicine	Radiology
Neurological Surgery	Radiation Oncology
Neurology	Surgery
Obstetrics, Gynecology & Reproductive Sciences	Urology

2. Additional services may be created or existing clinical services may be combined or eliminated by a three-fourths (3/4) affirmative vote of the Executive Medical Board provided only that such action shall parallel similar departmentalization in the Schools of Medicine or Dentistry.

Section B: Chiefs of Clinical Services

1. Each service shall have a chief who shall be the corresponding Chair in the School of Medicine or his/her designee, except for the Chief of Dental Service who shall be designated by the Dean of the School of Dentistry. Each Chief of Service shall be certified by an appropriate specialty board, or shall affirmatively establish comparable competence through the credentialing process.
2. Chiefs of Clinical Services, shall have the following duties and responsibilities, subject to the authority of the Executive Medical Board and the Chancellor and The Regents:
 - a. To supervise and evaluate clinical work carried out by members of the service.
 - b. To administer and implement these Bylaws, Rules and Regulations within the service.
 - c. To screen all applications for clinical Privileges in the service and to make recommendations to the Credentials Committee. No appointment shall be made without a recommendation of the Chief of Service.
 - d. To assure that members of the service practice within the limits of Privileges assigned to them.
 - e. To assume or assign patient care responsibilities on behalf of any service member who shall be unable to carry out same by virtue of disciplinary action, illness, or other causes.
 - f. To assure orientation and adequate opportunities for continuing professional education for members of the service.

- g. The continuous assessment and improvement of the quality of care, treatment and services and the maintenance of quality control programs, as appropriate.
 - h. Continuing surveillance of the professional performance of all individuals in the clinical service who have delineated clinical Privileges.
 - i. Recommending to the Medical Staff the criteria for clinical Privileges that are relevant to the care provided in the clinical service.
 - j. Assessing and recommending to the Executive Medical Board off-site resources for needed patient care services not provided by the clinical service or the organization.
 - k. The integration of the clinical service into the primary functions of the organization and the coordination and integration of interdepartmental and intradepartmental services.
 - l. The development and implementation of policies and procedures that guide and support the provision of care, treatment and services.
 - m. The recommendations for a sufficient number of qualified and competent persons, space and resources needed to provide care or service.
 - n. The determination of the qualifications and competence of clinical service personnel who are not licensed independent practitioners and who provide patient care services.
3. Subject to approval by the Executive Medical Board, Chiefs of Service may establish divisions or sections of their respective services where so doing will assist them in carrying out their duties and responsibilities.
4. Each Chief of Service shall maintain membership on the Attending Staff.

ARTICLE V: 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 Medical Board and Medical Staff.
 - b. Appointing chairs and members of the Medical Staff committees.
 - c. Establishing and disbanding special committees of the Medical Staff, subject to approval of the Executive Medical Board.
 - d. Serving as an ex-officio member of all Medical Staff committees.
 - e. Oversight of clinical work performed by the various clinical services, divisions, and services.
 - f. Representing the Medical Staff for the purpose of receiving and acting upon policies of the University, Campus and the Medical Center.

- g. Reporting on a regular periodic basis to the Chief Medical Officer and the Chancellor on the performance and quality of delegated responsibilities for the provision of patient care services.
 - h. Representing the Medical Staff in external professional and public relations.
 - i. Participating in the Fair Hearing Plan as indicated in Article III, Section J.
2. President-Elect: The President-Elect shall, in the absence of the President, assume all of the duties, responsibilities, and the authority of that office.

Section B: Election and Tenure of Offices

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 July 1 and ending on June 30, or shall serve until a successor is elected.
3. Nominations for the office of President-Elect shall be made by the Nominating Committee 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 Sections B.3 and B.4 above.
6. Officers may be removed for failure to perform duties and responsibilities as outlined under Section A. of this Article. Officers may be removed from office by a two-thirds (2/3) vote of the Executive Medical Board, or by a two-thirds (2/3) vote at any annual or special meeting of the Medical Staff.

ARTICLE VI: EXECUTIVE MEDICAL BOARD

Section A: Membership

1. The Executive Medical Board, hereinafter referred to as the Board, shall consist of the following voting members:
 - a. The Chairs of Clinical Departments or his/her designee
 - b. The Dean of the School of Medicine
 - c. The Officers of the Medical Staff
 - d. The Director of Nursing and Patient Care Services

- e. A member of the House Staff
 - f. Two members of the Medical Staff with clinical activity at UCSF Medical Center selected by the Nominating Committee
 - g. The past President of the Medical Staff
 - h. The Chair of the Department of Clinical Pharmacy
 - i. The Chair of the Quality Improvement Executive Committee
 - j. The Chief Executive Officer of the Medical Center
 - k. The Chief Medical Officer of the Medical Center
 - l. The Chief Operating Officer of the Medical Center
 - m. A Medical Staff member active at the Mount Zion Campus
 - n. The Associate Dean of the Graduate Medical Education Program
 - o. The Chair of the Credentials Committee
 - p. The Chair of the Risk Management Committee
 - q. UCSF Children's Hospital Physician in Chief
 - r. UCSF Children's Hospital Surgeon in Chief
 - s. Executive Director, UCSF Children's Hospital
 - t. Chair, UCSF Children's Hospital Quality Improvement Executive Committee
2. Members who are unable to attend meetings may send a non-voting substitute.
 3. The House Staff member shall be appointed by the President from a panel of nominees provided by the Chief Residents.
 4. A quorum shall consist of ten (10) voting members.

Section B: Duties of the Executive Medical Board

The duties of the Executive Medical Board 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 divisions and 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 Medical Center and to receive and act on reports from these committees.

4. To act for the Medical Staff as a whole under such limitations as may be imposed by the Medical Staff.
5. To assure conformity, where indicated, with external licensure, certification, and accreditation requirements.
6. To recommend to the Chancellor individuals proposed by Chiefs of Service, and endorsed by the Credentials Committee, for Medical Staff membership, and to recommend delineated clinical Privileges for each eligible individual.
7. To advise Medical Center leadership on the sources of the hospital's services that are provided by consultation, contractual arrangements, or other agreements.

Section C: Meetings of the Executive Medical Board

1. The Executive Medical Board shall meet monthly, with a minimum of ten (10) meetings per year, and shall hold such additional meetings, at the call of the President or any five (5) members, as may be necessary for the conduct of its business.
2. Additional Executive Medical Board meetings, as defined above, may be conducted by telephone conference which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Meetings may also be conducted utilizing other electronic methods that permit for the interchange of information prior to the EMB making recommendations to the Governing Body. This will include electronic meetings of the EMB Executive Committee (comprised of the President of the Medical Staff, the President-elect of the Medical Staff, the Chief Medical Officer and the Chair of the Bylaws Committee) for the purpose of expedited review and approval on behalf of the greater EMB of:
 - The approved applications for membership to the Medical Staff by the Credentials Committee Chair (or designee); and
 - Established Policies and Procedures to be approved for revisions only.
3. A permanent record shall be kept of the minutes of all meetings and a report of Board actions shall be made to the Medical Staff at the Annual Meeting.

ARTICLE VII: COMMITTEES OF THE MEDICAL STAFF

Section A: Membership

Except as otherwise noted below, and with the approval of the Executive Medical Board and the Chancellor, the President shall appoint a Chair and members for all committees and sub-committees of the Medical Staff. Each shall be composed of at least four members of the Medical Staff and such additional members and non-members as may be appropriate.

Section B: Meetings

Standing committees and sub-committees of the Medical Staff shall meet as often as necessary to conduct their business. A written record of these meetings shall be maintained and quarterly reports of committee activities shall be made to the Executive Medical Board and the Chancellor. Unless otherwise specified, fifty percent (50%) 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. There shall be no minimum attendance requirements, but all committee members are encouraged to attend.

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

Section C: Authority and Responsibility

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

Section D: Standing Committees

1. Governance Advisory Council: To assist in providing oversight and governance of the Medical Staff, the Chancellor shall establish and chair the Governance Advisory Council which shall be comprised of at least the following members: the Chancellor, Chief Executive Officer of the Medical Center, Dean of the School of Medicine, President, President-Elect and Immediate Past President of the Medical Staff, President of the Medical Group, Representative from General Counsel, the Chief Medical Officer, the Chief Operating Officer, Director of Nursing and Patient Care Services and one or more members at large from the Medical Staff appointed by the President of Medical Staff with approval from the Chancellor. The Council shall meet at least quarterly and shall maintain records of matters discussed and actions taken.
 - a. The Governance Advisory Council serves as the formal means of liaison between the Chancellor as the governing body, Medical Center Administration, and the Medical Staff for oversight and governance of performance improvement and Medical Staff matters as required by the Joint Commission on Accreditation of Health Care Organizations. The Governance Advisory Council also serves as the formal means for the medical staff to participate in the development of Medical Center policy.
 - b. This Council shall serve as a focal point for furthering an understanding of the roles, relationships, and responsibilities of the Governing Body, administration, and the Medical Staff and shall provide a forum for conflict resolution.
 - c. The final approval or disapproval of all Medical Staff recommendations concerning physicians' appointments, terminations, committee actions, or any other action requiring governance, lies with the Chancellor as the Governing Body.
 - d. The Chancellor shall act upon recommendations from the Medical Staff relating to Medical Staff issues (e.g., appointments to membership) within a reasonable period of time. The Chancellor shall not take an action contrary to such recommendations without first discussing the matter with the membership of the Governance Advisory Council.
 - e. Each member of the Council shall complete a "Statement of Interest" form and shall submit it to the Medical Staff Administration Office as required on an annual basis.
2. Nominating Committee: The Nominating Committee shall be composed of the outgoing President of the Medical Staff, the two most recent past presidents, the Dean of the School of Medicine, the President of the Clinical Faculty Association or his/her designee, and the Chief Executive Officer of the Medical Center. The Chair shall be the past President most removed

from office. The Committee shall biennially nominate one candidate for President-Elect and two Faculty members with clinical activity at UCSF Medical Center for the Executive Medical Board and shall present these names at the Annual Meeting of the Medical Staff.

3. **Credentials Committee:** The Chair of the Credentials Committee shall be the immediate past President of the Medical Staff. The Committee shall be responsible for recommending appointments and reappointments to the Medical Staff, delineation of staff Privileges, and application of corrective actions where indicated. The Credentials Committee shall be composed of at least one member from each Department and eight members shall constitute a quorum. Upon appointment to the committee, members shall attest credentialing decisions will be conducted in a non-discriminatory manner.
4. **Quality Improvement Executive Committee:** The Committee shall be responsible for the coordination of the overall Performance Improvement program, including the integration of activities of the other Quality Committees and of inter-departmental issues, the review of sensitive cases of provider performance, and articulation with the credentialing process. It shall be responsible for the development, implementation, and evaluation of a comprehensive Performance Improvement Plan, and shall regularly report its findings to the Executive Medical Board. The Performance Improvement Plan, as adopted by the Committee and approved by the Executive Medical Board, shall be a part of these Bylaws, Rules and Regulations. The Performance Improvement Plan indicates and defines additional Medical Staff committees.
5. **Physician Well-Being Committee (PWBC):**

The purpose of the PWBC is to support the well being of medical staff and housestaff members consistent with the obligation of the Medical Staff to protect patients, insure quality of patient care, and improve Medical Staff functioning.

The committee strives to achieve this purpose through facilitation of treatment for, prevention of, and intervention in physician impairment or potential impairment caused by chemical dependency or behavioral problems.

Policy and procedures shall be developed and implemented to confidentially manage physician well being matters which may affect patient care delivery and for which assistance to the physician member may be appropriate and necessary. PWBC operates as a peer review committee and its activities and proceedings are protected under evidence code 1156, et seq.

The PWBC commits to a non-punitive process that encompasses the following elements:

- The education of physician and hospital staff regarding recognition of potential impairment on the part of its members.
- A confidential environment for self-referral to the PWBC by a physician, as well as referral to the committee of concerns regarding physician colleagues by other organization staff.
- Evaluation of the credibility of a complaint, allegation or concern.
- Facilitation of referral of the affected physician to the appropriate professional internal and external resources for evaluation, diagnosis and treatment of the condition or concern.
- Maintenance of confidentiality of the physician, 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 complaint, allegation or concern which is brought to the committee
- Monitoring the affected physician and the safety of patients until the rehabilitation or any required monitoring process is complete and periodically thereafter, if required.
- Reporting to the President of the Medical Staff instances in which a physician is providing unsafe patient care.

The PWBC is comprised of representatives from at least the following areas: Faculty and Staff Assistance Program, Legal Affairs (*ex officio*), Departments of Psychiatry and Anesthesia and a Housestaff representative.

6. Bylaws Committee: The Chairperson of the Bylaws Committee shall be the immediate past Credentials Chair or as appointed by the President of the Medical Staff. The committee shall be responsible for the biennial review of the Medical Staff Bylaws, Rules and Regulations and recommend appropriate revisions to the Executive Medical Board for approval and recommendation to the Governing Body.
7. The Pharmacy and Therapeutics Committee: The Pharmacy & Therapeutics Committee is composed of physicians, pharmacists, nurses, and other healthcare professionals at UCSF Medical Center. The committee reports and recommends policies to the Executive Medical Board on matters related to the therapeutic use of medications and related pharmaceutical devices. Other responsibilities include, but are not limited to:
 - Developing, maintaining, and approving changes to the Medical Center formulary using evidence-based evaluations of efficacy, safety, and cost-effectiveness.
 - Reviewing and approving the use of medications in order sets and disease management protocols. This function may be delegated to a task force of members with expertise in the relevant clinical areas.
 - Educating the Medical Center community about the appropriate use of medications and notifying providers about important new concerns related to a medication's safety or availability
 - Reviewing Medical Center policies related to medication management
 - Reviewing drug utilization patterns at the Medical Center towards a goal of ensuring safety, appropriateness, and cost-effectiveness
 - Reviewing the findings and recommendations from the Anticoagulation, Antibiotic Advisory and Medication Safety Subcommittees
 - Monitoring the results of continuous quality improvement efforts regarding pharmaceutical services
8. The Committee on Interdisciplinary Practice ("CIDP") exists to provide medical staff oversight to non-medical staff members as well as fulfill State of California requirements related to performance of standardized procedures by registered nurses and privileging of health care professionals who are not members of the medical staff organization of UCSF Medical Center (UCSF) but who are required to be privileged by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"). The committee is responsible for recommending appointments and reappointments of Allied Health Professionals, delineation of staff privileges and practice protocols. The membership shall be consistent with the requirements set forth by Title 22 Section s70706.

9. The Risk Management Committee (RMC) has the responsibility for the review of claims and for determining trends and opportunities to reduce risk and recommend systems improvements to minimize risk.
 1. Defines approaches to clinical management to reduce risk and improve care
 2. Reviews changes in health care law and educates Medical Center staff about applicable legislation.
 3. Reviews and assesses professional liability claims and litigated cases with respect to standard of care causation and damage issues.
 4. Provides guidance and input to outside counsel regarding claims and clinical management issues.
 5. Reports monthly to the Governance Advisory Council
 6. Other duties as defined in the Performance Improvement Plan.

10. The Patient Safety Committee is a multidisciplinary Medical Staff committee that:
 1. Provides consistent oversight of the investigation and mitigation of adverse events, conducts root cause analysis activity.
 2. Monitors the effectiveness of risk reduction strategies and measures of change to ensure ongoing system improvement.
 3. Reviews and evaluates incidents ranked as serious, assigns responsibility for follow-up.
 4. Identifies system issues that would lead to the likelihood of the event occurring in other settings and delegates appropriate actions to mitigate those future risks.
 5. Reviews aggregate adverse event and incident report data for issues and trends.
 6. Prioritizes safety system issues that require action.
 7. Other duties as defined in the Performance Improvement Plan.

The Patient Safety Committee is chaired by the Chief Medical Officer with the following representatives: Chief Nursing Officer; Physician Representatives from Ambulatory, Medicine, Pediatrics and Surgery; the Chair of the Risk Management Committee; the Director of Patient Safety and Quality Services; the Director of Risk Management and other representatives as needed.

Section E: Special Committees

With the concurrence of the Executive Medical Board, 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 VIII: MEETINGS

Section A: Annual Meeting

An Annual Meeting of the Medical Staff shall be held in the spring of each year at a time and place designated by the President with thirty (30) days' advance written notice to the voting membership. For conduct of business fifty (50) members of the Attending Staff present and voting shall constitute a quorum.

Section B: Special Meetings

With thirty (30) days' advance written 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 (10) voting members of the Medical Staff. For the conduct of business, fifty (50) members of the Attending Staff present and voting shall constitute a quorum.

Section C: Clinical Service Meetings and Educational Conferences

Each clinical service shall hold monthly meetings for its members, and shall maintain a written record of the attendance and minutes of these meetings. In addition to routine clinical service business, such meetings or additional meetings called shall serve to provide continuing education opportunities for members of the clinical service, review deaths and complications occurring in the clinical service, and review clinical service participation in performance improvement activities. Unless otherwise specified by the Chief of Service, there shall be no minimum attendance requirements.

ARTICLE IX: RULES AND REGULATIONS

The Executive Medical Board shall adopt such Rules and Regulations as may be necessary to assure the proper conduct of Medical Staff business and provision of patient care. Such Rules and Regulations shall be consistent with the Bylaws. Following Executive Medical Board approval, a Rule shall become effective following approval of the Governing Body, which approval shall not be withheld unreasonably, or automatically within 60 days if no action is taken by the Governing Body.

Medical Staff policies shall be developed as necessary to implement more specifically the general principles found within these Bylaws and the Medical Staff Rules. The policies may be adopted, amended, or repealed by majority vote of the Executive Medical Board and approval by the Governing Body. Such policies shall not be inconsistent with the Medical Staff Bylaws, Rules or other Medical Center policies.

ARTICLE X: AMENDMENT OF BYLAWS

Section A: Amendment Procedure

The Bylaws may be amended at any Annual or Special Meeting of the Medical Staff provided that thirty (30) days' advance written notice of the proposed amendments is given to the voting membership. Amendments shall require an affirmative vote of two-thirds (2/3) of the members present and eligible to vote and approval of the Governing Body. Neither the Medical Staff nor the Governing Body may unilaterally amend the Medical Staff Bylaws.

Section B: Interim Amendment of Bylaws

The Bylaws may be temporarily amended by a two-thirds (2/3) affirmative vote at a regular or special meeting of the Executive Medical Board and subsequent approval by the Governing Body. Such temporary amendments shall be submitted to the Medical Staff at the next Annual 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.

Section C: Technical and Editorial Amendments

The Executive Medical Board 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 Governing Body within ninety (90) days after adoption by the Executive Medical Board. The action to amend may be taken by motion and acted upon in the same manner as any other motion before the Executive Medical Board. Such approved amendments shall be communicated in writing to the Medical Staff at the next Annual Meeting, or sooner if deemed necessary by the Executive Medical Board or Governing Body.

ARTICLE XI: ADOPTION OF BYLAWS

These Bylaws shall be adopted by the affirmative vote of a majority of the members of the Medical Staff attending a Special Meeting called for that purpose and shall be implemented following approval of the Governing Body

ARTICLE XII: CONFIDENTIALITY

Section A: General

Medical Staff, clinical service, section or committee minutes, files and records, including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the Medical Staff committee files and shall not become part of any particular patient's file or of the general Medical Center records. Dissemination of such information and records shall be made only where expressly required by law, pursuant to officially adopted policies of the Medical Staff, or, where no officially adopted policy exists, only with the express approval of the Executive Medical Board or its designee and the Chief Executive Officer.

Section B: Breach of Confidentiality

Inasmuch as effective credentialing, performance improvement, peer review, and consideration of the qualifications of Medical Staff Members and applicants to perform specific procedures must be based on free and candid discussions, and inasmuch as Practitioners and others participate in credentialing, performance improvement, and peer review activities with the reasonable expectations that this confidentiality will be preserved and maintained, any breach of confidentiality of the discussions or deliberations of Medical Staff clinical services, section or committees, except in conjunction with another health facility, professional society, or licensing authority peer review activities, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the Medical Center's operations. If it is determined that such a breach has occurred, the Executive Medical Board may undertake such corrective action as it deems appropriate.

Section C: Immunity and Releases

1. Immunity from Liability for Providing Information or Taking Action

Each representative of the Medical Staff and Medical Center and all third parties shall be exempt from liability to an applicant, member, or practitioner for damages or other relief by reason of

providing information to a representative of the Medical Staff, Medical Center, or any other health-related organization concerning such person who is, or has been, an applicant to or Member or who did, or does exercise Privileges or provide services at this Medical Center or by reason of otherwise participating in a Medical Staff or Medical Center credentialing, performance improvement or peer review activities.

2. Activities and Information Covered

The immunity provided in this article shall apply to all acts, communications, reports, recommendations, other information or disclosures performed or made in connection with this or any other health-related institution's or organization's activities concerning, but not limited to:

- a. Applications for appointment, Privileges or specified services;
- b. Periodic reappraisals for reappointment, Privileges, or specified services;
- c. Corrective action;
- d. Hearings and appellate reviews;
- e. Performance Improvement review, including patient care audit;
- f. Peer review;
- g. Utilization reviews;
- h. Morbidity and mortality conferences; and
- i. Other Medical Center, clinical service, section or committee activities related to monitoring and improving the quality of patient care and appropriate professional conduct.
- j. A Practitioner's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or other matters that might directly or indirectly affect patient care.

3. Releases

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

4. Cumulative Effect

Provisions in these Bylaws and in Medical Staff application forms relating to authorizations, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

5. Authority to Act

Any member who acts in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Executive Medical Board may deem appropriate.