

**UNIVERSITY OF CALIFORNIA
SAN FRANCISCO**

BYLAWS OF THE MEDICAL STAFF

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PREAMBLE

In recognition of their responsibilities for overseeing, on behalf of the Governing Body, the quality of patient care, treatment, and services provided at UCSF Medical Center (the “Medical Center”), the physicians, dentist/oral surgeons, and other eligible health care professionals at UCSF Medical Center, hereby organize themselves as the Medical Staff of UCSF Medical Center (the “Medical Staff”). This organization shall be self-governing in conformity with federal and state regulatory requirements, The Joint Commission accreditation standards, and the guiding principles set forth in these Bylaws and Rules and Regulations hereinafter stated, and is subject to the ultimate 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, who shall govern all activities of the Medical Center consistent with University policies and procedures and actions of The Regents.

These Bylaws address the Medical Staff’s rights and responsibilities with respect to self-governance. In particular, these Bylaws address the Medical Staff’s responsibilities to establish criteria and standards for Medical Staff membership and privileges, and to enforce those criteria and standards; they establish clinical criteria and standards to oversee and manage patient care, patient safety, performance improvement and resource utilization, and other Medical Staff activities. They provide for periodic meetings of the Medical Staff, its committees, departments, and clinical services, and they describe the means by which the Medical Staff shall participate in the development of Medical Center policy. With respect to all of the foregoing, the Medical Staff is accountable to the Chancellor, as The Regent’s designated Governing Body, for complying with and effectively performing the responsibilities set forth in these Bylaws and Rules and Regulations.

Finally, notwithstanding the provisions of these Bylaws, the Medical Staff acknowledges that the Governing Body must act to protect the quality of medical care provided and the competency of the Medical Staff. In adopting these Bylaws, the Medical Staff commits to exercise its responsibilities with diligence and good faith; and in approving these Bylaws, the Governing Body commits to allowing the Medical Staff reasonable independence in conducting the affairs of the Medical Staff. Accordingly, the Governing Body will not assume a duty or responsibility of the Medical Staff precipitously, unreasonably, or in bad faith; and will do so only in the reasonable and good faith belief that the Medical Staff has failed to fulfill a substantive duty or responsibility in matters pertaining to the quality of patient care.

DEFINITIONS

1. **ADVANCED HEALTH PRACTITIONER (“AHP”)** means an individual, other than a licensed physician, dentist/oral surgeon, clinical psychologist, podiatrist, or other professional allowed by the state to practice independently and approved by the Executive Medical Board and the Governance Advisory Council, 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 Governance Advisory Council, upon recommendation of the Committee on Interdisciplinary Practice and the Executive

- Medical Board, periodically determines the categories of individuals eligible for clinical privileges as an AHP. Advanced Health Practitioners 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 the physician appointed by the CEO and subject to approval by the Chancellor to serve as a liaison between the Medical Staff and the Medical Center.
 5. COMPLETE APPLICATION shall mean an application for either initial appointment or reappointment to the Medical Staff, or an application for clinical privileges, which has been determined by the applicable Department Chair or designee, the Credentials Committee, the Executive Medical Board (“EMB”) and/or the Governance Advisory Council 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 Governance Advisory Council, 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.
 6. 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.
 7. DEPARTMENT CHAIR shall mean the individual or designee who is responsible for administration and oversight of his/her respective Department at the Medical Center pursuant to the provisions of Article 4.2.
 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 (“GAC”) means the group, as chaired by the Chancellor, which facilitates the governance of the UCSF Medical Staff and oversees the quality of patient care, treatment and services provided at UCSF Medical Center, and as further described at Article 7.4.2.
 11. GOVERNING BODY means The Regents of the University of California who have delegated to the President of the University of California, who in turn has delegated the authority and responsibilities to the Chancellor of the University of California, San Francisco for the governance of UCSF Medical Center.
 12. HOUSESTAFF means post-medical school graduates who are pursuing an accredited course of study (e.g., ACGME- and ABMS-approved programs) at UCSF under the supervision of the Medical Staff.

13. **MEDICAL CENTER** means UCSF Medical Center, UCSF Benioff Children’s Hospital, UCSF Medical Center at Mount Zion and their licensed hospital-based outpatient departments, wherever located.
14. **MEDICAL STAFF** means the organizational component of the Medical Center that includes all physicians (M.D., M.B., or D.O.), dentist/oral surgeons, clinical psychologists, podiatrists, and other professionals allowed by the state to practice independently and approved by the Executive Medical Board and the Governance Advisory Council, who have been granted recognition as members pursuant to these Bylaws. The term Medical Staff shall also be deemed to refer to the “organized medical staff,” as that terminology may be used in various laws and regulations, and in any applicable standards of The Joint Commission.
15. **MEDICAL STAFF YEAR** means the period from July 1 through June 30.
16. **MEMBER** means any physician (M.D., M.B., or D.O.), dentist/oral surgeon, clinical psychologist, podiatrist, or other professional allowed by the state to practice independently and approved by the Executive Medical Board and the Governance Advisory Council, 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., M.B., or D.O. degree who is currently licensed to practice medicine in California.
19. **PRESIDENT** means the person who has been elected by the Medical Staff to act on their behalf.
20. **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.
21. **PRIVILEGES** means the permission granted to a Medical Staff member or AHP to render specific patient services.
22. **RULES AND REGULATIONS** refers to the Medical Staff Rules and Regulations adopted in accordance with these Bylaws unless specified otherwise.
23. **SCHOOL OF MEDICINE** means UCSF School of Medicine.
24. **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.
25. **THE REGENTS** means The Regents of the University of California pursuant to Article IX, Section 9 of the California Constitution.
26. **UCSF MEDICAL GROUP (“Medical Group”)** means the UCSF provider organization consisting of salaried faculty at UCSF and other Medical Group contracted health care providers.

1.0: NAME AND DESCRIPTION OF MEDICAL STAFF ORGANIZATION

1.1 Name

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

1.2 Relationship Between Medical Staff, Medical Center and Medical School

- 1.2.1 These Bylaws describe the roles, rights, and responsibilities of the Medical Staff and its members, in their capacity delivering and overseeing care, treatment, and services to patients.
- 1.2.2 The Medical Center operates as a teaching hospital to support the educational activities for the UCSF training programs. Members of the Medical Staff have clinical roles and responsibilities subject to the Bylaws, Rules and Regulations of the UCSF Medical Staff and may concurrently participate in teaching, administrative and/or research activities under the auspices of the UCSF School of Medicine.
- 1.2.3 These Bylaws relate solely to responsibilities of Medical Staff members in their capacity as clinicians delivering and overseeing the delivery of patient care. As such, all activities conducted on behalf of the Medical Staff shall have, as their overriding purpose, the delivery of safe, effective, and high quality patient care.
- 1.2.4 To accomplish these purposes, the Medical Staff is organized as follows. Each member is assigned to the attending, affiliate, or courtesy staff category. The rights, responsibilities, and prerogatives of each staff category are described in these Bylaws.
- 1.2.5 Each clinical department is subject to oversight by a department chair. As noted above, the department chairs often function in dual roles – one as a UCSF School of Medicine clinical department chair and as a clinical service chief (or the Department Chair may designate such an individual). For some departments the academic department chair may appoint a clinical service chief to oversee clinical activities within UCSF Medical Center. The clinical chiefs of service have a number of responsibilities for oversight of clinical activities within the UCSF Medical Center, including credentials review, peer review, and quality of care and utilization review, on behalf of the organized Medical Staff. Members of the UCSF Medical Center staff are also subject to Bylaws, Rules and Regulations and policies of the Medical Staff and the Medical Center and, if also a member of the faculty of the School of Medicine are also subject to University policies and procedures.
- 1.2.6 Medical Staff committees oversee activities of the clinical departments and clinical services, such as, but not limited to: credentialing and peer review, oversight of quality, safety and appropriateness of care, treatment, and services. Additionally, these committees participate, on behalf of the Medical

Staff, in the formulation and/or review of Medical Staff and Medical Center policies within the purview of the respective committees' responsibilities.

- 1.2.7 The Executive Medical Board, which is comprised of elected and appointed officials of the Medical Staff and the Medical Center, oversees the quality of patient care, treatment and services through Medical Staff committees and clinical Department activities. All Medical Staff committees and clinical Departments report to the Executive Medical Board.
- 1.2.8 The Chief Medical Officer serves as a liaison between the Medical Center and the Medical Staff.
- 1.2.9 The Executive Medical Board reports to the Governance Advisory Council, chaired by the Chancellor.
- 1.2.10 Matters involving faculty appointments and responsibilities are not governed by these Bylaws, but rather are subject to other University policies including the faculty code of conduct. However, matters that are relevant to a Medical Staff member's status both as a Medical Staff member and as a faculty member are subject to oversight by the responsible department chair and the President of the Medical Staff, who together will determine what appropriate action will be taken under these Bylaws and other University policies. If matters are unresolved at this level, Academic Affairs and Medical Staff leadership will determine further appropriate action

2.0: PREROGATIVES AND PURPOSE

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

- 2.1.1 To 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.
- 2.1.2 To ensure that all patients of the Medical Center receive care and consideration and to ensure that care, treatment, and services are not affected on the basis of race, color, national origin, religion, gender, physical or mental disability, medical condition, ancestry, marital status, age, sexual orientation, gender identity, citizenship, or status as a covered veteran (special disabled veteran, Vietnam era veteran, or any other veteran who served on active duty during a war or campaign or expedition for which a campaign badge has been authorized) or by source of payment, subject to state and federal laws and regulations. Nothing in the foregoing is intended to limit the responsibility of members of the Medical Staff to assess the appropriateness of treatment in light of the patient's total circumstances.
- 2.1.3 To initiate and maintain Bylaws, Rules and Regulations for self-governance.

- 2.1.4 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.
- 2.1.5 To work collaboratively with Medical Center administrative leadership in ensuring that the Medical Center is fiscally sound.
- 2.1.6 To foster education and research programs of the University of California in an integrated manner with the clinical programs of the Medical Center.
- 2.1.7 To ensure that the Medical Staff and its members exercise their rights and responsibilities in a manner that does not jeopardize the Medical Center's license, Medicare and Medi-Cal provider status, accreditations, or mission as an academic medical center.

3.0: MEMBERSHIP AND/OR CLINICAL PRIVILEGES

3.1: Eligibility and General Responsibilities of Membership and/or Clinical Privileges

- 3.1.1 Eligibility. Membership of the Medical Staff and/or granting of clinical privileges shall be extended only to professionally competent physicians, dentists/oral surgeons, clinical psychologists, and podiatrists, 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 Governance Advisory Council in accordance with these Bylaws. Only physicians (MDs, MBs and DOs) with the appropriate admitting privilege(s) are allowed to admit patients.
- 3.1.2 General Requirements for Physician Members
 - 3.1.2.1 Physician 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.
 - 3.1.2.2 Physician members of the Medical Staff must have a Federal DEA number or furnishing license if prescribing controlled substances.
 - 3.1.2.3 Physicians who are seeking new membership/privileges or reappointment of the same must meet the following requirements:
 - 3.1.2.3.1 Completion of residency program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Board of Oral and Maxillofacial Surgery (ABOMS) (or verifiable equivalent non-U.S. training*) that includes complete training in the specialty or subspecialty for which the physician or oral surgeon is applying for credentials.

And

3.1.2.3.2 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);

3.1.2.3.3 Physicians and oral surgeons 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 in which there is general training followed by subspecialty training, physicians may retain basic privileges in their general field if they maintain active board certification in their subspecialty.

Or

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

The physician or oral surgeon 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 (1) year of completing the appropriate ACGME/ABMS 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 physician or oral surgeon is required to become board certified within six (6) years following completion of his or her residency, the termination of the physician's or oral surgeon's 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 physician or oral surgeon 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.

3.1.2.3.5 *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 and presented, in writing, for consideration by the EMB through the Credentials Committee.

3.1.2.3.6 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 that is endorsed by the Department Chair and presented, in writing, for EMB consideration through the Credentials Committee. In certain exceptional circumstances, providers may be approved/granted membership/privileges by the Governing Advisory Council.

3.2

General Requirements for Non-Physician Members

- 3.2.1 Non-Physician 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.
- 3.2.2 Non-Physician members of the Medical Staff must have a Federal DEA number and furnishing license if prescribing controlled substances.

3.3 General Requirements for Medical Staff and Non-Physician Members

- 3.3.1 Physicians, dentists/oral surgeons, clinical psychologists, podiatrists, and AHPs must document their general competencies (as further described in Article 3.9) including but not limited to their experience, background, training, health status, and their ability to provide their patients with care at the generally recognized level of quality.
- 3.3.2 Physicians, dentists/oral surgeons, clinical psychologists, podiatrists, and AHPs must also document their adherence to the ethics of their profession, including refraining from fee splitting or other inducements relating to patient referral. The division of fees is prohibited, and will be cause for exclusion or removal from the Medical Staff.
- 3.3.3 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.
- 3.3.4 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 physician, dentist/oral surgeon, clinical psychologist, podiatrist or other professionals allowed by the state to practice independently and approved by the Executive Medical Board and the Governance Advisory Council, specializes.
- 3.3.5 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; however, except as otherwise provided with respect to temporary or visiting privileges, absence of Medical Staff membership will disqualify a person from providing patient care services at the Medical Center.
- 3.3.6 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 Department Chair.

- 3.3.7 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 Credentials Committee, of conforming coverage.
- 3.3.8 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.

3.4 Waiver of Qualifications

Insofar as is consistent with applicable laws, GAC 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 procedural hearing and appellate review rights provided for in the Fair Hearing Plan in these Bylaws.

3.5 General Responsibilities of Membership

- 3.5.1 Members must provide for continuous care and attend to patients at the Medical Center according to the principles established in these Bylaws, and Rules and Regulations.
- 3.5.2 Members agree to know these Bylaws, and Rules and Regulations and agree to be bound by them. Additionally, members are expected to comply with all applicable UCSF Medical Staff Bylaws, Rules and Regulations and Medical Center policies.
- 3.5.3 Only members of the Medical Staff shall have the privilege of independently managing treatment of patients at the Medical Center.
- 3.5.4 Except as otherwise approved by the Executive Medical Board, each Medical Staff member is expected to participate in the training of students and other trainees, develop and maintain teaching skills essential to effective functioning in contact with students and other trainees, and to 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.
- 3.5.5 Physicians supervising Advanced Health Practitioners are expected to provide such supervision in accordance with the applicable parameters for AHP supervision.

- 3.5.6 All members are responsible for timely completion of medical records, as more fully described in these Bylaws and Rules and Regulations. Members who admit patients, as well as members who are performing procedures requiring informed consent, are responsible to assure compliance with applicable laws, regulations and accreditation standards pertaining to history and physical examinations (see below, and Sections Two and Three of the Rules and Regulations) and informed consent (see below, and Section Two of the Rules and Regulations).
- 3.5.7 The requirements for performing and documenting medical histories and physical examinations are outlined in the Rules and Regulations. The medical history and physical examination are performed and documented by a physician, an oral surgeon, or other qualified licensed individuals in accordance with applicable laws, regulations and accreditation standards.
- As more fully described in the Rules and Regulations, prior to surgery or a procedure requiring anesthesia services and except in the case of emergencies, a history and physical examination requires compliance with either of the following:
- 3.5.7.1 The history and physical examination is performed and recorded within 24 hours after admission or registration and within 24 hours prior to surgery or a procedure requiring anesthesia; or
- 3.5.7.2 A history and physical examination is performed and recorded within the 30 days prior to admission or registration, and an update for changes is performed within 24 hours after admission or registration and within 24 hours prior to surgery or a procedure requiring anesthesia.
- 3.5.8 The requirements for obtaining informed consent are outlined in the Rules and Regulations, Section Two. At a minimum, informed consent shall be obtained for all surgeries, all invasive procedures, all other procedures requiring anesthesia, and for all procedures specifically required by applicable laws, regulations and accreditation standards.
- 3.5.9 Without limiting the obligations of each member to comply with the Medical Staff Bylaws, and Rules and Regulations, each member is expected to maintain all qualifications, participate in and cooperate with the Medical Staff in fulfilling quality improvement, peer review, utilization management, ongoing and focused professional practice evaluations, and related monitoring activities, and in discharging such other functions as may be reasonably required from time to time.
- 3.5.10 Reappointment and continuation of privileges are subject to at least biennial review, and ongoing monitoring is performed at least every six (6) months, and may be based upon criteria that include, but are not limited to quality of patient care, quality of teaching, and utilization of the Medical Center's resources.

3.6 Categories of Membership

3.6.1 Medical Staff

3.6.1.1 Attending Staff

Definition: Physicians, dentists/oral surgeons, podiatrists, or clinical psychologists or other professionals allowed by the state to practice independently and approved by the Executive Medical Board and the Governance Advisory Council, who are involved in patient care and/or in the supervision of students or house staff 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 staff at the Medical Center for a period of two (2) years shall automatically be transferred to Courtesy Status and/or be subject to a period of focused professional practice evaluation in order to maintain membership and privileges.

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.

3.6.1.2 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, and who have continuously maintained membership and privileges in active and good standing, and 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. Members of the Affiliate Staff who have not been involved in patient care at the Medical Center for a period of two (2) years shall automatically be subject to a period of focused professional practice evaluation in order to maintain membership and privileges. 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.

3.6.1.3 Courtesy Staff

Definition: Physicians, dentists/oral surgeons, 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 staff for a period of two (2) years shall be subject to a period of focused professional practice evaluation in order to maintain membership and privileges.

Prerogatives and Responsibilities: Such members may not vote or hold office and are not required to participate in Medical Staff committees (however, at the discretion of the Department Chair, and with the concurrence of the member, a Courtesy Staff member may be appointed to serve on sub-committees with or without vote, as specified by the President of the Medical Staff at the time of appointment).

3.6.1.4 Clinical Partner

Definition: Physicians, dentists/oral surgeons, podiatrists, clinical psychologists or other professionals allowed by the state to practice independently and approved by the Executive Medical Board and the Governance Advisory Council who are non-employed and/or non-faculty members of the University but affiliated and contracted members of the clinically-integrated physician network. Members of the Clinical Partner category are credentialed members of the UCSF Medical Staff but not required to request and maintain clinical privileges to practice at UCSF Medical Center and its licensed clinics. Members who require clinical privileges to practice at UCSF Medical Center and/or at its licensed clinics would be transferred to either the Attending Staff (as described in Bylaws 3.6.1.1) or Courtesy Staff (as described in Bylaws 3.6.1.3).

Prerogatives and Responsibilities: Clinical Partner members may advise UCSF Attending members; however, they may not admit patients. Clinical Partners are not required to supervise trainees. Members of the Clinical Partner category are not eligible to vote or to hold office except as otherwise provided in these Bylaws but they are encouraged to participate in continuing education activities, case conferences such as peer review, and in activities of the Medical Staff through membership on committees and attendance in its meetings. Members of the Clinical Partners category are required to report periodic quality and performance data.

3.7 Advanced Health Practitioners (AHPs)

3.7.1 Definition: Only AHPs in approved categories (see Credentialing Policy and Procedures in the Rules and Regulations) who are employed or contracted by the Medical Center, School of Medicine, or UCSF Medical Group are eligible to apply for Advanced Health Practitioner Staff. Applications (initial and reappointment) 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 Advanced Health Practitioner staff is automatically terminated if employment service contract is terminated.

3.7.2 General Requirement for AHPs

3.7.2.1 All AHPs must be licensed or otherwise certified to practice in the State of California or be specifically exempt from such requirements.

3.7.2.2 All AHPs must have a Federal DEA number and furnishing license if prescribing controlled substances.

3.7.2.3 Prerogatives and Responsibilities: AHPs shall provide services pursuant to approved standardized procedures and/or job descriptions delineated by the Department and granted by GAC through the Committee on Interdisciplinary Practice (CIDP) and EMB. Supervision requirements shall be specifically defined on any applicable Standardized Procedures, Nurse Practitioner Privilege Forms 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 rights 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 GAC, AHPs shall be expected to:

3.7.2.3.1 Meet the qualifications and perform responsibilities outlined in their respective privilege forms, Standardized Procedures, Delegation of Services Agreements and/or job descriptions;

3.7.2.3.2 Exercise independent judgment within their approved areas of competence, clinical privileges, applicable Standardized Procedures, and Delegation of Services Agreements, 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;

3.7.2.3.3 Participate directly in the management of patients;

3.7.2.3.4 May write orders;

3.7.2.3.5 Record reports and progress notes on patient charts;

3.7.2.3.6 Perform consultations, upon request.

3.7.2.3.7 Adhere to all requirements of the Medical Staff Bylaws and Rules and Regulations as may reasonably be construed to apply in the context of the limited role and scope of services of the AHP.

3.7.3 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. Notwithstanding the foregoing, clinical privileges exercised by AHPs are subject to oversight by the Medical Staff. Performance concerns, or problems with clinical care not believed to be sufficiently resolved through the foregoing policies, procedures, and/or service contract provisions may result in clinical privileges restriction, suspension or termination by the CIDP or the Executive Medical Board, subject to the following:

- 3.7.3.1 Prior to restriction, suspension or termination of clinical privileges of an AHP, the affected AHP shall be given notice of the proposed action and afforded an opportunity to present written or verbal response to the President of the Medical Staff (or his/her designee), who shall be authorized to take final action on behalf of the Medical Staff.
- 3.7.3.2 This section shall not be deemed to afford an AHP a right to a hearing pursuant to the Fair Hearing Plan of these Bylaws (Article 3.15).

3.8 Leave of Absence

- 3.8.1 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 Department Chair, which must be approved by the Credentials Committee and 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.
- 3.8.2 At least thirty (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 Department Chair who shall promptly forward the request to the Credentials Committee and to the EMB via the Medical 1 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 GAC 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. Failure to achieve a requested reinstatement does not give rise to procedural rights, as stated in the Fair Hearing Plan (Article 3.15) unless the reason for non-reinstatement is a medical disciplinary cause or reason.

3.9 Procedure for Appointment

- 3.9.1 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.

- 3.9.1.1 An applicant who does not meet the basic requirements 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 that does not meet the requirements is not entitled to the procedural hearing and appellate review rights provided for in the Fair Hearing Plan in the Bylaws.
- 3.9.1.2 Failure to File Reappointment Application: Failure without good cause to file a complete application for reappointment at least forty-five (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 the procedural hearing and appellate review rights provided for in the Fair Hearing Plan in the Bylaws.
- 3.9.2 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, including documentation of their general competencies regarding their experience, background, training, health status, and their ability to provide their patients with care at the generally recognized level of quality. Neither the Medical Staff nor GAC 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 is submitted directly to the Medical Staff Services Department by such sources.
- 3.9.2.1 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 GAC may request that

the applicant appear for an interview with regard to the application.

3.9.2.2 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 (6) 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 hearing and appellate review rights provided for in the Fair Hearing Plan in these Bylaws in the event of such withdrawal.

3.9.3 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:

3.9.3.1 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;

3.9.3.2 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;

3.9.3.3 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,

3.9.3.4 Whether the applicant has ever been charged with or convicted of a crime, other than a minor traffic violation, or whether any such action is pending.

3.9.3.5 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.

3.9.3.6 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.

3.9.3.7 A pledge from the applicant to provide continuous care to his/her patients.

- 3.9.3.8 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.
- 3.9.3.9 The applicant must also consent to and cooperate with any required physical or mental health evaluations and provide the results thereof as necessary to enable a full assessment of the applicant's fitness for duty. Noncooperation may result in: denial of the application for failure to satisfy his/her burden of producing adequate information for proper evaluation of qualifications.
- 3.9.3.10 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 laws or regulations, including those laws forbidding restraint 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.
- 3.9.4 Verification Process
- 3.9.4.1 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.
- 3.9.4.2 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.

- 3.9.5 Application Processing: After verification is accomplished and the application is fully complete it shall be reviewed and processed as follows:
- 3.9.5.1 Department Report: The Medical Staff Services Department shall make available the application and all supporting materials to the Chair of each Department 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 Department 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 Department Chair, the President of the Staff shall designate an alternate to make the evaluation and recommendations. Following the Department Chair's/designee's evaluation and recommendations, the report shall then be transmitted to the Credentials Committee. The time frame for completion of the Department report(s) shall be within thirty (30) days of receipt of a complete application.
- 3.9.5.2 Credentials Committee Report: The Credentials Committee shall review the application, supporting materials, the report of the Department Chair 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 Department 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 Department report, to be within thirty (30) days, unless the Credentials Committee requests additional information.
- 3.9.5.3 Executive Medical Board Recommendation: The EMB shall receive the reports and recommendations of the Department Chair 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 Governance Advisory Council as to Staff appointment and staff category in the case of applicants for Staff membership, the appointing Department, a general description of 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 GAC shall be at the next regular meeting of GAC following receipt of the Credentials Committee report, to be within thirty (30) days.

3.9.5.4 Effect of EMB Recommendation

3.9.5.4.1 Deferral: The EMB may defer making a recommendation for up to sixty (60) days 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 Department Chair as deemed appropriate.

3.9.5.4.2 Favorable Recommendation: When the recommendation is completely favorable, the application shall be forwarded promptly to the GAC for action.

3.9.5.4.3 Adverse Recommendation: If the recommendation of the EMB is adverse as defined in the Fair Hearing Plan (Article 3.15), the President of the Medical 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 GAC until after the applicant has exercised or waived such rights.

3.9.5.5 Governing Body Action

3.9.5.5.1 Deferral: The Governance Advisory Council may defer making a recommendation for up to sixty (60) days where the deferral is not solely for the purpose of causing delay. A decision 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. GAC may delegate the responsibility for further consideration to the EMB or Credentials Committee as deemed appropriate.

3.9.5.5.2 Unless subject to the provisions of the procedural hearing and appellate review provisions in the Fair Hearing Plan in these Bylaws, GAC shall act on the application no later than the second regularly scheduled meeting following receipt of the recommendation from the EMB. Action shall be taken within sixty (60) days after receiving a recommendation from the EMB.

3.9.5.5.3 Favorable Recommendation: If GAC adopts the recommendation of the EMB, the EMB recommendation shall become final.

3.9.5.5.4 Adverse Recommendation: If GAC does not adopt the recommendation of the EMB, the matter is referred back to the EMB

with instructions for further review and recommendation and a time frame for responding to GAC or GAC 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 GAC. If GAC adopts the recommendation, the recommendation becomes final.

3.9.5.5.5 If the action of GAC is adverse to the applicant, the President of the Medical Staff 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 (Article 3.15). In such case, the applicant shall be entitled to procedural hearings and appellate review rights provided in the Fair Hearing Plan of these Bylaws, and the adverse decision of GAC 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 procedural hearing and appellate review rights under the Fair Hearing Plan in these Bylaws have been exhausted or waived, GAC shall take final action.

3.9.5.5.6 All decisions to appoint shall include a delineation of clinical privileges, the designation of a staff category and clinical department, and any applicable conditions placed on the appointment or clinical privileges. The applicant shall be so notified within thirty (30) days of GAC's decision.

3.9.5.5.7 Subject to any applicable provisions of the Fair Hearing Plan in these Bylaws, notice of GAC's final decision shall be given in writing by the President of the Medical Staff to the applicant. In the event a hearing and/or appeal were held, provisions detailed in the Fair Hearing Plan in these Bylaws shall govern notice of GAC's final decision.

3.10 Term of Appointment

3.10.1 Appointments shall be effective on approval by GAC, and shall extend for a period of no more than two (2) years.

3.10.2 Initial appointments or the granting of new privileges shall be subjected to focused professional practice evaluation for a period of up to twelve (12) months, and extensions may be considered as indicated.

3.10.3 Reappointments will be for a period of not more than twenty-four (24) months.

3.11 Privileges

3.11.1 Delineation of Privileges in General

3.11.1.1 Exercise of Privileges: Except as otherwise provided in these Bylaws or the Rules and Regulations, every member or AHP providing direct clinical services at this Medical Center shall be entitled to exercise only those privileges specifically granted to him or her.

- 3.11.1.2 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.
- 3.11.1.3 Basis for Medical Staff Member or AHP Privilege Determination: Requests shall be evaluated on the basis of the medical staff member's or AHP's current clinical competence. This evaluation shall include, but is not limited to:
 - 3.11.1.3.1 Privileges for medical staff members shall generally require residency program training that encompasses the requested privileges; however, the Departments may establish alternative or additional criteria for specific clinical privileges; provided such criteria are approved by the Executive Medical Board and GAC.
 - 3.11.1.3.2 Evaluation of pertinent information concerning the medical staff member or AHP's general competencies obtained from other sources, peer references (especially when there are insufficient peer review data available) and information from other institutions and health care settings where a member or AHP exercises privileges; and
 - 3.11.1.3.3 Assessing the medical staff member's or AHP's education, training, experience, demonstrated professional competence and judgment, health status and evidence of physical ability to perform the requested privileges, clinical performance, and when available, the documented results of patient care and other performance improvement review and monitoring (including review of morbidity and mortality data, when available; and review of relevant provider-specific data as compared to aggregate data, when available), performance of a sufficient number of procedures each year to develop and maintain the member or AHP's skills and knowledge and compliance with any specific criteria applicable to the privileges requested.
 - 3.11.1.3.4 For medical staff members and AHPs, evaluation of challenges to any licensure or registration: involuntary restriction, suspension or termination of privileges or membership at another organization; or voluntary termination of privileges or membership after notice of investigation for a medical disciplinary cause or reason; or involuntary relinquishment of any license or registration; or voluntary relinquishment of any license or registration after notice of investigation for a medical disciplinary cause or reason; any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a settlement or final judgment against the applicant.
- 3.11.1.4 The processing of requests for clinical privileges is described in Article

3.9.

3.11.2 Visiting and Temporary Privileges

3.11.2.1 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 AHP 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) visiting privileges appointments in a twelve (12) month period and each visiting privilege appointment shall be granted for sixty (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:

- 3.11.2.1.1 Current licensure;
- 3.11.2.1.2 Relevant education and experience;
- 3.11.2.1.3 Current competence;
- 3.11.2.1.4 Ability to perform the privileges requested; and
- 3.11.2.1.5 Other criteria listed in the Credentialing Policy and Procedures for visiting privileges.

3.11.2.2 Temporary Privileges: In circumstances in which a new applicant for Medical Staff or Advanced Health Practitioner Staff membership is waiting for approval by GAC, temporary privileges may be granted for renewable sixty (60) day periods up to one hundred and twenty (120) days.

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

- 3.11.2.2.1 Current licensure;
- 3.11.2.2.2 Relevant education/training and experience;
- 3.11.2.2.3 Current competence;
- 3.11.2.2.4 Ability to perform the privileges requested; and
- 3.11.2.2.5 Other criteria listed in the Credentialing Policy and Procedures for initial appointments.

- 3.11.2.3 General Conditions and Termination
- 3.11.2.3.1 All requests for visiting or temporary privileges shall include a letter from the Department Chair providing the clinical rationale supporting the needed urgency of the privileges.
- 3.11.2.3.2 The results of the National Practitioner Data Bank and Medical Board of California queries have been obtained and evaluated.
- 3.11.2.3.3 The applicant has:
- 3.11.2.3.3.1 Filed a complete application with the Medical Staff office;
- 3.11.2.3.3.2 Demonstrated no current or previously successful challenge to licensure or registration exists;
- 3.11.2.3.3.3 Not been subject to involuntary termination of privileges at another organization, or not been subject to voluntary termination of privileges after notice of investigation for a medical disciplinary cause or reason; and
- 3.11.2.3.3.4 Not been subject to restriction of clinical privileges for a cumulative total of thirty (30) days or more for any twelve (12) month period, for a medical disciplinary cause or reason.
- 3.11.2.3.4 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.
- 3.11.2.3.5 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.
- 3.11.2.3.6 Visiting or temporary privileges may be granted by the President of the Medical Staff, the Chief Executive Officer, the Chair of the Credentials Committee for Medical Staff Members or the Chair of the Committee on Interdisciplinary Practice (CIDP) for AHPs (or their designees) on the recommendation of the Department Chair where the privilege(s) will be exercised.
- 3.11.2.3.7 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.
- 3.11.2.3.8 Providers granted visiting or temporary privileges shall be subject to focused professional practice evaluation and supervision specified by the Department, or as described in these Bylaws, Rules and Regulations.

- 3.11.2.3.9 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.
- 3.11.2.3.10 Visiting or temporary privileges may be terminated with or without cause at any time by the President of the Medical Staff, the responsible Department Chair, or the Chief Medical Officer after conferring with the President of the Medical Staff or the responsible Department Chair. A person shall not be entitled to the procedural rights afforded by the Fair Hearing Plan (Article 3.15) unless the reason for termination must be reported to the Medical Board of California as a medical disciplinary cause or reason.
- 3.11.2.3.11 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 physician's patient(s).
- 3.11.2.3.12 All persons requesting or receiving visiting or temporary privileges shall be bound by the Bylaws and Rules and Regulations.
- 3.11.2.4 Disaster Privileges: 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 (Medical Center Administrative Manual: Policy 1.02.13). The Section Chief of Logistics has the authority to grant privileges once the Hospital Incident Command System (HICS) is activated.
- 3.11.2.5 Emergency Privileges: In the event of an emergency, and whether or not the emergency management plan has been activated, 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.

3.12 Evaluation and Monitoring

3.12.1 General Overview of Evaluation and Monitoring

- 3.12.1.1 Routine evaluation and monitoring activities are conducted to assist the Medical Staff and Clinical Departments in assessing qualifications and performance of applicants, members of the Medical Staff, and AHPs. These activities consist of a variety of quality improvement activities, including but not limited to Focused Professional Practice Evaluations (FPPE), as further described in Article 3.12.2, Ongoing Professional Practice Evaluations (OPPE), as further described in Article 3.12.3, and

regular and systematic review of all reported issues or incidents involving members of the Medical Staff or AHPs exercising Clinical privileges.

- 3.12.1.2 Insofar as feasible, these activities should strive to produce detailed, current, accurate, objective and evidence-based information about the Medical Staff member or AHP. This information should be integrated into the general quality improvement and continuing education activities of the Clinical Departments. Specific information about the Medical Staff member or AHP should be reviewed on an ongoing basis, and considered in making decisions regarding the need for counseling and/or corrective action at any time, as well as in making appointment and reappointment decisions. Without limiting the foregoing, the President of the Medical Staff and CMO are to be promptly apprised of incident reports that involve significant patient care issues, patient safety or disruptive conduct.
- 3.12.1.3 These activities are to be conducted in a manner to preserve confidentiality established by applicable law and UCSF Medical Center and Medical Staff policy.
- 3.12.1.4 Routine FPPE and OPPE activities are not deemed medical disciplinary and do not give rise to procedural rights described in the Fair Hearing Plan (Article 3.15). However, where circumstances warrant, some of the same evaluation tools (such as proctoring or mandatory consultation) may be imposed as part of a medical disciplinary action, and in those cases only, procedural rights may apply if the measure imposed constitutes a reportable restriction of privileges, as further described in the Fair Hearing Plan (Article 3.15).
- 3.12.1.5 Information for focused and ongoing practice evaluations may be acquired through a variety of methods as deemed appropriate by the Department Chair, including but not limited to:
 - 3.12.1.5.1 Periodic random chart review
 - 3.12.1.5.2 Concurrent or retrospective review of selected charts
 - 3.12.1.5.3 Direct observation
 - 3.12.1.5.4 Proctoring (as further described below)
 - 3.12.1.5.5 Simulation
 - 3.12.1.5.6 Quality and Safety Dashboard data
 - 3.12.1.5.7 Monitoring of diagnostic and treatment techniques and/or clinical practice patterns
 - 3.12.1.5.8 Departmental Quality Review process

- 3.12.1.5.9 Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel
- 3.12.1.5.10 External peer review
- 3.12.1.5.11 Continuing Medical Education
- 3.12.1.5.12 Patient satisfaction data
- 3.12.1.5.13 Professional liability experience
- 3.12.1.5.14 Incident Reports
- 3.12.1.5.15 Compliance with Medical Staff Bylaws and Rules and Regulations
- 3.12.1.5.16 Compliance with Medical Center Policies and Procedures

3.12.2 Focused Professional Practice Evaluation (FPPE) Requirements

3.12.2.1 Initial and New Privileges. Except as otherwise determined by the Department Chair, FPPE for new applicants and members exercising new privileges will generally be conducted in accordance with standards and procedures defined in the FPPE policy and/or Rules and Regulations and will be documented on each Department's delineated clinical privileges form. FPPE should begin with the applicant's first admission or performance of the newly requested privilege. Each department/division will determine the number of cases or charts to be reviewed for privileging. While FPPE for new applicants should be completed within twelve (12) months, if indicated, the time may be extended at the discretion of the Department Chair. The inability to obtain an extension will be deemed a voluntary relinquishment of the privilege(s) and will not give rise to procedural rights described in the Fair Hearing Plan. While proctoring is the most common form of FPPE used in these circumstances, the Departments and Department Chairs are authorized to implement other methods for evaluating as deemed appropriate under the circumstances pursuant to the Medical Staff Focused Professional Practice Evaluation policy. In addition, members may be required to undergo FPPE 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).

3.12.2.2 Specific Professional Performance. FPPE processes are used to evaluate, for a time-limited period, a Practitioner's professional performance to include quality of care, patient safety and unprofessional behavior. The Medical Staff may supplement these Bylaws with Rules and Regulations, for approval by the Executive Medical Board and Governance Advisory Council, that will clearly define the general circumstances when a FPPE will occur, what criteria and methods should be used for conducting the focused evaluations, the appropriate duration of evaluation periods and requirements for extending the evaluation period, and how the information

gathered during the evaluation process will be analyzed and communicated, as per the Medical Staff Focused Professional Practice Evaluation policy (see Rules and Regulations, Section TBD). FPPE may also be implemented whenever the responsible Department Chair, Credentials Committee or Executive Medical Board determines that additional information is needed to assess a member's competence pursuant to the FPPE policy and/or Rules and Regulations. FPPE 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. During FPPE, the member must demonstrate that he/she is qualified to exercise the privileges that were granted.

3.12.2.3 Completion of FPPE. FPPE shall be deemed successfully completed when the practitioner completes the required number of cases or other criteria established by the FPPE plan within the time frame established in the Bylaws or as required by the Department Chair and the member's professional performance met the standard of care or other applicable requirements of the Medical Center.

3.12.2.4 Failure to Satisfactorily Complete FPPE. If a member completes the necessary volume of cases or meets other criteria established by the FPPE plan, but fails to perform satisfactorily during FPPE, he or she may voluntarily withdraw the privilege or request a review by the Credentials Committee.

3.12.3 Ongoing Professional Practice Evaluation (OPPE)

3.12.3.1 Ongoing evaluations of each member or AHP's professional performance will be conducted pursuant to the Medical Staff Ongoing Professional Practice Evaluation policy (see Rules and Regulations, Section TBD). Individual Departments will monitor and review clinical data, trends and outliers through the electronic Ongoing Professional Practice Evaluation (eOPPE) system per the Medical Staff OPPE policy in the Rules and Regulations. This process not only allows any potential performance problems to be identified and resolved as soon as possible, but also fosters a more efficient, evidence-based privilege renewal process.

3.12.3.2 The eOPPE allows the organization to identify professional practice trends that impact on quality of care and patient safety. Such identification may require intervention by the responsible Service Chief, Department Chair, Committee Chair, or officers of the Medical Staff.

3.12.3.3 If during the course of the ongoing professional practice evaluation there is uncertainty regarding the member or AHP's professional performance, further evaluation (i.e., FPPE) or referral for formal investigation and/or corrective action should be implemented, as appropriate under the circumstances.

3.13 Standard of Conduct

- 3.13.1 Medical Staff members are expected to fulfill their Medical Staff obligations in a manner that is within generally accepted bounds of professional interaction and behavior as defined by the EMB, consistent with UC policies, and communicated to the Medical Staff. The Medical Staff is committed to supporting a culture and environment that values integrity, honesty and fair dealing with each other and all staff, and to promoting a caring environment for patients, employees and visitors.
- 3.13.2 The Executive Medical Board may promulgate Rules and Regulations and policies implementing the purposes of this section, which may include, but are not limited to, specific conduct guidelines for professionalism, procedures for investigating and addressing incidents of perceived misconduct, and remedial measures including, when necessary, disciplinary action that generally should attempt to resolve matters through progressive counseling and opportunity to correct behavior and conduct, but may include, in appropriate circumstances, restriction, summary suspension or termination of Medical Staff membership and/or privileges.
- 3.13.3 Concerns, complaints or grievances should be brought to the attention of the most directly-responsible individual or body, such as the responsible Service/Division Chief, Department Chair, responsible committee chair, or the Chief Medical Officer through written notification, verbal notification or an incident report. The Executive Medical Board may establish in the Rules and Regulations formal processes for handling concerns, complaints or grievances.
- 3.13.4 Neither the Medical Staff, its members, committees, officers, leaders, GAC, nor any employee or agent of the Medical Center shall discriminate or retaliate in any manner against any person because that person has done either of the following:
 - 3.13.4.1 Presented a complaint, concern or grievance as noted above to the Medical Staff, or to an entity or agency responsible for evaluation, accreditation or regulatory oversight of the Medical Center or the Medical Staff, or to any other governmental agency.
 - 3.13.4.2 Has initiated, participated, or cooperated in an investigation or administrative proceeding related to the quality of care, services, or conditions at the Medical Center that is carried out by a governmental agency or by an entity or agency responsible for evaluation, accreditation or regulatory oversight of the Medical Center or the Medical Staff.

3.14 Termination or Suspension of Medical Staff Membership, Reduction of Clinical Privileges, and Other Corrective Action

- 3.14.1 Corrective action may be taken for a “medical disciplinary” cause or reason (meaning that aspect of an applicant’s or Member’s competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care) or as an administrative action (all corrective actions that are not for a medical disciplinary cause or reason shall be deemed administrative actions).

3.14.2 Grounds for Action

- 3.14.2.1 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, and as necessary to evaluate ongoing compliance with all qualifications and requirements of Medical Staff membership.
- 3.14.2.2 Violation of Specific Rules and Regulations of the Medical Center or of 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.
- 3.14.2.3 Misconduct; Disruptive Behavior Involving Patient Care, Quality of Care and/or Patient Safety: This shall include, but not be limited to, violations as indicated in Article 3.14.2.2 above, abandonment of a patient, unethical behavior, falsification of records; as well as disruptive behavior that does or reasonably may affect patient care, quality of care or patient safety, whether directly or indirectly.
- 3.14.2.4 Care Below Applicable Standards: This shall include, but not be limited to, incompetence, other unprofessional conduct (as excluded in Article 3.14.2.3 above), failure to adhere to patient care policies of the Medical Center, clinical performance below the standards of practice established by the clinical Department, provision of sub-optimal and/or sub-standard care, substantial or consistent misdiagnosis, and/or a demonstrated lack of clinical competence.
- 3.14.2.5 Disruptive Conduct that Interferes with Medical Center Operations and Medical Staff Functions: Continuous inability to work in harmony with others or evidence of disruptive behavior that interferes with Medical Center operations, or Medical Staff functions, or that inhibits others from carrying out their responsibilities may be cause for action where, in the judgment of the Executive Medical Board the conduct is otherwise sufficiently egregious in terms of severity or frequency that it constitutes unprofessional behavior or misconduct as to warrant corrective action. (Nothing in the foregoing is intended to limit the authority of academic leadership to initiate action as deemed necessary pursuant to University policies.)
- 3.14.2.6 Improper use of Medical Center resources.

3.14.3 Procedures

- 3.14.3.1 Any person may provide information to the Department Chair, the President of the Medical Staff, or the Chief Medical Officer about the conduct, performance, or competence of its members. When such information about a member of his/her Department comes to the

attention of the Department Chair, he/she may conduct a preliminary review of the matter, either directly or by delegation. The Department Chair shall keep the President of the Medical Staff apprised of all reports of potentially significant problems, as well as of any reviews or investigations conducted as a result thereof. If the Department Chair thereafter concludes that there appear to be grounds for invoking an investigation which may result in corrective action, he/she must submit a request for such an investigation to the President of the Medical Staff.

- 3.14.3.2 Any member of the Active Medical Staff, the President of the Medical Staff, the Chief Medical Officer or the Chief Executive Officer of the Medical Center may request the Executive Medical Board to undertake an investigation of a Medical Staff member when there are grounds for action as set forth herein. Requests for an investigation shall be in writing to the President of the Medical Staff and shall be supported by reference to specific activities or conduct constituting grounds for the request.
- 3.14.3.3 Within fifteen (15) days of receipt of the request to undertake an investigation, the President of the Medical Staff shall assess whether a formal investigation appears to be warranted, and if deemed warranted, assign the conduct of a formal investigation to the Credentials Committee, or a standing or ad hoc committee of the Medical Staff, 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. This time frame may be extended for good cause by the President of the Medical Staff who will document the reason for such extension.
- 3.14.3.4 If a formal investigation is initiated, the member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The timing of the notification and opportunity to provide information shall be determined by the chair of the committee conducting the investigation, and may be deferred if deemed necessary to assure that the investigation is not impaired; however, prior to finalizing any report or recommendations, the member shall be offered an opportunity to make an appearance before the committee and/or submit written materials. Neither this appearance nor the investigation referred to herein, shall constitute a hearing. This appearance shall be preliminary in nature, and none of the procedures contained in the Bylaws with respect to hearings shall apply. If a formal investigation is not initiated, the President of the Medical Staff will document the request and the reason(s) why an investigation was not warranted, and submit this documentation to the Medical Staff Office.
- 3.14.3.5 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.

- 3.14.3.6 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.
- 3.14.3.7 Within ten (10) 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.
- 3.14.3.8 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 or at a meeting to be held no later than thirty-five (35) days after the next regularly scheduled meeting
- 3.14.3.9 The Executive Medical Board may take any of the following actions on a request for corrective action after reviewing the findings and recommendations of the investigating body, 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:
- 3.14.3.9.1 Determine that no corrective action is to be taken. In this case, the information is removed from the member's credentialing file; provided, however, this information may be retained with the records of the EMB, and may be revisited and reintroduced to the member's file at a later date if future circumstances reasonably demonstrate a recurrence of past problems. When a decision is made to reintroduce evidence of past problems into a member's file, the member shall be notified and afforded an opportunity to provide a written response that will also be included in the member's file.
 - 3.14.3.9.2 Defer action for a reasonable time where circumstances warrant.
 - 3.14.3.9.3 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.
 - 3.14.3.9.4 Recommend restriction, suspension, or termination of clinical privileges.
 - 3.14.3.9.5 Recommend reduction of membership status or limitation of any prerogatives directly related to the member's delivery of patient care.

- 3.14.3.9.6 Recommend suspension, revocation, or probation of Medical Staff membership.
- 3.14.3.9.7 Take other appropriate action.
- 3.14.3.9.8 Recommend to the Governance Advisory Council that an already-imposed summary suspension of privileges, as described in this Article, be terminated, modified, or sustained.
- 3.14.3.9.9 Any action which, pursuant to these provisions constitutes grounds for a hearing, shall entitle the affected staff member to the procedural rights contained in Fair Hearing Plan (Article 3.15). Except for summary suspensions, any adverse recommendation shall be held in abeyance until the member has waived or exercised his/her rights under Article 3.15.4.
- 3.14.3.9.10 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.
- 3.14.3.9.11 If the Executive Medical Board fails to investigate or initiate corrective action and the Governance Advisory Council determines that its failure to do so is contrary to the weight of the evidence then available, the Governance Advisory Council 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 Governance Advisory Council, the Governance Advisory Council 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 Governance Advisory Council.
- 3.14.3.9.12 Nothing in this section shall prevent imposition of a summary suspension, below, at any time that circumstances appear to warrant.
- 3.14.3.9.13 The time frames established in these Bylaws for conduct of investigations and corrective actions are intended to guide the good faith and diligent exercise of responsibilities. However, failure to meet a time limitation stated in this Section shall not affect the authority of the Executive Medical Board to take such action as deemed warranted under the circumstances.

3.14.4 Summary Suspension

- 3.14.4.1 The Executive Medical Board or 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 operations of the Medical Center: the Department Chair, the President of the Medical Staff, the Chief Medical Officer, the Chief Executive Officer of the Medical Center, the Chancellor or Chancellor's designee. If the summary suspension is imposed by individuals other than the President of the Medical Staff (Department Chair, the Chief Medical Officer, the Chief Executive Officer of the Medical Center, the Chancellor or Chancellor's designee), he/she will consult with the President of the Medical Staff shortly after the summary suspension is imposed.

- 3.14.4.2 If the persons 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 or to prevent the disruption of the operations of the Medical Center, 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 Department Chair, the President of the Medical Staff, the Chief Medical Officer, the Chief Executive Officer of the Medical Center, 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.
- 3.14.4.3 The person(s) responsible shall promptly give written notice of the suspension or restriction to the member and the person(s) 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 Department Chair or designee, shall provide for alternative medical coverage for patient care with the wishes of the patients taken into consideration.
- 3.14.4.4 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 Fair Hearing Plan (Article 3.15).
- 3.14.4.5 In the event that an investigation is undertaken prior to the imposition of a summary suspension, the investigation shall be conducted in accordance with these Bylaws.
- 3.14.4.6 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. Except as otherwise determined by the Executive Medical Board, 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 Article 3.15 have been exhausted. Unless a postponement is concurred in by the affected staff member and the President of the Medical Staff, or an extension is granted by the Hearing Officer on a showing of good cause, 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.

3.14.5 Administrative Suspension

3.14.5.1 The President of the Medical Staff and the Chief Executive Officer of the Medical Center or his/her designee shall have the duty of enforcing all administrative suspensions. A member's Medical Staff membership and/or privileges shall be administratively revoked or suspended in the following circumstances:

3.14.5.1.1 License Revocation, Suspension and Expiration: Whenever a member's or AHP's license or other legal credential authorizing practice in this state is revoked, suspended, or expired, Medical Staff membership and clinical privileges shall be revoked or suspended administratively as of the date such action becomes effective and throughout its term.

3.14.5.1.2 Restriction: Whenever a member's or AHP'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 administratively be limited or restricted in a similar manner as of the date such action becomes effective and throughout its term.

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

3.14.5.1.4 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 thirty (30) days prior to cancellation or termination shall constitute administrative suspension of all privileges and membership on the Medical Staff.

3.14.5.1.5 Whenever a member's DEA certificate is revoked, limited, or suspended, the member shall be divested of the right to prescribe

medications covered by the certificate as of the date such action becomes effective and throughout its term.

- 3.14.5.1.6 Failure or refusal to complete medical records (for an in-patient or an out-patient) in accordance with applicable Medical Center and legal requirements after notice to the member of incomplete records, per the Medical Staff Administrative Suspensions Policy (see Rules and Regulations Section TBD). When a member has accumulated more than twenty-five (25) administrative 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 application shall be considered as if it were an initial application. Nothing in the foregoing precludes the imposition of other penalties pursuant to the Rules and Regulations or other actions where circumstances warrant.
- 3.14.5.1.7 Medicare/Medicaid Number: If a member or AHP 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 member's or AHP's privileges to provide services to or to order or prescribe any items, medications or services for any federal health care beneficiary, shall immediately and administratively be suspended, and the member's right to admit new (non federal health care beneficiary) patients shall also be immediately and administratively suspended. The member or AHP shall be permitted to complete providing services to other current hospital inpatients through the patients' discharge. Once such member's or AHP's participating provider status is fully restored and in good standing, then the member or AHP may apply for reinstatement of full privileges, which reinstatement shall be at the discretion of the EMB.
- 3.14.5.1.8 A member or AHP is required to advise the President of the Medical Staff or the Chief Executive Officer in writing immediately upon any exclusion, suspension, or change in status of the member's or AHP's participating provider status in a federal health care program or any investigation by a governmental agency relating to the member's or AHP'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.
- 3.14.5.1.9 Testing and Immunization Requirements: All Medical Staff members and AHPs 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 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, Article II: Infection Control and Communicable Diseases.

3.14.5.1.10 No hearing rights: Administrative suspension shall not constitute grounds for a hearing and are not reportable to the Medical Board of California.

3.14.5.1.11 Reinstatement: Except as otherwise provided herein, the President of the Medical Staff or designee may reinstate the member when the reason for the administrative suspension no longer exists. If the member's appointment to the Medical Staff has expired during the term of the administrative 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.

3.14.5.1.12 Other corrective action: In addition to administrative actions imposed pursuant to this Article 3.14.5, the Executive Medical Board may review the circumstances surrounding the action, conduct such further investigation as it deems necessary, and impose such other corrective action as it deems warranted. Should that occur, the member may have hearing rights, pursuant to Fair Hearing Plan (Article 3.15), only with respect to any additional disciplinary actions (i.e., those actions above and beyond the administrative actions).

3.14.6 No Right to Duplicative Hearings

3.14.6.1 If a member's membership or privileges is restricted, suspended or terminated based on Medical Staff's independent determination that cause for discipline exists, the 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 any 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. This is not intended to preclude the University from pursuing an investigation under the Faculty Code of Conduct and Medical Staff Bylaws as warranted in the University's judgment.

3.14.6.2 Any allegation regarding failure to comply with UCSF's billing policies shall be forwarded to UCSF's Chief Compliance Officer and/or the UC's Chief Compliance Officer and /or the Office of the General Counsel for resolution in accordance with UCSF's Compliance Program.

3.14.7 Mediation of Disputes (Between the EMB and a Practitioner)

3.14.7.1 Mediation is a confidential process in which a neutral person facilitates

communication between the Executive Medical Board and a Practitioner to assist them in reaching a mutually acceptable resolution of a peer review or other controversy in a manner that is consistent with the best interests of Medical Center operations, patient safety and/or quality of care. Parties to a dispute are encouraged to consider mediation whenever it appears reasonably likely to contribute to a productive resolution of a dispute. There is no right to mediation, and it need not be pursued if either party is unable or unwilling to proceed collaboratively and expeditiously.

- 3.14.7.2 If a member and the Executive Medical Board do agree to mediation, all deadlines and time frames relating to the Fair Hearing Plan (Article 3.15) process shall be suspended while the mediation is in process, and the Practitioner agrees that no damages may accrue as a result of any delays attributable to the mediation.
- 3.14.7.3 Mediation may be terminated at any time, and the request of either party.
- 3.14.7.4 The Executive Medical Board may promulgate further Rules and Regulations outlining appropriate procedures for initiating and conducting mediation.

3.15 Fair Hearing Plan

3.15.1 Request for Hearing; Hearing Arrangements and Notices

- 3.15.1.1 Nature of Hearing; Exhaustion of Remedies: 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 Termination or Suspension of Medical Staff Membership, Reduction of Privileges, and Other Corrective Action (Article 3.14), prior to invoking the process set forth in this Fair Hearing Plan (Article 3.15), and must exhaust the remedies set forth in these Bylaws before resorting to legal action.
- 3.15.1.2 Notice of Action: In any case where action has been taken constituting grounds for hearing, as set forth in Article 3.15.1.3, 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, or by personal delivery with documentation of receipt. Such notice shall include: (i) a description of the recommendation or action; (ii) a summary of the reasons therefore; (iii) if applicable, notification that such action, or recommended action if adopted, shall be reported to the Medical Board of California and/or National Practitioner Data Bank as required by law; (iv) that he/she has a right to request a hearing within thirty (30) days; and (v) of his/her rights with respect to such hearing. The applicant or member shall have thirty (30) days following date of receipt of the notice (which receipt shall be deemed to occur on the earlier of the date of actual receipt or three (3) days from the date of

mailing) within which to request a hearing by a Hearing Committee, as defined in subsection Article 3.15.1.3. The applicant or member shall also be given a copy of Fair Hearing Plan, Article 3.15. 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 receipt of notice to him/her and in the manner described within this subsection, he/she shall be deemed to have accepted this action, and, the recommendation of the Executive Medical Board shall be transmitted to the Governing Body for final action.

3.15.1.3 Grounds for Hearing: Any one or more of the following actions shall constitute grounds for a hearing:

3.15.1.3.1 Denial of application for Medical Staff membership or reappointment.

3.15.1.3.2 Denial, revocation, suspension, or involuntary restriction or reduction of Medical Staff clinical privileges.

3.15.1.3.3 Excluding proctoring incidental to initial appointment, or the granting of new clinical privileges, or imposed because of insufficient activity, or proctoring or consultation that does not restrict the practitioner's clinical privileges.

3.15.1.3.4 Summary suspension of Medical Staff membership and/or clinical privileges during the pendency of corrective action and hearings and appeals procedures.

3.15.1.3.5 Suspension or summary suspension of clinical privileges (excluding Visiting Privileges).

3.15.1.3.6 Any other disciplinary action or recommendation that must be reported to the Medical Board of California.

3.15.1.4 Notice of Charges and 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 (i) the reasons the action has been taken or recommended, including the acts or omissions with which the practitioner is charged; and (ii) the time, place, and date of the hearing.

3.15.1.4.1 The date of commencement of the hearing shall be not less than thirty (30) 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.

- 3.15.1.4.2 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 for good cause extended by the Hearing Officer, if one has been appointed, or by the Hearing Committee or its Chair.
- 3.15.1.4.3 However, when the request is received from a member who is under summary suspension, the hearing should be scheduled to commence on a date not more than forty-five (45) days from the date of receipt of the request unless extended for good cause by the Hearing Officer, if one has been appointed, or by the Hearing Committee or its Chair.
- 3.15.1.5 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. A majority of the hearing panel members are peers of the affected physician. The Hearing Committee shall consist of individuals who are not in direct economic competition with the member 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 President of the Medical Staff may designate one of the Hearing Committee members to serve as chair, failing which the Hearing Committee shall nominate, from amongst its members, a Chair. A Hearing Officer may be appointed pursuant to Article 3.15.1.6 below. Knowledge of the matter involved shall not preclude a member from serving on the Hearing Committee.
- 3.15.1.6 The Hearing Officer: The President of the Medical Staff in conjunction with the Office of Legal Affairs shall appoint a Hearing Officer to preside at the hearing. The Hearing Officer shall be an attorney at law, qualified to preside over a medical staff peer review hearing. Except as otherwise stipulated by the parties, an attorney from a law firm that regularly represents the Medical Center or the practitioner shall not be eligible to serve as a Hearing Officer.

- 3.15.1.6.1 Unless the parties agree, the parties shall be afforded a reasonable opportunity to participate in the selection of the Hearing Officer, as follows: (a) the practitioner shall be provided a list of at least three (3) but no more than five (5) potential Hearing Officers, meeting the criteria in this Article 3.15.1.6 the practitioner shall have five (5) working days to accept any of the listed potential Hearing Officers, (b) or to propose at least three (3) but no more than five (5) other names of potential Hearing Officers who meet the criteria in this Article 3.15.1.6 if the parties are not able to reach agreement on the selection of a Hearing Officer within five (5) working days of receipt of the practitioner's proposed list, the President of the Medical Staff in conjunction with the Office of Legal Affairs shall select an individual from the composite list.
- 3.15.1.6.2 Unless the Hearing Officer is selected by stipulation of the parties, he/she shall be subject to reasonable voir dire, as described at Article 3.15.1.7.
- 3.15.1.6.3 The Hearing Officer shall not act as a prosecuting officer or as an advocate for the Medical Staff, Medical Center or the Chancellor and shall gain no direct financial benefit from the outcome. He/she may participate in the deliberations of such body, but shall not 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.
- 3.15.1.6.4 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. This shall include, with the concurrence of the Hearing Committee and after reasonable notice and opportunity to cure, termination of the hearing in extraordinary circumstances of the practitioner's egregious noncompliance with the provisions of these Bylaws with respect to the conduct of the hearing and/or failure to proceed in an expeditious manner in light of the circumstances.
- 3.15.1.6.5 A termination of the hearing in this manner shall be deemed an adverse decision made by the Hearing Committee. The Hearing Committee will recommend termination of the hearing to the EMB for EMB's approval. The EMB decision may be appealed pursuant to Article 3.15.4 below.
- 3.15.1.7 Voir Dire: Except as provided above in Article 3.15.1.6.2, 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 shall be ruled on by the Hearing Officer. Challenges to the impartiality of the Hearing Officer shall be ruled on by the President of the Medical Staff in consultation with the Office of Legal Affairs.

3.15.2 Prehearing Matters

3.15.2.1 Pre-Hearing Conduct: The parties shall cooperate as reasonably necessary to facilitate each party's preparation and timely commencement of the hearing. This shall include, but is not limited to, timely exchange of prehearing documents, timely disclosure of requested witness lists, and timely raising and resolving such matters as can reasonably be resolved prior to actual commencement of the hearing, as further described below.

3.15.2.2 Access to and Exchange of Documents: The practitioner shall have a right to inspect and copy, at his/her expense, any documentary information relevant to the charges which the EMB has in its possession or under its control, as soon as practicable after the receipt of the practitioner's request for a hearing. Similarly, the EMB shall have the right to inspect and copy, at its expense, any documentary information relevant to the charges which the practitioner has in his or her possession or control as soon as practicable after receipt of the EMB's request. Additionally, both parties shall exchange all documents that they intend to offer into evidence at the hearing at least ten (10) working days prior to the commencement of the hearing. If a party fails to provide documents, the Hearing Officer in his/her discretion may for good cause grant a continuance or preclude the admission of documents that have not been produced. The right to inspect and copy by either party does not extend to information about individually identifiable licentiates other than the affected Member or initial applicant under review. The Hearing 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 requires.

3.15.2.3 Witnesses: Each party shall have the right to present witnesses. Each party is responsible for producing its own witnesses that it has identified. If either party by notice to the other requests a list of witnesses, the recipient, within the sooner of fifteen (15) working days from the receipt of the request or ten (10) working 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 for good cause grant a continuance or 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.

3.15.2.4 Effect of Noncooperation: As noted above, the failure to disclose the identity of a witness or to produce copies of all documents expected to be

introduced at the hearing at least ten (10) working 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. Repeated acts of noncooperation are also subject to the provisions of Article 3.15.3.1.

- 3.15.2.5 Timely Notification of Issues: 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 Hearing Officer (or if the Hearing Officer has not yet been appointed, 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.
- 3.15.2.6 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 Officer, the Hearing Committee or its Chair, acting upon its behalf.

3.15.3 Hearing Procedure

3.15.3.1 Failure to Schedule or Appear: If a person requesting the hearing fails to reasonably cooperate in establishing either the initial date for commencement of the hearing date or subsequent dates for continuance of a hearing once underway, or 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. Except as otherwise agreed by the parties, failure to appear and proceed shall be presumed if the person requesting the hearing is unwilling to agree to any proffered commencement dates within sixty (60) days of the initial request for hearing, or any continuation dates within a thirty (30) day period from the most recent day of hearing (i.e., unless agreed by the parties, the hearing must commence within sixty (60) days, and additional hearing dates must be conducted within thirty (30) days) unless the Hearing Committee members are not available to convene within this time frame.

3.15.3.2 Representation: The person requesting the hearings may be represented, at his/her expense, by a member of the Medical Staff or legal counsel of his/her choice, as next described; 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 EMB may be represented by an attorney from the Office of the General Counsel, but the EMB may not be represented by an attorney if the affected Member or applicant is not. When attorneys are not allowed, both parties may be represented at the hearing by a member of the Medical Staff 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. The Hearing Officer shall determine the role of attorneys or other representatives, and may eject any attorney or representative whose activities at the hearing, in his or her judgment, disrupt the proceedings.

3.15.3.3 Record of Hearing: The Hearing Officer 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 or can be shared if both parties agree. Except as otherwise provided in these Bylaws or authorized by the President of the Medical Staff or the Executive Medical Board, access to the records of the Hearing Committee shall be limited to the President of the Medical Staff, EMB, 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. Except as next provided, the affected member or applicant shall maintain the confidentiality of the

hearing record and the protections of California Evidence Code Section 1157 are not waived. The affected member or applicant may introduce the hearing record into a judicial proceeding challenging the final action taken or any procedural rulings that may be made by the Hearing Officer; provided, however, that UCSF may request a protective order as deemed necessary to protect the interests of peer review.

3.15.3.4 Rights of Both Sides: At a hearing, both parties shall have the following rights: 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. If the affected member or applicant does not testify on his/her own behalf, he/she may be called to testify. Both parties to the proceedings shall have a right to submit closing arguments and/or a written statement at the close of the hearing. The hearing shall be confidential and closed to the public.

3.15.3.5 Admissibility of Evidence: Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses and presentation of evidence do 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. EMB may object to the introduction of evidence that was not produced by the Petitioner during the appointment, reappointment, privilege delineation or corrective action process. The Hearing Officer shall bar such evidence unless the Petitioner reasonably demonstrates that he or she previously acted diligently and could not have previously produced it. The Hearing Committee may examine 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 shall consider the following:

3.15.3.5.1 Whether the information sought may be introduced to defend or support the charges.

3.15.3.5.2 The exculpatory or inculpatory nature of the information sought, if any.

3.15.3.5.3 The burden imposed on the party in possession of the information sought, if access is granted.

3.15.3.5.4 Any previous requests for access to information submitted or resisted by the parties to the same proceeding.

3.15.3.6 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.

3.15.3.7 Continuances: Continuances may be granted by the Hearing Officer upon agreement of the parties or upon a showing of good cause.

3.15.3.8 A majority of the Hearing Committee must be present throughout the hearing and deliberations. In unusual circumstances when a Hearing Committee member must be absent from any part of the proceedings, he or she shall not be permitted to participate in the deliberations or the decision until he or she has read the entire transcript or has listened to the taped recording of the portion of the hearing from which he or she was absent.

3.15.3.9 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 material fact.

3.15.3.10 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, EMB 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.

3.15.3.11 Adjournment and Conclusions: Subject to the provisions of Article 3.15.2.6, 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 and Hearing Officer shall conduct any deliberations outside the presence of the parties.

3.15.3.12 Decision of the Hearing Committee: Within thirty (30) 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 Medical Staff Office, 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.

3.15.3.13 Appeal: The decision of the Hearing Committee shall be final, subject only to the right of appeal as outlined in Article 3.15.4.

3.15.4 Appeal

3.15.4.1 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 an Appellate 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 take effect immediately, and be forwarded to the GAC for final action. The GAC shall affirm a Hearing Committee decision if it is supported by substantial evidence, following a fair procedure.

3.15.4.2 Grounds for Appeal: A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be:

3.15.4.2.1 Substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice.

3.15.4.2.2 The decision was not supported by substantial evidence based upon the hearing record.

3.15.4.2.3 The decision is not sustainable in light of new evidence as may be permitted pursuant to Article 3.15.4.4.

3.15.4.3 Time, Place, and Notice: An appeal to the Appellate Review Committee which meets one or more of the grounds indicated above in Article 3.15.4 will be considered. The Chancellor or his/her designee will, within fifteen (15) working days after receipt of such notice of appeal, schedule and arrange for an appellate review if he/she determines that valid grounds for review have been stated. 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 Appellate Review Committee for good cause.

3.15.4.4 Appellate Review Committee. A committee shall hear all appeals and be comprised of the Chancellor or the Chancellor's designee and two (2)

additional members from the Governance Advisory Council or the Medical Staff who have not been involved in any aspect of the case to be heard and who are selected by the Chancellor or his/her designee. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appellate Review Committee so long as that person did not take part in a prior investigation or hearing on the same matter. The Chancellor or his/her designee may select an attorney to assist the Appellate Review Committee in the proceeding. That attorney may function as an appeal Hearing Officer, with comparable authority to that described for the Hearing Officer per Article 3.15.1.6 and Article 3.15.3 of these Bylaws.

3.15.4.5 Appellate Review Procedure: The proceeding by the Appellate Review Committee shall be in the nature of an appellate review, based upon the record before the Hearing Committee; provided that the Appellate 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 Appellate 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 Appellate Review Committee and its attorney/appeal Hearing Officer may conduct deliberations outside the presence of the parties and their representatives.

3.15.4.6 Final Decision: Within thirty (30) days after the conclusion of the proceedings, the Appellate 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 Appellate Review Committee shall give great weight to the recommended decision of the Hearing Committee; however the Appellate Review Committee may exercise its independent judgment in determining whether a practitioner was afforded a fair hearing, and the decision is reasonable and warranted. The final decision of the Appellate Review Committee shall be effective immediately.

3.16 Waiting Period after Adverse Action

3.16.1 Who Is Affected

3.16.1.1 A waiting period of twenty-four (24) months shall apply to the following applicant or member:

3.16.1.1.1 An applicant who:

3.16.1.1.1.1 Has received a final adverse decision regarding appointment; or

- 3.16.1.1.1.2 Withdrew his or her application or request for membership or Privileges following an adverse recommendation by the Executive Medical Board or GAC.
- 3.16.1.1.2 A former member who:
 - 3.16.1.1.2.1 Has received a final adverse decision resulting in termination of Medical Staff membership and/or privileges; or
 - 3.16.1.1.2.2 Resigned from the Medical Staff or relinquished privileges while an investigation was pending or following the Executive Medical Board or GAC issuing an adverse recommendation.
- 3.16.1.1.3 A member who has received a final adverse decision resulting in:
 - 3.16.1.1.3.1 Termination or restriction of his or her privileges; or
 - 3.16.1.1.3.2 Denial of his or her request for additional privileges.
- 3.16.1.2 Ordinarily the waiting period shall be twenty-four (24) months; however, for applicants or members 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 GAC, to waive the twenty-four (24) month period in other circumstances where it reasonably appears, by objective measures, that changed circumstances warrant earlier consideration of an application.
- 3.16.1.3 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).
- 3.16.2 Date When the Action Becomes Final
 - 3.16.2.1 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 Fair hearings and appellate reviews and (b) all judicial proceedings pertinent to the action served within two (2) years after the completion of the Medical Center proceedings.
- 3.16.3 Effect of the Waiting Period
 - 3.16.3.1 Except as otherwise allowed (Article 3.16.1.2), Physicians subject to waiting periods cannot reapply for Medical Staff membership or the privileges affected by the adverse action for at least twenty-four (24)

months after the action became final. After the waiting period, the physician may reapply. The application will be processed like an initial application or request, plus the physician 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.

4.0: ORGANIZATION

4.1 Departments

4.1.1 The Medical Staff shall be organized into the Departments detailed below. Each member of the Medical Staff must belong to at least one of the following Departments:

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

4.1.2 Additional Departments may be created or existing Departments 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.

4.2 Department Chairs

4.2.1 Each Department shall have a Chair who shall be the corresponding Chair in the School of Medicine or his/her designee, except for the Chair of Dentistry/Oral Surgery Department who shall be designated by the Dean of the School of Dentistry. Each Department Chair shall be certified by an appropriate specialty board, or shall affirmatively establish comparable competence through the credentialing process.

4.2.2 Each Department Chair (or designee) shall maintain membership on the Attending Staff.

4.2.3 Department Chairs, or their designee(s), shall have the following duties and responsibilities, subject to the authority of the Executive Medical Board, the Chancellor and The Regents:

- 4.2.3.1 To supervise and evaluate clinical work carried out by members and AHPs of the Department.
- 4.2.3.2 To administer and implement these Bylaws, Rules and Regulations and Medical Staff and Medical Center policies within the Department.
- 4.2.3.3 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 Chair of the Department or his/her designee; provided, however, that if the Chair or his/her designee fails, without good cause, to render a recommendation within sixty (60) days, the application may be forwarded to the Credentials Committee without such recommendation.
- 4.2.3.4 To assure that members and AHP exercising clinical privileges within the Department practice within the limits of privileges assigned to them.
- 4.2.3.5 To assume or assign patient care responsibilities on behalf of any Department member or physician exercising clinical privileges within the Department who shall be unable to carry out same by virtue of disciplinary action, illness, or other causes.
- 4.2.3.6 To assure orientation and adequate opportunities for continuing professional education for members and AHPs exercising clinical privileges within the Department.
- 4.2.3.7 The continuous assessment and improvement of the quality of care, treatment and services, and the maintenance of quality control programs, as appropriate.
- 4.2.3.8 Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges within the Department.
- 4.2.3.9 Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Department.
- 4.2.3.10 Assessing and recommending to the Executive Medical Board off-site resources for needed patient care services not provided by the Department or the organization.
- 4.2.3.11 The integration of the Department into the primary functions of the organization and the coordination and integration of interdepartmental and intradepartmental services.
- 4.2.3.12 The development and implementation of policies and procedures that promote safe patient care, treatment and services, and that enhance quality of care.
- 4.2.3.13 The recommendations for a sufficient number of qualified and competent persons, space and resources needed to provide care or service.

- 4.2.3.14 The evaluation and recommendation of the qualifications and competence of Department personnel who are not licensed independent practitioners and who provide patient care services.
- 4.2.4 Subject to approval by the Executive Medical Board, Department Chairs may establish divisions, sections, or services of their respective Departments where so doing will assist them in carrying out their duties and responsibilities.

5.0: OFFICERS OF THE MEDICAL STAFF

5.1 Officers and Their Duties

- 5.1.1 President: The President shall be responsible for the organization and conduct of the Medical Staff, including but not limited to:
 - 5.1.1.1 Calling, preparing the agenda for, and presiding over meetings of the Executive Medical Board and Medical Staff.
 - 5.1.1.2 Appointing chairs and members of the Medical Staff committees with the approval of the Executive Medical Board. Establishing and disbanding special committees of the Medical Staff, subject to approval of the Executive Medical Board.
 - 5.1.1.3 Serving as an ex-officio member of all Medical Staff committees.
 - 5.1.1.4 Oversight of clinical work performed by the various departments, divisions, and sections.
 - 5.1.1.5 Representing the Medical Staff for the purpose of receiving and acting upon policies of the University, Campus and Medical Center.
 - 5.1.1.6 Reporting on a regular periodic basis to the Chief Medical Officer, the Chief Executive Officer, and the Chancellor on the performance and quality of delegated responsibilities for the provision of patient care services.
 - 5.1.1.7 Representing the Medical Staff in external professional and public relations.
 - 5.1.1.8 Participating in the Fair Hearing Plan as indicated in Article 3.15.
- 5.1.2 President-Elect: The President-Elect shall, in the absence of the President, assume all of the duties, responsibilities, and the authority of that office. The President-Elect or alternate designee appointed by the President shall serve as chair of the Credentials Committee.

5.2 Election and Tenure of Offices

- 5.2.1 The President and President-Elect shall be members in good standing of the Attending Staff at the time of nomination and election and must retain membership and good standing during their terms of office. Failure to maintain such status shall create a vacancy in the office. An officer who is the subject of a formal investigation shall be deemed to remain in good standing to perform the responsibilities and duties set forth in Article 5.1 until such time as an action has been taken or recommended that gives rise to a Fair Hearing pursuant to Article 3.15.
- 5.2.2 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.
- 5.2.3 The Nominating Committee will announce that it is accepting nominations for President-Elect ninety (90) days before the Annual Meeting of the Medical Staff or the date of the Special Election. Nominations supported by written petition signed by at least three (3) active/voting Medical Staff members and delivered to the Nominating Committee at least sixty (60) days prior to the Annual Meeting or the date of the Special Election will be considered by the Nominating Committee. The Nominating Committee will review the qualifications of these nominees. At least forty-five (45) days prior to the Annual Meeting or the date of the Special Election, the Nominating Committee will prepare a written ballot with no more than three nominees, including at least one nominated by the Medical Staff if there are any, and any recommendations regarding qualifications and conflict of interest. The Nominating Committee will set the date of the Special Election. This section will also be referenced in case of a mid-term vacancy of an elected member.
- 5.2.4 Voting shall be conducted by secret mail/electronic ballot that must be returned at least thirty (30) days prior to the Annual Meeting with election by a plurality of the votes cast. The results of the election shall be announced at or before the Annual Meeting at which time the new officers shall be installed.
- 5.2.5 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 Articles 5.2.1, 5.2.3, and 5.2.4 above.
- 5.2.6 Officers may be removed for failure to perform duties and responsibilities as outlined under Article 5.1. 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.

6.0: EXECUTIVE MEDICAL BOARD (EMB)

6.1 Membership

- 6.1.1 The majority of EMB must be physicians (MDs, MBs and DOs). The Executive Medical Board, hereinafter referred to as the Board, shall consist of the following voting members:
- 6.1.1.1 The Chairs of Clinical Departments specified in Article 4.2, or his/her designee
 - 6.1.1.2 The Dean of the School of Medicine
 - 6.1.1.3 The President of the Medical Staff
 - 6.1.1.4 The President-Elect of the Medical Staff
 - 6.1.1.5 The Chief Nursing Officer/Executive Director of Patient Care Services
 - 6.1.1.6 The Chair (or designee) of the Resident and Fellow's Council
 - 6.1.1.7 Two members of the Medical Staff with clinical activity at UCSF Medical Center, selected by the Nominating Committee
 - 6.1.1.8 The Immediate Past President of the Medical Staff
 - 6.1.1.9 The Chair of the Department of Clinical Pharmacy
 - 6.1.1.10 The Chair of the Quality Improvement Executive Committee
 - 6.1.1.11 The Chief Executive Officer of the Medical Center
 - 6.1.1.12 The Chief Medical Officer of the Medical Center
 - 6.1.1.13 The Chief Operating Officer of the Medical Center
 - 6.1.1.14 The Associate Dean at Mount Zion
 - 6.1.1.15 The Associate Dean of Graduate Medical Education
 - 6.1.1.16 The Chair of the Credentials Committee
 - 6.1.1.17 The Chair of the Risk Management Committee
 - 6.1.1.18 Children's Hospital Physician in Chief
 - 6.1.1.19 Children's Hospital Surgeon in Chief
 - 6.1.1.20 The Executive Director of Children's Hospital
 - 6.1.1.21 The Chair of Children's Hospital Quality Improvement Executive Committee
- 6.1.2 Non-voting ex-officio members:

- 6.1.2.1 UCSF Medical Center Associate CMO
- 6.1.2.2 Children’s Hospital Associate CMO
- 6.1.3 Members who are unable to attend meetings may send a non-voting substitute.
- 6.1.4 A quorum shall consist of ten (10) voting members.

6.2 Duties of the Executive Medical Board

- 6.2.1 The duties of the Executive Medical Board shall be:
 - 6.2.1.1 To recommend and enforce Rules and Regulations for the Medical Staff and Medical Center policies consistent with the purposes delineated in these Bylaws.
 - 6.2.1.2 To coordinate the activities and general policies of the various departments, divisions, sections, and services, and to be responsible for the quality of patient care provided by them.
 - 6.2.1.3 To review and make recommendations regarding Medical Center policies that apply to or affect the performance or responsibilities of the Medical Staff.
 - 6.2.1.4 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.
 - 6.2.1.5 To act for the Medical Staff as a whole under such limitations as may be imposed by the Medical Staff.
 - 6.2.1.6 To assure conformity, where indicated, with external licensure, certification, and accreditation requirements.
 - 6.2.1.7 To recommend to the Governance Advisory Council, after considering the recommendations of the Department Chairs and the Credentials Committee, and to recommend clinical privileges for each Medical Staff member and AHP.
 - 6.2.1.8 To oversee the ongoing professional practice evaluation (OPPE) of Medical Staff Members and AHPs exercising clinical privileges, to make recommendations for improvement, and to initiate focused professional practice evaluations (FPPE) and/or corrective actions as circumstances may warrant.
 - 6.2.1.9 To advise Medical Center leadership on the sources of the hospital’s services that are provided by consultation, contractual arrangements, or other agreements.

- 6.2.1.10 To report to the Governance Advisory Council regarding the performance and activities of the Medical Staff members and AHPs.

6.3 Meetings of the Executive Medical Board

- 6.3.1 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 of the Executive Medical Board, as may be necessary for the conduct of its business.
- 6.3.2 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 the interchange of information prior to the EMB making recommendations to GAC. 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, Chair of the Credentials Committee and the Chair of the Bylaws Committee) for the purpose of expedited review and approval on behalf of the greater EMB of:
 - 6.3.2.1 The approved applications for membership to the Medical Staff by the Credentials Committee Chair (or designee); and
 - 6.3.2.2 Established Medical Center policies and procedures to be approved for revisions only.
- 6.3.3 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.
- 6.3.4 EMB Members must remain in good standing as a member of the UCSF Medical Staff. An EMB member will be automatically removed for a medical staff disciplinary or corrective action that gives rise to a fair hearing process.

In addition, a member who loses the ability to serve effectively can be removed from the EMB by a two-thirds (2/3) majority of those voting members of the Medical Staff who submit a vote. The affected Department may then select a designee to represent the Department on the EMB.

7.0: COMMITTEES OF THE MEDICAL STAFF

7.1 Membership

- 7.1.1 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. In making membership appointments, the following factors should be considered and balanced: leadership skills and developing new leaders, continuity and turnover (i.e., recognizing the value of experience as well as new insight), knowledge and/or willingness to learn about the roles and

responsibilities of the committee, and willingness to attend and to participate in the activities of the committee. Each committee shall be composed of at least four members of the Medical Staff and such additional non-Medical Staff members as may be appropriate. While non-Medical Staff members may be appointed to serve on Medical Staff committees with voting rights, except as otherwise required by law, it is the objective that at least a majority of the voting membership of each Medical Staff committee be members of the Medical Staff. Subject to the foregoing, the individual or body making the committee appointment shall delineate whether the committee member is to serve in a voting or nonvoting capacity.

7.2 Meetings

- 7.2.1 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 standing committee activities shall be made to the Executive Medical Board and the Chancellor. Unless otherwise specified, one-third (1/3), or in any case, no less than three (3) of the active Medical Staff members of a committee shall constitute 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.

7.3 Authority and Responsibility

- 7.3.1 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. Inherent in each committee's responsibilities shall be to develop and/or review and recommend to the Executive Medical Board those Medical Staff and Medical Center policies within the purview of the respective committee's functions.

7.4 Standing Committees

- 7.4.1 In general, Standing Committees are established to serve the interests of all of the Medical Staff on an ongoing basis.

- 7.4.2 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 the Office of Legal Affairs, the Chief Medical Officer, the Chief Operating Officer, Director of Nursing and Patient Care Services and one or more at large Medical Staff appointed by the President of the Medical Staff with approval from the Chancellor. The Council shall meet

at least quarterly and shall maintain records of matters discussed and actions taken.

- 7.4.2.1 The Governance Advisory Council serves as the formal means of liaison between the Chancellor, Medical Center administrative leadership and the Medical Staff for oversight and governance of performance improvement and Medical Staff matters as required by federal and state laws and regulations and the accreditation standards of The Joint Commission. The Governance Advisory Council also serves as the formal means for the Medical Staff to participate in governance and in the development of Medical Center policies.
 - 7.4.2.2 This Council shall serve as a focal point for furthering an understanding of the roles, relationships, and responsibilities of GAC, the Medical Staff, and the Medical Center, and shall provide a forum for conflict resolution. The conflict management process shall include meeting with involved parties as early as possible to identify the conflict; gather information regarding the conflict; working with the parties to manage and, when feasible, resolve the conflict with the objective of protecting patient safety and enhancing quality of care.
 - 7.4.2.3 The final approval or disapproval of all EMB recommendations concerning physician and AHP appointments, terminations, committee actions, or any other action requiring governance, lies with the Chancellor as Chair of GAC.
 - 7.4.2.4 The Chancellor shall act upon recommendations from the EMB 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.
 - 7.4.2.5 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.
- 7.4.3 Nominating Committee. The Nominating Committee shall be chaired by the Immediate Past President or alternate designee appointed by the President of the Medical Staff, and shall be composed of the outgoing President of the Medical Staff, the two (2) most recent past presidents, the Dean of the School of Medicine, and the Chief Executive Officer of the Medical Center. The Committee shall nominate candidates for President-Elect and as set forth above in further detail at Article 5.2.3. The Committee shall review and consider the nomination of two (2) Faculty members with clinical activity at UCSF Medical Center for the Executive Medical Board upon review and consideration of the nominee's qualifications. The Committee shall present these names and any recommendations regarding qualifications and conflicts of interest at the Annual Meeting of the Medical Staff. The Committee shall present no more than three nominees for each office, including at least one nominated by the Medical Staff, if there are any.

7.4.4 Credentials Committee. The Chair of the Credentials Committee shall be the President-Elect or his/her designee as appointed by the 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 (1) member from each Department and a representative from Patient Safety and Quality Services, a representative from Risk Management, and a representative from the Office of Legal Affairs. Eight (8) physicians shall constitute a quorum.

7.4.5 Quality Improvement Executive Committee (QIEC). The committee shall be responsible for the coordination of the hospital-wide 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 membership of the Quality Improvement Executive Committee shall be stated in the Performance Improvement Plan, as adopted by the Committee and approved by the Executive Medical Board, which Plan shall be a part of these Bylaws, Rules and Regulations. The Performance Improvement Plan indicates and defines additional Medical Staff committees.

7.4.6 Physician Well-Being Committee (PWBC). The purpose of the PWBC is to support the well being of Medical Staff and house staff members consistent with the obligation of the Medical Staff to protect patients, assure 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 and house staff well being matters which may affect patient care delivery or Medical Center operations, and for which assistance to the Medical Staff member or house staff may be appropriate and necessary. PWBC activities and proceedings are protected under California Evidence Code § 1157 et seq.

The PWBC is an advisory committee that has no responsibility for peer review or involvement in any credentialing, corrective or disciplinary action. It makes no recommendation or final decision regarding any disciplinary action. The committee shall meet as often as necessary, but at least quarterly. It shall maintain only such records of its proceedings as it deems advisable, and shall report on its activities to the Executive Medical Board.

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

representative. The responsibilities of the PWBC are provided in further detail in the PWBC policy.

- 7.4.7 Bylaws Committee. The Chair of the Bylaws Committee shall be the Immediate Past President or alternate designee appointed by the President of the Medical Staff. The committee shall be responsible for the review of the Medical Staff Bylaws, Rules and Regulations and recommend appropriate revisions to the Executive Medical Board for approval and recommendation to GAC.
- 7.4.8 Pharmacy and Therapeutics Committee (P&T). The P&T 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:
- 7.4.8.1 Developing, maintaining, and approving changes to the Medical Center formulary using evidence-based evaluations of efficacy, safety, and cost-effectiveness.
 - 7.4.8.2 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.
 - 7.4.8.3 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.
 - 7.4.8.4 Reviewing Medical Center policies related to medication management.
 - 7.4.8.5 Reviewing drug utilization patterns at the Medical Center towards a goal of ensuring safety, appropriateness, and cost-effectiveness.
 - 7.4.8.6 Reviewing the findings and recommendations from the Anticoagulation, Antibiotic Advisory and Medication Safety Subcommittees.
 - 7.4.8.7 Monitoring the results of continuous quality improvement efforts regarding pharmaceutical services.
 - 7.4.8.8 The Secretary and Chair of the P&T Committee, on behalf of the entire Committee, shall have the authority to enforce prescribing restrictions and any other necessary immediate actions to address urgent drug supply issues, without a full P&T Committee vote. The full P&T Committee will be kept apprised of any such action.
- 7.4.9 Committee on Interdisciplinary Practice (CIDP). CIDP exists to provide Medical Staff oversight to non-Medical Staff members regarding the performance of Standardized Procedures and Delegation Service Agreements with the privileging of AHPs who are not members of the Medical Staff but who are required to be privileged by federal and state laws and regulations,

and by Joint Commission accreditation standards. The committee is responsible for recommending appointments and reappointments of AHPs, delineation of staff privileges, practice protocols and supervision oversight. The membership shall be consistent with the requirements set forth by 22 California Code of Regulations § 70706.

7.4.10 Risk Management Committee (RMC). The responsibilities and composition of the RMC shall be as stated in the Performance Improvement Plan. The 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.

7.4.11 Patient Safety Committee. The responsibilities of the Patient Safety Committee shall be as stated in the Performance Improvement Plan.

The Patient Safety Committee is chaired by the Chief Medical Officer (or designee) with the following representatives: Chief Nursing Officer; Chief Operating Officer; Physician Representatives from Ambulatory, Medicine, Pediatrics, Surgery and Anesthesia; 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.

7.4.12 Committee on Professionalism. All UCSF physicians and other medical providers are expected to treat each other, other staff, as well as patients and family members in a courteous, dignified, and culturally respectful manner. If a medical professional exhibits unprofessional behavior, and this behavior is referred to Medical Staff leadership, the Committee on Professionalism will review the referral and make recommendations regarding the need to improve behavior.

The Committee is chaired by a medical staff member, and is composed of two medical professional from surgical departments, one medical professional from the Department of Anesthesia, two medical professionals from non-surgical departments, and an advanced health practitioner (AHP). Ex-officio members with vote rights include the Chief Medical Officer (CMO), a representative from Risk Management, and a representative from the School of Medicine Dean's Office.

Refer to the Medical Staff Rules and Regulations for additional information.

7.5 Special Committees

7.5.1 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 and approved annually.

8.0: MEETINGS

8.1 Annual Meeting

- 8.1.1 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.

8.2 Special Meetings

- 8.2.1 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.

8.3 Department Meetings and Educational Conferences

- 8.3.1 Each Department may hold regular meetings to review deaths and complications occurring in the Department. The purpose of this review is to ensure the Department's participation in performance improvement activities and to report these activities in accordance with the Performance Improvement Plan.

8.4 Voting

- 8.4.1 Unless otherwise specifically provided in these Bylaws, a majority of the votes cast shall be required to carry any motion or pass on any matter put to the vote of the voting Medical Staff.

9.0: RULES AND REGULATIONS AND POLICIES

9.1 Rules and Regulations

- 9.1.1 Adoption of 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 and other Medical Center and UCSF policies, and the University of California Office of the President (UCOP) policies.
- 9.1.2 Notice. Except when urgent action is required to comply with law or regulation, as set forth below, the Executive Medical Board shall give at least thirty (30) days prior notice (as described in Section 9.1.1) of the proposed adoption or amendment.

- 9.1.3 Urgent Action. However when urgent action is required to comply with law or regulation, the Executive Medical Board is authorized to adopt a Rule or Regulation subject to promptly informing the Medical Staff of the Rule and Regulation, and providing an opportunity for subsequent review and action. Subsequent review and consideration of the urgently adopted Rule or Regulation is triggered by a written petition signed by at least fifty (50) voting members of the Medical Staff. The initially adopted Rule and Regulation shall remain effective until such time as a superseding rule or regulation is adopted.
- 9.1.4 New or Amended Rule and Regulation. Additionally, the Medical Staff may, by a written petition signed by at least fifty (50) voting members of the Medical Staff and upon at least thirty (30) days notice to the Executive Medical Board, propose a new or amended Rule and Regulation for adoption by the voting Medical Staff. Approval shall require a majority vote by the voting members present and voting at a meeting called for that purpose; or by majority vote by mail/electronic ballot, provided at least fifty (50) mail/electronic ballots must have been timely cast.
- 9.1.5 Approval Governance Advisory Council. Following Executive Medical Board approval or Medical Staff approval (as applicable), a Rule and Regulation shall become effective following the approval of GAC, which approval shall not be withheld unreasonably, or automatically within sixty (60) days if no action is taken by the Governance Advisory Council; provided, however, an automatic approval may be withdrawn at a later date within the discretion of the Governance Advisory Council.
- 9.1.6 Post-Approval Notice and Force and Effect. Upon approval of GAC the Medical Staff shall be given written notice of all adopted or amended Rules and Regulations. Properly adopted Rules and Regulations shall have the force and effect of Bylaws.

9.2 Policies

- 9.2.1 Development and Implementation. Medical Staff policies shall be developed as necessary to implement more specifically the general principles found within these Bylaws and the Medical Staff Rules and Regulations. The policies may be adopted, amended, or repealed by majority vote of the Executive Medical Board and approval by GAC. Such policies shall not be inconsistent with the Medical Staff Bylaws, Rules or other Medical Center policies, or the University of California Office of the President (UCOP) policies.
- 9.2.2 New or Amended Policies. Additionally, the Medical Staff may, by petition signed by fifty (50) voting members of the Medical Staff, and upon at least thirty (30) days notice to the Executive Medical Board, propose a new or amended policy for adoption by the voting Medical Staff. Approval shall require a majority vote by the voting members present and voting at a meeting called for that purpose; or by majority vote by mail/electronic ballot, provided at least fifty (50) mail/electronic ballots must have been timely cast.

- 9.2.3 Post-Approval Notice and Force and Effect. Upon approval of GAC, the Medical Staff shall be given written notice of all adopted or amended policies. Properly adopted Policies shall have the force and effect of Bylaws.

9.3 Notices

- 9.3.1 Notice of pending or adopted changes to Rules and Regulations or policies may be effectuated by email notification, and reasonable opportunity (e.g., by emailing the full text, or making the text available for review via secure website, or by visiting the Medical Staff office) to review the text of the proposed or adopted Rule and Regulation or policy.

9.4 Conflict Management

- 9.4.1 In the event of conflict between the Executive Medical Board and the Medical Staff (as represented by written petition signed by at least fifty (50) voting members of the Medical Staff) regarding a proposed or adopted Rule and Regulation or policy, the President of the Medical Staff shall convene a meeting with the petitioners. The Executive Medical Board and the petitioners shall exchange information relevant to the conflict and shall work in good faith efforts to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Executive Medical Board, and the safety and quality of patient care at the Medical Center. Unresolved differences shall be submitted to the Governance Advisory Council or the Chancellor for final resolution.

10.0: AMENDMENT OF BYLAWS

10.1 Amendment Procedure

- 10.1.1 Bylaw amendments are reviewed and recommended by the Bylaws Committee and the Executive Medical Board prior to being submitted for vote of the Medical Staff; provided, however, that upon at least thirty (30) days prior written notice to the Executive Medical Board, Bylaw amendments may be proposed by petition signed by at least twenty-five percent (25%) of the members of the voting Medical Staff. The Bylaws may be amended at any Annual or Special Meeting of the Medical Staff, or by mail/electronic ballot 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 a majority of the members present and eligible to vote; or by a majority of the members who cast mail/electronic ballots, provided at least fifty (50) mail ballots must have been timely cast, and approval by GAC. Neither the Medical Staff nor GAC may unilaterally amend the Medical Staff Bylaws.

10.2 Interim Amendment of Bylaws

- 10.2.1 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 GAC. 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 Article 10.1.1. 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.

10.3 Technical and Editorial Amendments

- 10.3.1 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 GAC 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 GAC.

11.0: ADOPTION OF BYLAWS

- 11.1 These Bylaws shall be adopted by the affirmative vote of a majority of the voting members of the Medical Staff attending the Annual Meeting or a Special Meeting called for that purpose and shall be implemented following approval of GAC.

12.0: CONFIDENTIALITY

12.1 General

- 12.1.1 Medical Staff, Department, division, 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.

12.2 Breach of Confidentiality

- 12.2.1 Inasmuch as effective credentialing, performance improvement, peer review, and consideration of the qualifications of Medical Staff members and AHPs and applicants to perform specific procedures must be based on free and candid discussions, and inasmuch as physicians 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.

12.3 Immunity and Releases

12.3.1 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, physician, dentist/oral surgeon, clinical psychologist, podiatrist, other professionals allowed by the state to practice independently and approved by the Executive Medical Board and the Governance Advisory Council, or AHP for damages or other relief by reason of providing information to a representative of the Medical Staff, AHP 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.

12.3.2 Activities and Information Covered

12.3.2.1 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:

- 12.3.2.1.1 Applications for appointment, privileges or specified services;
- 12.3.2.1.2 Periodic reappraisals for reappointment, privileges, or specified services;
- 12.3.2.1.3 Corrective action;
- 12.3.2.1.4 Hearings and appellate reviews;
- 12.3.2.1.5 Performance improvement review, including patient care audit;
- 12.3.2.1.6 Peer review;
- 12.3.2.1.7 Utilization reviews;
- 12.3.2.1.8 Morbidity and mortality conferences;

12.3.2.1.9 Other Medical Center, clinical service, section or committee activities, including but not limited to OPPE/FPPE, related to monitoring and improving the quality of patient care and appropriate professional conduct; and

12.3.2.1.10 A member's and AHP's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional conduct, professional ethics, or other matters that might directly or indirectly affect patient care or Medical Center operations.

12.3.3 Releases

12.3.3.1 Each practitioner physician, dentist/oral surgeon, clinical psychologist, podiatrist, other professionals allowed by the state to practice independently and approved by the Executive Medical Board and the Governance Advisory Council and AHP shall, upon request of the Medical Staff, 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.

12.3.4 Cumulative Effect

12.3.4.1 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.

12.3.5 Authority to Act

12.3.5.1 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.

13.0: OTHER RIGHTS AND RESPONSIBILITIES OF THE MEDICAL STAFF

13.1 Legal Counsel

13.1.1 Medical Staff may at its expense, retain and be represented by independent legal counsel with approval by UCSF Chief Campus Counsel at the Office of Legal Affairs and/or by Deputy General Counsel for Health Affairs at the Office of General Counsel.

13.2 Disputes with the Governing Body

13.2.1 In the event of a significant dispute between the Medical Staff and the Governance Advisory Council relating to the independent rights of the Medical Staff, as further described in California Business and Professions Code § 2282.5, the Medical Staff and Governance Advisory Council will meet and confer in good faith to resolve the dispute.