BYLAWS OF THE MEDICAL STAFF

PREAMBLE

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

ARTICLE I

Section A: NAME

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

ARTICLE II

Section B: PURPOSE

1. The purposes of the Medical Staff shall be:

   a. To provide a system for Medical Staff self-governance and accountability to the Governing Body for patient care, whereby patients treated at Langley Porter shall receive the level of care consistent with the generally recognized standards of the profession.

   b. To ensure that all patients of Langley Porter 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.

c. To initiate and maintain Bylaws, Rules and Regulations for self-governance.

d. 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 Langley Porter.

e. Medical Staff leaders and members will work collaboratively the Hospital's administrative leadership to ensure that Langley Porter is fiscally sound.

f. To foster education and research programs of the University of California in an integrated manner with the clinical programs of Langley Porter.

g. To provide a means whereby problems of a medico-administrative nature may receive discussion and action.

h. To ensure that the Medical Staff and its members exercise their rights and responsibilities in a manner that does not jeopardize Langley Porter's license, Medicare and Medi-Cal provider status, accreditations, or mission as an academic psychiatric hospital and clinics.

i. To ensure that all patients of the Hospital are treated with consideration and to ensure that access to care is not affected by race, color, sex, religion, national origin, age, disability or sexual orientation subject to state and federal laws and regulations.

j. To provide a means whereby problems of a medico-administrative nature may receive discussion and action.

k. To initiate and maintain Rules and Regulations for self-government.

l. To ensure that all Medical Staff members maintain the quality performance of their professional duties

ARTICLE III

MEMBERSHIP

Section A. Eligibility and General Responsibilities of Membership

1. Except as permitted under Article III.A.8 and 9 below, only faculty members of the University of California, San Francisco School of Medicine or employees of the Department of Psychiatry shall be eligible for membership on the Medical Staff (hereinafter referred to as Members).

2. A Medical Staff appointment is required for physicians and clinical psychologists who provide patient care services with the exception of the providers who hold Visiting Privileges for the care of specific patients. Social workers, pharmacists or other master's prepared therapists who provide independent patient care services are required to hold Medical Staff appointment.

3. Members must be licensed or otherwise certified to practice in the State of California.

4. At the time of initial appointment or reappointment, Members must document their experience, background, training, health status, and ability to provide their patients with care at the generally recognized level of quality.

5. Members must adhere to the ethics of their profession, including refraining from fee-splitting or other inducements relating to patient referral.

6. Members must provide care to patients at the Hospital, patients referred by the UCSF Medical Center to the Langley Porter Consultation Liaison Service, and/or patients treated in Langley Porter Faculty Practices according in accordance with to the principles established in these Bylaws, Rules and Regulations.

7. Membership shall not be denied on the basis race, color, national origin, religion, sex, age, veterans of the Vietnam era, ancestry, marital status, citizenship, sexual orientation or gender identity or the types of procedures (e.g. abortions) or the types of patients (e.g. Medicaid) in which the Practitioner specializes or any other criterion unrelated to the delivery of quality patient care in accordance with applicable bylaws, rules and regulations, hospital policies and procedures and the standards of ethical and competent patient care

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.

9. Appointment to the faculty of the School of Medicine, University of California, San Francisco, shall not automatically result in conferral of Medical Staff membership, nor shall appointment to the Medical Staff automatically result in a faculty appointment. Neither appointment to the Medical Staff nor the granting of privileges to perform specific procedures shall confer entitlement to unrestricted use of the facilities of the Hospital or the resources thereof. Allocation of resources, including, but not limited to, patient beds shall be subject to administrative allocation pursuant to procedures established by authority of the Medical director.

10. Individuals who are not members of the faculty of the University of California, San Francisco, or not otherwise employed by The Regents, must maintain professional liability insurance coverage with limits of coverage not less than those which may, from time to time, be established by The Regents, and with The Regents included as an additional insured.

11. Each Medical Staff member shall be willing and qualified to participate in the training of students, shall develop and maintain teaching skills essential to effective functioning in contact with students, and shall perform his/her responsibilities in such a way as to serve as an exemplary role model for the students and for the teaching programs of the Hospital.

12. Reappointment and continuation of privileges is subject to at least biennial review. This review may result in the expansion or reduction of privileges based upon criteria that include quality of patient care, quality of teaching, and utilization of the Hospital's resources.

13. Members of the Medical Staff agree to participate in the execution of Hospital functions. These are defined to include, but are not limited to, continuous performance improvement, peer review, utilization management, quality evaluation and related monitoring activities, on call and after-hours patient care responsibility, and in discharging such other functions as may be required from time to time.

14. All Medical Staff members are required to comply with all Infection Control testing and immunization requirements upon initial application and annually thereafter for selected requirements.

15. Medical staff members of UCSF Medical Center (UCSFMC) who are fully credentialed by and approved for active medical staff privileges at UCSFMC may provide consultations to Langley Porter Hospital within the area of their clinical specialty as defined by their privileges. Current privileges of medical staff members at UCSFMC who provide consultations to the Langley Porter Hospital are available for verification through on-line computerized systems.

16. 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.

17. Reappointment and continuation of privileges are subject to at least biennial review, and ongoing monitoring is performed at least every (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 Hospital's resources.

18. It is the responsibility of the Attending Physician to determine the need for and authorize consultations with specialists from UCSF Medical Center concerning patients under his or her direct care. Although a House Officer or fellow may prepare the consultant note, the consultation should be reviewed, confirmed, and the note countersigned by the participating consulting faculty member who has examined the patient.

19. 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, as described below.

    a. 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 physician, an oral surgeon, or other qualified licensed individuals in accordance with applicable laws, regulations and accreditation standards.

    b. 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:

        (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
        (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 24hours after admission or registration and within 24 hours prior to surgery or a procedure requiring anesthesia.

c. (3) The requirements for obtaining informed consent are outlined in the Rules and Regulations, Patient Care Delivery, Section III, Consents, Permits and Legal Affairs. At a minimum, informed consent shall be obtained for all invasive procedures, all other procedures requiring anesthesia, and for all procedures specifically required by applicable laws, regulations and accreditation standards.

Section B: Categories of Membership

1. Active Provisional

   a. All initial appointments to membership of any category of the Medical Staff shall be provisional for a period of six months. The Provisional Staff shall consist of physicians, psychologists and allied health professionals (AHPs) who meet the qualifications specified for Attending, Courtesy or Allied Health Professional Staff except that they have not yet satisfactorily completed the proctoring requirements specified by the Hospital.

   b. Prerogatives: The prerogatives for Provisional Staff are as for Attending, Courtesy or Allied Health Professional Staff with the following limitations: The Provisional Staff are not eligible to hold office or vote. A Provisional Member shall be assigned to a service where his/her performance shall be proctored by the Chief of Service or another Member designated by the President of the Medical Staff to determine the eligibility of such Provisional Member for Attending, Courtesy or Allied Health Professional Staff membership and for exercising the clinical privileges granted to them.

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

2. Active Attending

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

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

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

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

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

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

3. Active Courtesy Staff

a. Physicians who admit or clinical psychologists who treat 1-5 patients per year may apply for appointment to the Courtesy Staff. Members of the Courtesy Staff who have not been involved in patient care and who have not been involved in the clinical oversight of house officers for a period of two years shall automatically be transferred to Inactive Status. These physicians or clinical psychologists may reapply for active membership by completing a new application.

b. Prerogatives: They are not eligible to vote or hold office.

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

4. Active Allied Health Professional Staff

1. Individuals who meet the eligibility requirements described in Section C

may be appointed to the Allied Health Professional (AHP) Staff. This category may include L.C.S.W.s, M.F.T.s, Nurse Practitioners, Pharmacists and other health professionals deemed eligible by the Governing Body after recommendation and approval from the Credentials Committee and the Executive Committee of the Medical Staff. Upon appointment, Allied Health Professional Staff shall, as outlined in their job descriptions and to the extent approved by the Credentials Committee and the Executive Committee of the Medical Staff, be expected to:

(1) Exercise independent judgment within their areas of competence and as defined by licensure.

(2) Participate directly in the management of patients.

(3) Record initial evaluations and on-going treatment progress notes on patient charts

(4) Perform consultation, upon request.

2. Prerogatives: They are not eligible to vote or hold office. They may participate in the activities of the Medical Staff through membership on its committees and attendance at its meetings. They may be expected to attend and actively participate in the clinical meetings of their respective clinical services, to the extent permitted by the Chief of the Service. All decisions to appoint shall include a standardized procedure or delineation of clinical privileges that the applicant may exercise. In exercising such privileges, the applicant shall act under the supervision of the Chief of the Service to which he/she is assigned and shall be proctored and monitored in accordance with UCSF Human Resources and/or clinical service guidelines.

c. Limitations: None of the provisions for corrective action in Article III.D shall be applicable, in the event of any modification, suspension, restriction or termination of an AHP Staff Member's status. For AHPs who are University employees, the provisions of the University's applicable grievance procedure for such category of employee shall be followed. For AHPs who are independent contractors, the corrective action provisions of their respective service contract will be initiated by the Chair of the Credentials Committee.

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

Allied Health Professional status is automatically terminated if employment or service contract is terminated.

5. Inactive Status

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

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

Section C. Requirements for Courtesy and Attending Medical Staff Appointments

1. Physicians

   a. Licensed as a physician in the State of California.

   b. Federal DEA number.

   c. Board Certification or Board Eligibility.

   d. Completion of an accredited residency.

   e. A minimum of two peer recommendations by licensed physicians who are familiar with applicant's professional work and demonstrated competence (waived for applicants who completed house staff or residency training no more than 12 months prior to application, and who spend the intervening time in an extension of training).

   f. Absence of health problems which, even with reasonable accommodation, would interfere with the ability to perform the activities for which clinical privileges are being requested.

   g. Adequate professional liability insurance.

2. Psychologists

    a. Licensed as a psychologist in the State of California.

    b. A doctoral degree from an accredited program training psychologists which meets the criteria specified in the California Laws and Regulations Relating to the Practice of Psychology.

    c. A minimum of two peer recommendations by licensed psychologists who are familiar with applicant's professional work and demonstrated competence.

    d. Absence of health problems which, even with reasonable accommodation, would interfere with the ability to perform the activities for which clinical privileges are being requested.

    e. Adequate professional liability insurance.

3. Allied Health

a. Licensed to practice as a health care provider in the State of California in the profession defined in applicant's UCSF job description.

b. A minimum of two peer recommendations preferable within applicant's specialty that are familiar with applicant's professional work and demonstrated competence.

c. Absence of health problems which, even with reasonable accommodation, would interfere with the ability to perform the activities for which clinical privileges are being requested.

d. Adequate professional liability insurance.

4. Leave Of Absence

a. 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 Executive Committee of the Medical Staff. 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 Langley Porter Psychiatric Hospital & Clinics, and membership rights and responsibilities shall be inactive. The time period for consideration of reappointment shall be stayed during the leave of absence.

b. 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 Executive Committee of the Medical Staff via the Medical Staff Services Department. The member shall submit a written summary of his or her relevant clinical activities during the leave. The Executive Committee of the Medical Staff, upon receipt of the request, shall recommend to Governance Advisory Committee 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 (Section E) unless the reason for non-reinstatement is a medical disciplinary cause or reason.

Section D. Procedure for Medical Staff Appointment

1. All initial appointments and reappointments shall be made by the Chancellor upon the recommendation of the Credentials Committee and the Executive Committee of the Medical Staff.

   a. Applications are deemed complete when all necessary verifications have been obtained. Licensure will be verified before any appointment to the Medical Staff, and will be verified at each expiration date. Copy of license is requested from Members before the current license expiration date.

   b. Applications for appointment to the Medical Staff shall be screened by the Chair, Department of Psychiatry ("the Chair"), who shall be responsible for verifying statements made by the Applicant, delineating the service privileges for which the Applicant shall qualify, and attesting to the health status of the Applicant.

   c. After review and investigation of the completed and signed application, Chair's recommendation and such other information as may be deemed pertinent (see Clinical Privileges Plan, #9, Section VII, D), the Credentials Committee will recommend approval or disapproval of the application.

   d. The Credentials Committee reviews credentials, professional competence, health and ethical character of applicants for appointment or reappointment to the Medical Staff. This review enables the Committee to establish to its satisfaction the following:

      (1) That the applicant possesses any and all licenses or certificates which are required under the laws of the State of California for his or her professional field.

      (2) That the scope of practice proposed to be carried out is within the limits authorized for licensure or certifications by the appropriate examining board.

      (3) That the applicant possesses the necessary educational background and current professional expertise.

      (4) That the applicant has adequate professional liability insurance.

      (5) That the applicant will strictly abide by the Principles of the Code of Ethics applicable to his or her profession.

      (6) That the applicant agrees to be bound by the Medical Staff Bylaws and Rules and Regulations.

   e. Information reviewed for initial appointment to the Medical Staff includes:

(1) Delineation of privileges requested.

(2) Relevant licensure or certificates.

(3) CV and/ or relevant training verified with the primary source.

(4) Documentation of health status and evidence of specific ability to perform the requested privilege.

(5) Any current challenge or a previously successful challenge to licensure or registration.

(6) Any involuntary termination of medical staff membership at another hospital.

(7) Any involuntary limitation, reduction, denial or loss of clinical privileges.

(8) An unusual pattern of, or an excessive number or, professional liability actions resulting in a final judgment against the applicant.

(9) Other information as requested during the credentialing process.

(10) Data from professional practice review by an organization that currently privileges the applicant if available.

(11) Peer and/or faculty recommendation.

(12) Any significant issues regarding the above items may make an applicant ineligible for an expedited privileging process for temporary or visiting privileges.

f. Information reviewed for advancement from provisional status includes:

(1) Completed proctoring form.

(2) Recommendation of Proctor and Chair for advancement from provisional status.

g. Information reviewed for reappointment to the Medical Staff includes:

(1) Changes in the applicant's qualifications since last review.

(2) Delineation of privileges requested.

(3) Peer reviewed patterns of care and utilization as demonstrated in the findings of performance improvement, risk management and utilization management activities.

(4) Timely and accurate preparation and completion of medical records documentation.

(5) Cooperativeness and general demeanor in relationship with other medical staff members, clinical staff, other personnel and patients.

(6) Compliance with Medical Staff Bylaws, Rules and Regulations and Hospital policies and procedures.

h. The burden shall be on the applicant to establish that he or she is professionally competent and worthy in character, professional ethics, and conduct. Applicants certify that they have in the past and will continue in the future to abide by the lawful Principles of Medical Ethics of the American Psychiatric Association, or the Code of Ethics of the respective profession (e.g., American Psychological Association).

i. In making application, the Applicant signifies willingness to appear for interviews; authorizes the Credentials Committee to consult with others who may have information bearing on competence or qualifications; and consents to examination of records that may be material to evaluation of competence and qualifications to carry out the clinical privileges requested, establishment of physical or mental health status, and assessment of professional ethical qualifications. The Applicant furthermore releases the Chair, the Credentials Committee, and its representatives from any liability for their acts performed in good faith and without malice in connection with evaluation of the application, and recognizes that the privileges accorded practitioners at the Hospital shall be considered a public record.

j. It shall be the responsibility of the Applicant to provide such documentation as may be required by the Credentials Committee in a form specified by the Committee. The Applicant shall have the burden of producing adequate information for evaluation of the application.

k. After reviewing all pertinent information concerning the applicant for appointment or reappointment, the Credentials Committee makes a recommendation to the Executive Committee of the Medical Staff.

Subsequently, the Executive Committee of the Medical Staff makes a recommendation to the Governing Body for approval.

l. All applications, correspondence, and records pertaining to verification of credentials and delineation of privileges are confidential.

m. A Medical Staff Member may request modification of clinical privileges at any time by written application to the Credentials Committee.

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

1. Grounds for action:

a. Noncompliance with Medical Staff Bylaws and Rules and Regulations. This shall include, but not be limited to, failure to disclose information pertinent to and necessary in the evaluation of a member's qualifications for appointment or reappointment to the Medical Staff.

b. Violation of specific rules of the Hospital or this Medical Staff. This shall include, but not be limited to, failure to complete medical records, failure to adhere to approved admitting and discharge policies, or failure to discharge Attending staff responsibilities relative to consultation and call.

c. Misconduct. This shall include, but not be limited to, violations as indicated in Section D.1.b above, abandonment of a patient, disruptive behavior, violation of the American Medical Association Principles of Ethics or the American Psychological Association’s Business Code, or falsification of records.

d. Care below applicable standards. This shall include, but not be limited to, incompetence, unprofessional conduct (as excluded from Section D.1.c above), failure to adhere to patient care policies of the Hospital, clinical performance below the standards of practice established by the Hospital, provision of suboptimal and/or substandard care, consistent misdiagnosis, and/or a demonstrated lack of clinical competence.

e. Personality conflict. Inability to work in harmony with others or evidence of disruptive behavior may be cause for such action.

2. Procedures:

a. Any person may provide information to an officer of the Medical Staff, the Medical Director, the Chair, or the Chancellor about the conduct,

performance, or competence of its members. Any Member of the Active Medical Staff, the Medical Director, or the Chancellor may request the Executive Committee of the Medical Staff to institute action against a Medical Staff Member when there are grounds for action as set forth herein. Requests for corrective action shall be in writing to the Executive Committee of the Medical Staff and shall be supported by reference to specific activities or conduct constituting grounds for the request.

b. Within 15 days of receipt of the request to institute corrective action, the Executive Committee of the Medical Staff shall assign the conduct of an investigation to the Credentials Committee. The Member shall be notified that an investigation is being conducted and may be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The Member's failure without good cause to attend any investigating body committee meeting upon request shall constitute a waiver of his/her rights. Following full investigation, a report of findings and recommendations will be made to the Executive Committee of the Medical Staff within 30 days of receipt of the assignment. The Executive Committee of the Medical Staff may authorize extension of this time period for good cause.

c. If a member or members of the Credentials Committee or the investigating body have a conflict of interest, such person(s) shall not sit on either committee when the corrective action issues are being discussed nor shall such person(s) vote or take an action, formal or informal, which may have a tendency to influence the decision for corrective action.

d. Within five days of receipt of the report of findings and recommendations, the Credentials Committee shall notify the affected staff Member, furnish copies of the request for corrective action and the report of findings and recommendations, and offer him/her an opportunity to make an appearance before the Credentials Committee prior to taking adverse action against the affected staff Member. Neither this appearance nor the investigation referred to herein shall constitute a hearing. This appearance shall be at the next regularly scheduled meeting of the Credentials Committee, shall be preliminary in nature, and none of the procedural rules of the Bylaws with respect to hearings shall apply.

e. The Credentials Committee may take any of the following actions on a request for corrective action after reviewing the findings and recommendations, giving the affected staff Member an opportunity to make an appearance as specified in this Article, and considering any past remedial action involving the same or similar acts or omissions:

(1) Determine no corrective action be taken and, if the Credentials Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the Member's file.

(2) Defer action for a reasonable time where circumstances warrant.

(3) Recommend the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring.

(4) Recommend reduction, modification, suspension, or revocation of clinical privileges.

(5) Recommend reduction of membership status or limitation of any prerogatives directly related to the Member's delivery of patient care.

(6) Recommend suspension, revocation, or probation of Medical Staff membership.

(7) Take other appropriate action.

(8) Recommend to the Chancellor that an already-imposed summary suspension of privileges, as described in this Article, be terminated, modified, or sustained.

f. Any action of the Credentials Committee which, pursuant to these provisions, constitutes grounds for a hearing shall entitle the affected Member to the procedural rights contained in Section E, Fair Hearing Plan.

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

h. If the Executive Committee of the Medical Staff fails to investigate or initiate corrective action and the Chancellor determines that its failure to do so is contrary to the weight of the evidence then available, the Chancellor may, after consulting with the Executive Committee of the Medical Staff, direct the Executive Committee of the Medical Staff to investigate or initiate corrective action. If the Executive Committee of the Medical Staff fails to act after a directive from the Chancellor, the Chancellor may, in accordance with these Bylaws, after written notice to

the Executive Committee of the Medical Staff, take action directly against a Medical Staff member. If the action is favorable to the practitioner, or if it constitutes an admonition, reprimand, or warning to the practitioner, it shall become effective as the final decision of the Chancellor.

3. Summary suspension:

a. Any one of the following shall have the authority summarily to suspend or restrict all or part of the privileges and/or membership of a Medical Staff Member whenever the Member's conduct appears to require that immediate action is necessary to protect the best interest of the Hospital, to protect the life of any patient, or to reduce the likelihood of imminent danger to the health or safety of any individual: the Officer of the Medical Staff, the Executive Committee of the Medical Staff, the Chief of a Clinical Service, the Medical Director, and/or the Chancellor.

b. A summary restriction or suspension shall be effective immediately upon imposition; however, a summary restriction or suspension imposed by the Chancellor must be ratified by the Executive Committee of the Medical Staff within two (2) working days of its imposition, excluding weekends and holidays, or it shall terminate automatically.

c. Unless otherwise stated, a summary suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice of the suspension or restriction to the Member and the person or bodies set forth in the previous section. The summary suspension or restriction may be limited in duration and shall remain in effect for the period stated or, if unlimited in duration, until otherwise resolved. The President of the Medical Staff or responsible Chief of the Clinical Service shall provide for alternative medical coverage for patient care with the wishes of the patients taken into consideration.

d. A staff Member who has been summarily suspended or restricted shall be entitled to request a hearing on the matter according to procedural rights outlined in Section E, Fair Hearing Plan.

e. In the event that the Credentials Committee determines that an investigation is warranted, it shall direct an investigation to be conducted immediately in accordance with these Bylaws. The summary suspension or restriction shall remain in effect until a final decision by the appropriate judicial or quasi-judicial body and all procedural rights contained in Section E have been exhausted.

2. Administrative Suspension

The President of the Medical Staff and Department Chair 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:

a. 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.

b. 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 administratively be limited or restricted in a similar manner as of the date such action becomes effective and throughout its term.

c. Probation: Whenever a member 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.

d. Failure to maintain professional liability insurance with limits of liability required by the University and naming The Regents of the University of California as an additional insured, with provision for notice to The Regents thirty (30) days prior to cancellation or termination shall constitute administrative suspension of all privileges and membership on the Medical Staff.

e. 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.

f. Failure or refusal to complete medical records (for an in-patient or an out-patient) in accordance with applicable Langley Porter 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.

g. 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 Executive Committee of the Medical Board.

h. A member or AHP is required to advise the President of the Medical Staff 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.

i. Testing and Immunization Requirements: All Medical Staff members and AHPs are required to comply with all Infection Control testing and immunization requirement's 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.

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

k. 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.

l. Other corrective action: In addition to administrative actions imposed pursuant to Section E. (Termination or Suspension of Medical Staff Membership, Reduction of Clinical Privileges, and Other Corrective Action), the Executive Committee of the Medical Staff 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 (Section F), only with respect to any additional disciplinary actions (i.e., those actions above and beyond the administrative actions).

m. No Right to Duplicative Hearings. 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 Langley Porter'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.

n. 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.

Section F. Mediation of Disputes & Fair Hearing Plan

1. Mediation of Disputes (Between the Executive Committee of the Medical Staff and a Practitioner)

   a. Mediation is a confidential process in which a neutral person facilitates communication between the Executive Committee of the 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 Langley Porter's 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.

b. If a member and the Executive Committee of the Medical Staff do agree to mediation, all deadlines and time frames relating to the Fair Hearing Plan (see below) 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.

c. Mediation may be terminated at any time, and the request of either party.

d. The Committee of the Medical Board may promulgate further Rules and Regulations outlining appropriate procedures for initiating and conducting mediation.

2. Request for hearing:

a. The hearing and appeals procedure is the administrative adjudicatory process for resolution of actions to be taken against Medical Staff Members. An aggrieved Medical Staff Member must follow the applicable procedures set forth in Section D prior to invoking the process set forth in Section E and must exhaust the remedies set forth in these Bylaws before resorting to legal action.

b. Notice of decision. In any case where action has been taken constituting grounds for hearing, as set forth in the subsection Grounds for Hearing (Section E.1.c), the Applicant or Medical Staff Member, as the case may be, shall be notified promptly by the President of the Medical Staff with a written communication sent by certified or registered mail, return receipt requested. The Applicant or Member shall have 30 days following date of the mailing of the notice within which to request a hearing by a Hearing Committee, as defined in Section E.1.g, Hearing Committee. The Applicant or Member shall also be given a copy of Article III, Section E, and Fair Hearing Plan. The request shall be made in writing and sent by certified or registered mail, return receipt requested, to the President of the Medical Staff. In the event the applicant or member does not request a hearing within 30 days following mailing of notice to him/her and in the manner described within this subsection, he/she shall be deemed to have accepted this action.

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

(1) Denial of application for Medical Staff membership.

(2) Denial of Medical Staff reappointment.

(3) Denial of promotion from probationary to regular status.

(4) Demotion to a lower staff category.

(5) Suspension or summary suspension from Medical Staff membership, except suspension resulting from action by the appropriate State of California examining board to suspend the license of a Medical Staff member, or his/her placement on probation.

(6) Revocation of Medical Staff membership, except expulsion resulting from action by the appropriate State of California examining board to revoke the license of a Medical Staff member.

(7) Denial of requested privileges (excluding temporary privileges).

(8) Involuntary reduction of privileges (excluding temporary privileges).

(9) Suspension or summary suspension of privileges (excluding temporary privileges).

(10) Termination of privileges (excluding temporary privileges).

d. Time and place of hearing. Upon receipt of a request for a hearing, the President of the Medical Staff shall schedule a hearing and, within 15 days (but in no event less than ten days prior to the hearing) give written notice sent registered or certified mail, return receipt requested, to the Member of the time, place, and date of the hearing. The date of commencement of the hearing shall be not less than five days, nor more than 90 days from the date of receipt of the request by the President of the Medical Staff for a hearing; however, when the request is received from a Member who is under summary suspension, the hearing shall be held as soon as arrangements may reasonably be made, but not to exceed 45 days from the date of receipt of the request.

e. Notice of charges. As a part of, or together with, the notice of hearing, the Credentials Committee shall state in writing in concise language the acts or omissions with which the Medical Staff Member is charged, a list of

charges to include medical record numbers, if applicable, or the reasons for the denial of the request of the Applicant or Medical Staff Member.

f. Witnesses. Each party shall have the right to present witnesses. If either party by notice to the other requests a list of witnesses, the recipient, within ten days, shall furnish to the other a list in writing of the names and addresses of the individuals, so far as is then reasonably known, who will give testimony or evidence at the hearing. If a party fails to provide names and addresses of witnesses, the hearing officer in his/her discretion may preclude the testimony of witnesses whose names have not been disclosed. In any event, each party shall furnish to the other a written list of the names and addresses of the individuals.

g. Hearing Committee. When a hearing is requested, the President of the Medical Staff shall appoint a Hearing Committee which shall be composed of not less than three members of the Attending Medical Staff who shall not have actively participated in the consideration of the matter involved at any previous level. The Hearing Committee shall consist of individuals who are not in direct economic competition with the Members or Applicant involved. The Hearing Committee shall nominate, from amongst its members, a Chairperson. Knowledge of the matter involved shall not preclude a member from serving on the Hearing Committee.

h. Prehearing conduct. While neither side in a hearing shall have any right to discovery of documents or other evidence in advance of hearing, the hearing officer may confer with both sides to encourage an advance mutual exchange of documents which are relevant to the issues to be presented at the hearing. It shall be the duty of the Member and the Credentials Committee or its designee to exercise reasonable diligence in notifying the Chairperson of the Hearing Committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that the hearing officer may make prehearing decisions concerning such matters. Reconsideration of any prehearing decisions may be made at the hearing.

i. Postponements and extensions. Postponements and extensions of time beyond the times expressly permitted in these Bylaws in connection with the hearing process may be requested by any party and may be permitted by the Hearing Committee or its Chairperson acting upon its behalf.

3. Hearing procedure:

a. Failure to appear. If a person requesting the hearing fails to appear and proceed at such a hearing, this will constitute that person's voluntary acceptance of the recommendations or actions involved, and these recommendations or actions will become final and effective immediately.

b. Representation. The hearings provided for in these Bylaws are for the purpose of professional resolution of matters bearing on conduct or professional competency. Accordingly, the person requesting the hearings may be represented by the person or legal counsel of his/her choice. However, the person requesting the hearing must notify the Secretary of the Medical Staff, in writing, of his/her intention to be so represented no later than five days after submission of the request for a hearing.

c. The hearing officer. At the request of the person who requested the hearing, the Credentials Committee, the Hearing Committee, or on his/her own motion, the Chancellor, will appoint a hearing officer, who may be an attorney at law, to preside at the hearing. The hearing officer shall not act as a prosecuting officer or as an advocate for the Hospital, Chancellor, or Credentials Committee. If requested by the Hearing Committee, he/she may participate in the deliberations of such body, but he/she shall not be entitled to vote. The Chairperson of the Committee shall be the hearing officer if the Chancellor has failed to appoint a hearing officer. The hearing officer shall act to provide that all participants in the hearing have a reasonable opportunity to be heard, to present all oral and documentary evidence, and to insure that decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or admissibility of evidence. If the hearing officer determines that either party in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary actions as seem warranted by the circumstances.

d. Record of hearing. The Hearing Committee shall maintain a record of the hearing by one of the following methods: a tape-recording or a shorthand reporter present to make a record of the hearing. The cost of shorthand reporting shall be borne by the party requesting same.

e. Rights of both sides. At a hearing, both parties shall have the following rights: to call and examine witnesses, to introduce exhibits, to cross-examine any witness on any matter relevant to the issues, to impeach any witness, and to rebut any evidence. Both parties to the proceedings shall have a right to submit a written statement at the close of the hearing. The hearing shall be confidential and closed to the public.

f. Admissibility of evidence. Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses and presentation of evidence need not apply to a hearing conducted under this Article. Any relevant evidence shall be admitted by the hearing officer if it is the sort of evidence on which responsible persons are accustomed to

rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a memorandum to be filed following the close of the hearing. The Hearing Committee may interrogate the witnesses or call additional witnesses if it deems it appropriate.

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

h. Basis of decision. The decision of the Hearing Committee shall be based only on the evidence admitted at the hearing. Hearsay alone shall not be used as a basis for a finding of fact.

i. Burden of proof. At any hearing involving evidence or the receipt of closing written arguments, if requested, the hearing shall be closed. The Hearing Committee shall conduct any deliberations outside the presence of any other person unless the hearing officer is invited to participate in accordance with Section E.2.c.

j. Decision of the Hearing Committee. Within 15 working days after the final adjournment of the hearing, the Hearing Committee shall render a final written decision which shall contain a concise statement of the reasons justifying the decision made. The decision shall be delivered to the Credentials Committee, the Executive Committee of the Medical Staff, the Medical Director, and the Chancellor. At the same time, a copy of the decision shall be delivered to the Applicant or Member who requested the hearing by registered or certified mail, return receipt requested.

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

4. Appeal:

a. Time for requesting appeal. Within ten days after receipt of the decision of the Hearing Committee, either the person who requested the hearing or the Credentials Committee may request an appellate review by a Review Committee. This request shall be delivered either in person or by certified or registered mail, return receipt requested, to the Chancellor. If such appellate review is not requested within such period, the Hearing

Committee's decision shall be final and effective immediately upon expiration of that ten-day period.

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

(1) Substantial noncompliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice.

(2) The decision was not supported by substantial evidence based upon the hearing record.

(3) The decision is not sustainable in light of new evidence as may be permitted pursuant to Section E.3.e.

c. Time, place and notice. In the event of any appeal to the Review Committee as set forth in the preceding subsection, the Chancellor shall, within 15 days after receipt of such notice of appeal, schedule and arrange for an appellate review if he/she determines that valid grounds exist for review. The Chancellor shall cause the Applicant or Member to be given notice of the time, place and date of the appellate review or that the request for appellate review is denied. The date of appellate review shall not be more than 30 days from the date of receipt of the request for appellate review; however, when a request for appellate review is from a Member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made. The time within which appellate review will be held may be extended by the Review Committee for good cause.

d. Review Committee. A committee shall hear all appeals and shall be comprised of the Chancellor, the Dean of the School of Medicine, the Medical Director, and two additional Members from the Medical Staff who have not been involved in any aspect of the case to be heard and who are selected by the President of the Medical Staff. Knowledge of the matter involved shall not preclude any person from serving as a member of the Review Committee so long as that person did not take part in a prior investigation or hearing on the same matter. The Review Committee may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal.

e. Review procedure. The proceeding by the Review Committee shall be in the nature of an appellate hearing based upon the record before the Hearing Committee provided that the Review Committee may accept new

oral or written evidence, subject to a foundational showing that such evidence is not cumulative and could not have been made available to the Hearing Committee in the exercise of reasonable diligence. Presentation of such evidence shall be subject to the same rights of cross-examination or confrontation provided to the Hearing Committee. The Review Committee may remand the matter to the Hearing Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel in connection with the appeal, and to present a written statement in support of his/her position on appeal. In its sole discretion, the Review Committee may allow each party or representative to appear personally and make oral argument. The Review Committee may conduct deliberations outside the presence of the parties and their representatives.

f. Final decision. Within ten days, or as soon thereafter as reasonably possible at the conclusion of the proceedings, the Review Committee shall render a final decision in writing and shall deliver copies to the parties and to the Executive Committee of the Medical Staff in person or by certified or registered mail, return receipt requested. The final decision of the Review Committee shall be effective immediately.

ARTICLE IV

CLINICAL PRIVILEGES

Section A. Requirements for Clinical Privileges

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

2. Every initial application for any category of staff appointment or application for reappointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated current competence and judgment, clinical performance, health, references, the documented results of patient care and other quality review and monitoring which the medical staff deems appropriate, and other relevant information, including an appraisal by the Hospital. The applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges he/she requests.

3. Periodic redetermination of clinical privileges and the increase or curtailment of same shall be based upon, review of the records of patients treated, review of Medical Staff documentation which provides information about the member's

participation in the delivery of medical care, and the other factors described in Article III.C.

Section B. Temporary and Visiting Privileges

1. Visiting Privileges:

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

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

   c. 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:
      (1) current licensure;
      (2) relevant education and experience;
      (3) current competence;
      (4) ability to perform the privileges requested; and

2. Temporary Privileges

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

   b. 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:
      (1) Current licensure;
      (2) Relevant education/training and experience;
      (3) Current competence;
      (4) Ability to perform the Privileges requested
      (5) Results of the National Practitioner Data Bank query have been obtained and evaluated.
      (6) The applicant has a complete, clean application.

3. General Conditions and Termination

   a. All requests for Visiting or Temporary privileges shall include a clinical rationale supporting the needed urgency of the privileges.

b. The results of the National Practitioner Data Bank and Medical Board of California queries have been obtained and evaluated.

c. The applicant has filed a complete application with the Medical Staff office;

d. The applicant has demonstrated no current or previously successful challenge to licensure or registration exists;

e. The applicant has not been subject to voluntary/involuntary termination of medical staff membership at another organization;

f. The applicant has not been subject to voluntary/involuntary limitation, reduction, denial, or loss of clinical privileges.

g. 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.

h. 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.

i. Visiting or Temporary privileges may be granted by the Department Chair, the President of the Medical Staff and the Credentials Committee Chair (or their designees) on the recommendation of the department chair where the privileges will be exercised.

j. 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.

k. Providers granted visiting or temporary privileges shall be subject to the proctoring and supervision specified by the clinical department, or as described in these Bylaws, Rules and Regulations.

l. 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.

m. Visiting or Temporary privileges may be terminated with or without cause at any time by the Department Chair, the President of the Medical Staff or the Credentials Committee Chair (or their designees). A person shall not be entitled to the procedural rights afforded by Bylaws Article III, Section J, Fair Hearing Plan.

n. Whenever visiting or temporary privileges are terminated, the appropriate department chair or, in the chair's absence, the President of the Medical Staff shall assign a member to assume responsibility for the care of the affected practitioner's patient(s).

o. All persons requesting or receiving visiting or temporary privileges shall be bound by the Bylaws and rules.

Section C. Disaster and Emergency Privileges

1. Disaster Privileges may be granted when Langley Porter's emergency management plan has been activated and the organization is unable to handle the immediate patient needs. A medical disaster occurs when the destructive effects of natural or man-made forces overwhelm the ability of Langley Porter to meet the demand for health care services. Disaster privileges are granted pursuant to the Disaster Privileges Policy and Procedures.

2. If Disaster Privileges are granted, the provisions below apply.

   a. Disaster Privileges may be granted by the Director of Administration, Medical director, or their designees, based upon recommendation of the President of the Medical Staff, or in his or her absence, the recommendation of the responsible service director, upon presentation of valid government-issued photo identification and at least one of the following:

      (1) A current picture identification card from a healthcare organization that clearly identifies professional designation;

      (2) A current license to practice;

      (3) Identification indicating that the practitioner is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for the Advance Registration of Health Professionals (ESAR-VHP), or other recognized state or federal organization or group;

      (4) Identification indicating that the practitioner has been granted authority by a government agency to render patient care in emergency circumstances;

      (5) Presentation by current Langley Porter Psychiatric Hospital and Clinics or Medical Staff Member(s) with personal knowledge regarding the practitioner's ability to act as a licensed independent practitioner during a disaster.

3. Persons granted Disaster Privileges shall wear identification badges denoting their status as a Disaster Clinical Volunteer.

4. The Medical Staff office shall begin the process of verification of credentials and Privileges as soon as the immediate situation is under control or within 72 hours of the volunteer presenting themselves to the hospital or whichever comes first. The process used for verification of credentials is identical to that described as Section C, Procedure for Medical Staff Appointment (except that the individual is permitted to begin rendering services immediately, as needed).

5. If primary source verification of a volunteer licensed independent practitioner's credentials is unable to be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the hospital documents the following:

    a. Reasons it could not be performed within 72 hours of the practitioner's arrival
    b. Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment and services
    c. Evidence of the hospital's attempt to perform primary source verification as soon as possible.

6. The responsible service chair shall arrange for appropriate concurrent or retrospective monitoring of the activities of practitioners granted Disaster Privileges. This must include one of the following as applicable – direct observation, record review or mentoring.

7. Emergency Privileges

    a. In the event of an emergency, any member of the Medical Staff 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.

Section D. Evaluation and Monitoring

1. General Overview of Evaluation and Monitoring

    a. Routine evaluation and monitoring activities are conducted to assist the Medical Staff and Clinical services 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 Section D, 2, and regular and systematic review of all reported issues or incidents involving members of the Medical Staff or AHPs exercising Clinical privileges.

b. 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 Services. 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 is to be promptly apprised of incident reports that involve significant patient care issues, patient safety or disruptive conduct.

c. These activities are to be conducted in a manner to preserve confidentiality established by applicable law and Hospital Medical Staff policy.

d. 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, Section E). 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, Section E).

e. 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:

(1) Periodic random chart review

(2) Concurrent or retrospective review of selected charts

(3) Direct observation

(4) Proctoring (as further described below)

(5) Simulation

(6) Quality and Safety Dashboard data

(7) Monitoring of diagnostic and treatment techniques and/or clinical practice patterns

(8) Departmental Quality Review process

(9) Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel

(10) External peer review

(11) Continuing Medical Education

(12) Patient satisfaction data

(13) Professional liability experience

(14) Incident Reports

(15) Compliance with Medical Staff Bylaws and Rules and Regulations

(16) Compliance with Hospital Policies and Procedures

2. Focused Professional Practice Evaluation (FPPE) Requirements

   a. 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 Department Chair is authorized to implement other methods for evaluating as deemed appropriate under the circumstances... 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).

b. 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 Committee of the Medical staff, 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. FPPE may also be implemented whenever the Department Chair, Credentials Committee or Executive Committee of the Medical Staff determines that additional information is needed to assess a member's competence. 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.

c. 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.

d. 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. Ongoing Professional Practice Evaluation (OPPE)

a. Ongoing evaluations of each member or AHP's professional performance will be conducted.

b. 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.

ARTICLE V

CLINICAL ORGANIZATION

Section A. Clinical Services

1. Purpose: the Hospital is an acute psychiatric hospital and all patients are admitted for treatment of psychiatric disorders. The Hospital consists of inpatient services for adults, and outpatient services for adults, children, and adolescents.

2. The Medical Director has full responsibility for the operation and management of the Hospital and is accountable for all professional and administrative activities The Medical Director is responsible for: assessing needs on an ongoing basis; allocating resources; planning for changes in treatment services, training, and program evaluation; responding to community needs, laws and regulations; coordinating the operations of the Hospital within the University of California, San Francisco system and external agencies; and negotiating all contractual agreements. She/he is responsible for monitoring the quality of patient care and professional performance rendered by individuals with clinical privileges who practice in the hospital and clinics; assuring that the quality and appropriateness of patient care provided within the Hospital are monitored and evaluated; recommending to the Medical Staff the criteria for clinical privileges in the Hospital; and recommending clinical privileges for each member of the Hospital. The Medical Director position is filled by the Chair, Department of Psychiatry, or by his/her appointee.

3. Clinical services at LPPH&C are organized into intensive services and outpatient services. Each is managed by a director who is responsible for the overall quality of the professional and administrative functions of the service. Each director is responsible to the Medical Director for the overall oversight of the clinical work and the administrative functions within his/her programs. The directors are appointed by the Medical Director and the Chair, Department of Psychiatry. The Directors are responsible for the following functions:

    a. Plan, design, and implement the service goals to maintain high standards of clinical practice and administrative accountability.

    b. Coordinate programs within the service to support the goals of the Hospital.

c. Review and approve the qualifications of and assign appropriate responsibilities to the various clinical and administrative personnel under span of control.

d. Ensure, the protection of patient rights, including informed consent, and the adherence to the Hospital procedures.

e. Assess the competence of new members of the Medical Staff. Make recommendations regarding clinical privileges based on evaluations of current clinical performance of physicians or psychologists under his/her oversight.

f. Functions as the medical staff leader for his/her programs in utilization management activities.

g. Actively participates in the Hospital's performance improvement activities

4. Each inpatient and outpatient treatment program is managed by a Chief of Service, a qualified professional who shall be responsible to the Medical Director for the overall oversight of the clinical work within his/her unit or program. The Chiefs of Services are appointed by the Medical Director and the Chair, Department of Psychiatry. The Chief of Service is responsible for the following functions:

   a. Plan, design, and implement the program's goals to maintain high standards of clinical practice

   b. Determine the number of appropriately qualified clinical, administrative, and support staff necessary to meet the clinical service needs of the program.

   c. Ensure that the selection, evaluation, advancement, and termination of staff members are carried out in accordance with Hospital and University policies.

   d. Review and approve the qualifications of and assign appropriate responsibilities to the various clinical and administrative personnel who are part of the program.

   e. Ensure that clinical responsibilities assigned to members of the treatment team are appropriate and in keeping with their established, approved clinical privileges and recognized competence and abilities.

   f. Ensure, on behalf of all patients in the program, the protection of patient rights, including informed consent, and the adherence to the Hospital procedures.

g. Ensure the development and implementation of individualized treatment plans for all patients of the program and that appropriate documentation is included in the patient's record.

h. Ensure, prior to implementation, review of the rationale, justification, and necessity of the use of special treatment procedures such as restraint and seclusion.

i. Serve as a member of the Executive Committee of the Medical Staff, as appointed.

j. Serve as a proctor to assess the competence of new members of the Medical Staff, and to make recommendations regarding clinical privileges based on evaluations of current clinical performance of physicians or psychologists under his/her oversight.

k. Assume responsibility for oversight of house staff and other professional trainees assigned to the service or program.

l. Function as the service leader in utilization management activities for assigned clinical staff.

m. Actively participate in the Hospital's performance improvement activities.

5. The Hospital treatment programs are:

   a. Inpatient and Partial Hospitalization Services (adult)

   b. Outpatient Services (child, adolescent, adult)

   c. Detailed description of programs in Policy 100

Section B. Department Chair

1. The Department of Psychiatry ("the Department") shall have a chair who shall serve as Chair of the Department of Psychiatry in the School of Medicine.

2. The Department chair shall be an active Medical Staff member certified by an appropriate specialty board in at least one of the clinical areas covered by the Department or shall satisfy the Credentials Committee of equivalent competence, and shall be willing and able to discharge faithfully the functions of his or her office.

3. The Department chair shall have the following duties and responsibilities, subject to the authority of the Chancellor and The Regents to:

a. Maintain membership on the Medical Staff

b. Supervise and evaluate all clinically related activities of the department

c. Supervise and evaluate all administratively related activities of the department, unless otherwise provided by the hospital

d. Administer and implement these Bylaws, Rules, and Regulations within the Department to continually survey the professional

e. Performance of all individuals in the department who have delineated clinical privileges

f. Recommend to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department

g. Screen all Departmental applications for clinical privileges and make recommendations for clinical privileging to the Credentials Committee. Provide applicant evaluations in accordance with the provisions of these Bylaws for all appointments and reappointments. No appointment or re-appointment shall be made without a recommendation of the chair.

h. Assure that Members of the Department practice within the limits of privileges assigned to them and in accordance with the Medical Staff Bylaws and Rules and Regulations as well as the applicable sections of Title 22 of the California Code of Regulations, Conditions of Participation of the health Care Financing Administration and guidelines set forth by the Joint Commission on Accreditation of Healthcare Organizations.

i. Promptly report the failure of any Medical Staff member to discharge patient care responsibilities in accordance with the standard practice within the community and these Bylaws, Rules and Regulations, and recommend appropriate disciplinary actions.

j. Assume or assign patient care responsibilities on behalf of any Member of the Department who shall be unable to carry out same by virtue of disciplinary action, illness, or other causes.

k. Receive information and take action on, as may be appropriate, issues of quality of care and professional standards regarding Members of the Department.

l. Assess and recommend to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization

m. Coordinate and integrate interdepartmental and intradepartmental services

n. Develop and implement policies and procedures that guide and support the provision of care, treatment, and services

o. Assure that there is adequate coverage of the services provided by the Department. Coverage includes assessment and assignment of a sufficient number of qualified and competent persons to provide care, treatment, and services. Appropriate back-up and on-call services shall also be provided. The Chair shall inform the President of the Medical Staff and/or the Medical Director of coverage deficiencies or inability to provide services.

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

q. Continually assess and improve the quality of care, treatment, and services

r. Establish and maintain quality control programs to evaluate the quality of care, as appropriate

s. Assure adequate orientation and continuous education to all persons in the department or service

t. Recommend space and other resources needed by the department or service.

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

ARTICLE VI

OFFICERS OF THE MEDICAL STAFF

Section A. Officers and Their Duties

1. President. The President shall be responsible for:

   a. Calling, preparing the agenda for, and presiding over meetings of the Executive Committee of the Medical Staff and Medical Staff.

b. Appointing Chairs and members of the Medical Staff committees, and appointing proctors.

c. Establishing and disbanding special committees of the Medical Staff, subject to approval of the Executive Committee of the Medical Staff.

d. Serving as an ex-officio member of all Medical Staff committees.

e. Representing the views, policies, needs, and grievances of the Medical Staff to the Medical Director, the Chancellor, and The Regents, and representing the Medical Staff for the purpose of receiving and acting upon policies of the University of California, San Francisco and its School of Medicine.

f. Representing the Medical Staff for the purpose of receiving and acting upon policies of the Hospital.

g. Reporting on a regular periodic basis to the Executive Committee of the Medical Staff on the performance and quality of delegated responsibilities for the provision of patient care services.

h. Reporting on a regular periodic basis to the Chancellor and The Regents on the performance and quality of delegated responsibilities for the provision of patient care services.

i. Representing the Medical Staff in external professional and public relations.

j. Participating in the Fair Hearing Plan as indicated in Article III.E.

2. President Elect. The President Elect shall succeed the President following his/her two-year term. The President Elect shall function in place of the President, if the President is absent. The President Elect shall chair the Quality Council (Committee of the Whole).

3. Secretary. The Secretary shall be responsible for:

a. Maintaining accurate and permanent records of all meetings of the Medical Staff, Executive Committee of the Medical Staff, and Medical Staff committees.

b. Handling all Medical Staff correspondence.

c. Serving or assigning a representative to serve as an ex-officio member of all Medical Staff committees.

d. Establishing systems for the gathering, maintaining, and reporting of Medical Staff information required by government agencies and other external parties.

e. The duties of the Secretary shall be performed by the Medical Director or his/her designee.

Section B. Election and Tenure of Officers

1. The President and President Elect shall be Members of the Attending Staff at the time of nomination and election and must retain membership during their terms of office. Failure to maintain such status shall create a vacancy in the office.

2. The President and President Elect shall serve two-year terms beginning on January 1 and ending on December 31, or shall serve until a successor is elected.

3. Nominations for the office of President Elect shall be made by the Executive Committee of the Medical Staff and announced at a meeting of the Medical Staff. Further nominations may be made from the floor.

4. Voting shall be conducted by secret electronic/mail ballot with election by a plurality of the votes cast.

5. After serving in office, the President Elect shall succeed to the office of President. Should the President leave office before expiration of the term, the President Elect shall complete the remaining portion of the term as well as the succeeding term as President. If the President Elect leaves office prior to expiration of the term, a successor will be nominated and elected as provided in Section B.3 and 4 above.

6. The Medical Director shall serve as permanent Secretary of the Medical Staff.

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

ARTICLE VII

EXECUTIVE COMMITTEE OF THE MEDICAL STAFF

Section A. Membership

1. The Executive Committee of the Medical Staff shall consist of the following members:

   a. The Secretary.
      The Medical Director or his/her designee attends each meeting of the Executive Committee of the Medical Staff.

   b. The President and President Elect.

   c. The Director of Ambulatory Services.

   d. The Director of Intensive Services.

   e. The Director of Pharmacy.

   f. The Director of Patient Care Services.

   g. The Department Chair.

3. A quorum shall consist of five members, three of whom are Attending Medical Staff members.

4. Any member of the Medical Staff actively practicing in the hospital is eligible for membership on the Executive Committee

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

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

   a. To establish Rules and Regulations for the functions of the Medical Staff consistent with the purposes delineated in these Bylaws.

   b. To coordinate the activities and general policies of the various services and to be responsible for the quality of patient care provided by them.

   c. To establish such committees as may be necessary to govern clinical activities at the Hospital.

   d. To review, approve, and act on recommendations of the committees of the Medical Staff.

e. To act for the Medical Staff as a whole under such limitations as may be imposed by the Medical Staff.

f. Is empowered to act for the Medical Staff in the intervals between Medical Staff meetings.

g. To support the strategic initiatives and objectives of the Hospital.

h. To assure conformity, where indicated, with external licensure, certification, and accreditation requirements.

i. To review the credentials of applicants for medical staff membership and delineated clinical privileges.

j. To make recommendations regarding the mechanism designed to review credentials and delineate individual clinical privileges to the governing body.

k. Make recommendations for medical staff membership and delineated privileges to the governing body.

l. To organize the Medical Staff's performance improvement activities and establish a mechanism designed to conduct, evaluate, and revise such activities.

(1) Develop the mechanism by which Medical Staff membership may be terminated
(2) Create the mechanism designed for use in fair hearing procedures.

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

1. The Executive Committee of the Medical Staff shall meet monthly and shall hold such additional meetings, at the call of the President or any three members, as may be necessary for the conduct of its business.

2. A permanent record shall be kept of the minutes of all meetings, and a *summary* report of Committee actions shall be made annually to the Medical Staff.

ARTICLE VIII

COMMITTEES OF THE MEDICAL STAFF

Section A. Membership

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

Section B. Meetings

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

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

Section C. Authority and Responsibility

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

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

Section D. Standing Committees

1. Executive Committee of the Medical Staff

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

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

2. Quality Council

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

a. The Quality Council shall specifically review goals and objectives of the organization as well as significant sources of data which include but are not limited to: findings of continuous monitoring activities; feedback from patients and families, the community, and other customers; regulatory findings and requirements; strategic planning; and program evaluation information.

b. Performance Improvement Function: The Quality Council shall monitor and evaluate, objectively and systematically, the quality and appropriateness of patient care in order to pursue opportunities to improve patient care, to resolve identified problems, and to evaluate the effectiveness of the scope of practice of the organization. The Council shall be responsible for the coordination of the overall performance improvement plan and program, and shall evaluate the actions of the organization in its implementation of the performance improvement plan.

c. Utilization Management Function: The Quality Council shall be responsible for establishing utilization management standards and monitoring professional performance in order to assess the appropriateness of patient admission to the Hospital and continued care therein, and the appropriateness of services rendered on an ambulatory basis. The Council shall monitor and evaluate the effectiveness and efficiency of the use of health care resources in providing patient care.

d. Medical Records Function: The Quality Council shall be responsible for the form and content of medical records and shall approve the format of all materials filed therein. The committee shall appraise the quality of patient records, assuring that they meet necessary standards of patient care, usefulness, and historical validity, shall assure that all records reflect accurate documentation of medical events, and shall establish standards for the content and timely completion of records.

e. Pharmacy and Therapeutics Function: The Quality Council shall establish or adopt a formulary, develop guidelines for the control and distribution of

investigational drugs, and shall consider general problems of pharmacological therapeutics throughout the Hospital.

f. Infection Control Function: The Quality Council shall examine all Hospital infections and shall establish proper precautions for the care of the Hospital's patients with communicable diseases. The Committee shall establish a program of environmental surveillance throughout the Hospital.Risk Management Function: The Quality Council shall review risk management activities for trends which may indicate practices which pose a potential for exposure. The Council shall recommend actions to be taken which may include: referral to the Executive Committee of the Medical Staff, Service Chiefs, and Discipline Directors; or drafting policy and procedure.

g. Safety Function: The Quality Council shall function as the Environment of Care (EC) Committee and establish a safety program that includes risk assessment, hazard surveillance, collection/review/monitoring of safety activities and incident data, safety training and performance improvement measures for the seven areas of safety, security, fire prevention, emergency management, hazardous materials and waste, medical equipment and utilities. The Council shall evaluate the effectiveness of the seven EC program areas on an annual basis.

h. The Quality Council shall report to the Executive Committee of the Medical Staff and to the LPPH&C Leadership Committee.

3. Credentials Committee

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

4. Peer Review Committee

a. The Peer Review Committee shall meet at least monthly. This committee shall be responsible for monitoring and evaluating on a continual basis, the conduct, utilization, documentation and performance of its members to ensure quality and appropriateness of patient services and the clinical performance of each clinically privileged individual at LPPH&C. Minutes of these meetings shall be sent to the Executive Committee of the Medical Staff. These minutes shall document individual and aggregate review of clinical care and shall include:

(1) individual patient care monitoring;

(2) review of patient care incidents;

(3) other clinical care problems brought to the Committee's attention.

b. The Peer Review Committee's evaluation shall be used by the Credentialing Committee for determining recommendations for reappointment of medical staff members, or the renewal or revision of individual clinical privileges. The Peer Review Committee shall receive minutes from committees and workgroups for review of the full range of clinical activities. The composition shall be determined annually by the Executive Committee of the Medical Staff to reflect the range of clinical services at LPPH&C.

c. Minutes of its proceedings shall be maintained as privileged. The committee shall submit minutes of its meetings to the Executive Committee of the Medical Staff.

5. Well-Being Committee

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

Through the provision of preventive, supportive responses to the individual, the Medical Staff is able to meet its obligation to limit potential risk to patient safety in a manner which makes its resources available to Members in the interests of maximizing Medical Staff Member health and preventing professional failure.

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

health or impairment of the Member poses a risk of harm to patients or staff.

b. The Well-Being Committee strives to achieve this purpose through facilitation of treatment for, prevention of, and intervention in Medical Staff member impairment or potential impairment caused by chemical dependency, medical or behavioral problems.

c. Policy and procedures shall be developed and implemented to confidentially manage Medical Staff member well-being matters which may affect patient care delivery and for which assistance to the Medical Staff member may be appropriate and necessary. The Well-Being Committee operates as a peer review committee and its activities and proceedings are protected under federal and state peer review statutory privileges and protections, including but not limited to those provided pursuant to California Evidence Code 1156.

d. The Well-Being Committee commits to a non-punitive process that encompasses the following elements:

(1) The education of medical staff members and hospital staff regarding recognition of potential impairment on the part of its members.

(2) A confidential environment for self-referral to the Well-Being Committee by a medical staff member, as well as referral to the committee by other organization staff regarding medical staff colleagues.

(3) Evaluation of the credibility of a complaint, allegation or concern.

(4) Facilitation of referral of the affected medical staff member to the appropriate professional internal and external resources for evaluation, diagnosis and treatment of the condition or concern.

(5) Maintenance of confidentiality of the medical staff member, except under the following circumstances:

a) as limited by law or ethical obligation
b) when the health and safety of a patient is threatened; or
c) as may be necessary to obtain information to evaluate the credibility of a third party concern
d) complaint, allegation or concern which is brought to the committee.

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

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

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

d. In cases where a member has been diagnosed with a problem of chemical dependency, received treatment, and now has a Medical Staff appointment, it is the policy of the Medical Staff that lack of total abstinence is an indication for immediate investigation.

e. The Well-Being committee will meet at the direction of the President of the Medical Staff or as required in managing a referred affected medical staff member through the investigative, evaluation and monitoring processes.

f. The Well-Being committee is comprised of at least three Medical Staff members and Legal Affairs (ex officio). The Chair of the Well-Being Committee is a physician.

6. Ethics Committee

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

b. This committee is available for ethical consultations. The UCSF Ethics Committee meets regularly to identify and discuss issues involving medical ethics, to convene consultations to assist in resolution of clinical ethical dilemmas, to make recommendations about their resolution to the President of the LPPH&C Medical Staff and to educate its members and the hospital community on issues relating to medical ethics.

c. The purpose of the Ethics committee is to provide guidance for the resolution of specific ethical dilemmas arising from direct patient care. The Ethics Committee provides consultative services to all clinical departments of UCSF.

Section E. Special Committees

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

ARTICLE IX

MEETINGS

Section A. Meetings

The Medical Staff shall meet *annually* with thirty days' advance notice to the voting membership.

Section B. Special Meetings

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

Section C. Attendance at Meetings

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

ARTICLE X

RULES and REGULATIONS, POLICIES AND BYLAWS

Section A. Adoption of Rules and Regulations

1. Adoption of Rules and Regulations. The Executive Committee of the Medical Staff shall adopt such Rules and Regulations as may be necessary to assure the proper conduct of Medical Staff business and provision of patient care. Such Rules and Regulations shall be consistent with the Bylaws and other LPPH&C and UCSF policies, and the University of California Office of the President (UCOP) policies.

2. Notice. Except when urgent action is required to comply with law or regulation, as set forth below, the Executive Committee of the Medical Staff shall give at least thirty (30) days prior notice. The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process (as described in Article III, D) of the proposed adoption or amendment.

3. Urgent Action. However when urgent action is required to comply with law or regulation, the Executive Committee of the Medical Staff 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.

    a. Subsequent review and consideration of the urgently adopted Rule or Regulation is triggered by a written petition signed by at least fifteen (15) 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.

4. New or Amended Rule and Regulation. Additionally, the Medical Staff may, by a written petition signed by at least twenty (10) voting members of the Medical Staff and upon at least thirty (30) days notice to the Executive Committee of the Medical Staff, 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 fifteen (15) mail/electronic ballots must have been timely cast.

5. Approval Chancellor. Following Executive Committee of the Medical Staff approval or Medical Staff approval (as applicable), a Rule and Regulation shall become effective following the approval of the Chancellor.

6. Post-Approval Notice and Force and Effect. Upon approval of the Chancellor 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.

Section B. Policies

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 Committee of the Medical Staff and approval by the Chancellor. Such policies shall not be inconsistent with the Medical Staff Bylaws, Rules or other LPPH&C policies, or the University of California Office of the President (UCOP) policies.

2. New or Amended Policies. Additionally, the Medical Staff may, by petition signed by fifteen (15) voting members of the Medical Staff, and upon at least thirty (30) days notice to the Executive Committee of the Medical Staff, 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 fifteen (15) mail/electronic ballots must have been timely cast.

3. Post-Approval Notice and Force and Effect. Upon approval of the Chancellor, 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.

Section C. Notices

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.

Section D. Conflict Management

1. In the event of conflict between the Executive Committee of the Medical Staff and the Medical Staff (as represented by written petition signed by at least fifteen (15) 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 Committee of the Medical Staff 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 Committee of the Medical Staff, and the safety and quality of patient care at the LPPH&C. Unresolved differences shall be submitted to the Chancellor for final resolution.

Section E. Amendment of Bylaws

1. Bylaw amendments are reviewed and recommended by the Executive Committee of the Medical Staff 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 Committee of the Medical Staff, 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 fifteen (15) mail ballots must have been timely cast, and approval by the Chancellor. Neither the Medical Staff nor the Chancellor may unilaterally amend the Medical Staff Bylaws.

2. The Bylaws may be temporarily amended by a two-thirds (2/3) affirmative vote at a regular or special meeting of the Executive Committee of the Medical Staff and subsequent approval by the Chancellor. 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 above in Section E, 1. Review of these Bylaws, Rules and Regulations shall occur at least once every 3 years and revisions made as may be necessary and appropriate.

Section F. Technical and Editorial Amendments

1. The Executive Committee of the Medical Staff shall have the power to adopt such amendments to the Bylaws as are, in its judgment, technical modifications or clarifications, reorganization or renumbering of existing Bylaws, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression, or inaccurate cross-references. Such amendments shall be effective immediately, and shall be permanent if not disapproved by the Chancellor within ninety (90) days after adoption by the Executive Committee of the Medical Staff. The action to amend may be taken by motion and acted upon in the same manner as any other motion before the Executive Committee of the Medical Staff. Such approved amendments shall be communicated in writing to the Medical Staff at the next Annual Meeting, or sooner if deemed necessary by the Executive Committee of the Medical Staff or the Chancellor.

Section G. Adoption of Bylaws

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 the Chancellor.

Section H. Confidentiality

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 LPPH&C 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 Committee of the Medical Staff or its designee and the Department Chair.

2. 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 LPPH&C's operations. If it is determined that such a breach has occurred, the Executive Committee of the Medical Staff may undertake such corrective action as it deems appropriate.

Section I. Immunity and Releases

1. Each representative of the Medical Staff and LPPH&C 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 Committee of the Medical Staff and the Chancellor or AHP for damages or other relief by reason of providing information to a representative of the Medical Staff, AHP staff, LPPH&C, 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 LPPH&C or by reason of otherwise participating in a Medical Staff or LPPH&C credentialing, performance improvement or peer review activities.

2. 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:

    1. Applications for appointment, privileges or specified services;

2. Periodic reappraisals for reappointment, privileges, or specified services;

3. Corrective action;

4. Hearings and appellate reviews;

5. Performance improvement review, including patient care audit;

6. Peer review;

7. Utilization reviews;

8. Morbidity and mortality conferences;

9. Other LPPH&C, 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

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 LPPH&C operations.

3. Immunity. Each practitioner physician, clinical psychologist, or other professionals allowed by the state to practice independently and approved by the Executive Committee of the Medical Staff and the Chancellor 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.

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

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

6. Legal Counsel. 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.

7. Disputes with the Governing Body. In the event of a significant dispute between the Medical Staff and the Chancellor relating to the independent rights of the Medical Staff, as further described in California Business and Professions Code § 2282.5, the Medical Staff, Hospital Leadership and the Department Chair will meet and confer in good faith to resolve the dispute.