LANGLEY PORTER PSYCHIATRIC HOSPITAL
UNIVERSITY OF CALIFORNIA SAN FRANCISCO MEDICAL STAFF

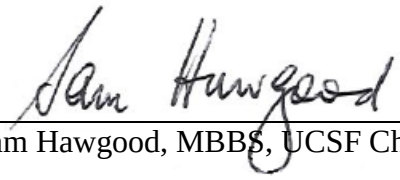
MEDICAL STAFF BYLAWS

UNIVERSITY OF CALIFORNIA
LANGLEY PORTER PSYCHIATRIC HOSPITAL

MEDICAL STAFF BYLAWS
APPROVALS

02/09/2023

Andreea Seritan, MD, LPPH Medical Staff President — Date



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Sam Hawgood, MBBS, UCSF Chancellor — Date

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PREAMBLE

In recognition of their responsibilities for overseeing, on behalf of the Governance Advisory Council, the quality of patient care, treatment, and services provided at Langley Porter Psychiatric Hospital (the "Hospital"), the physicians, and other eligible health care professionals at Langley Porter Psychiatric Hospital hereby organize themselves as the Medical Staff of Langley Porter Psychiatric Hospital (the "Medical Staff".) This organization shall be self-governing in conformity with federal and state regulatory requirements, The Joint Commission accreditation standards, and the guiding principles set forth in these Bylaws, as well as the Medical Staff Plans, Rules, Regulations and Policies, and is subject to the ultimate authority of The Regents of the University of California. The Regents have delegated authority for the governance of the Hospital to the Chancellor of the University of California, San Francisco, who shall govern all activities of the Hospital consistent with the Hospital, UCSF Health, UCSF Medical Center and University policies and procedures and actions of The Regents.

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

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

DEFINITIONS

The definitions set forth below apply to these Bylaws and all Governing Documents, including all Medical Staff Plans, Rules, Regulations, Policies and Procedures, unless otherwise stated.

1. ADVANCED PRACTICE PROVIDER ("APP") means an individual, other than a licensed physician, clinical psychologist, or other professional allowed by the state to practice independently and approved by the Medical Staff Executive Committee and the Governance Advisory Council, who provides direct patient care services at LPPH under a defined degree of supervision by a Medical Staff Member who has been granted clinical privileges. APPs are not eligible for Medical Staff membership.

2. CHANCELLOR means the Chancellor of the University of California, San Francisco ("UCSF").

3. CHIEF EXECUTIVE OFFICER ("CEO") means the person appointed by the Chancellor to serve as Chief Executive Officer and President of Langley Porter Psychiatric Hospital (LPPH). The CEO is the Chair of the UCSF Department of Psychiatry and Behavioral Sciences (DPBS) or is the Chair's designee.

4. CHIEF MEDICAL OFFICER ("CMO") is appointed by the CEO, and subject to approval by the Chancellor, to serve as a liaison between the Medical Staff and the Hospital.

5. CHIEF OF SERVICE or SERVICE CHIEF means the applicable Chair of the Department of the UCSF School of Medicine or one or more designee(s) of the Chair, responsible for safe and competent clinical care provided to patients evaluated or treated under that Service.

6. CLINICAL DEPARTMENT means the Department of Psychiatry and Behavioral Sciences at LPPH and corresponds to the academic department in the UCSF School of Medicine. Additional departments may be included.

7. CLINICALLY INDICATED means health care services are clinically indicated in either of the following circumstances: (1) a health care provider, exercising prudent clinical judgment, would provide them to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, condition, or its symptoms; (2) as performed, the clinical services provided meet the applicable Standard of Care (as defined below); (3) as performed, they are appropriate, in terms of type, frequency, extent, site, and duration; and (4) as performed, they are considered potentially effective for the patient's illness, injury, disease, condition, or symptoms.

8. COMPLETE APPLICATION shall mean an application for either initial appointment or reappointment to the Medical Staff, or an application for clinical privileges, which has been determined by the applicable Department Chair or

designee, the Credentials Committee, the MSEC and/or the Governance Advisory Council to meet the requirements of these Bylaws and related policies and procedures. Specifically, to be complete the application must be submitted timely and in the form approved by the MSEC and Governance Advisory Council, and include all required supporting documentation and verifications of information, and any additional information requested from the applicant for the required review of qualifications and competence of the applicant.

9. CONFLICT OF INTEREST means a personal, professional, or financial interest, or conflicting fiduciary obligation on the part of a Member or his/her immediate family member (including a spouse, domestic partner, child or parent) that may impact, as a practical matter, the Member's ability to act in the best interest of the Medical Staff without regard to the individual's private or personal interest, or circumstances which create the impression of such a conflict.

10. CREDENTIALING means the process of obtaining, verifying and assessing the qualification of a practitioner to provide patient care or services within the practitioner's training, license and experience.

11. CREDENTIALS means documented evidence of licensure, education, training, experience, board certification or other qualifications.

12. DATE OF RECEIPT means, unless otherwise stated, the date any Notice or other communication was delivered personally or electronically; or if such Notice or communication was sent by regular US mail, it shall mean seventy-two (72) hours after the Notice or communication was deposited, postage prepaid, in the US mail.

13. DAYS means, unless otherwise stated, calendar days, not counting Saturday, Sunday or legal holidays.

14. DEPARTMENT CHAIR or CHAIR OF DEPARTMENT corresponds with the UCSF School of Medicine Department Chair. Each School of Medicine Department Chair may serve as a Chief of Clinical Service or may appoint one or more Chief (s)of Clinical Service to carry out his/her roles and responsibilities as defined in these Bylaws.

15. ELECTRONIC/DIGITAL COMMUNICATION means the use of a secure UCSF electronic mail platform as the sole acceptable means of electronic/digital communication under these Bylaws.

16. EX OFFICIO means service by virtue of office or position held. An ex officio appointment is with vote unless specified otherwise.

17. MEDICAL STAFF EXECUTIVE COMMITTEE ("MSEC") means the executive committee of the Medical Staff.

18. FAIR HEARING PLAN means the Investigation, Corrective Action and Fair Hearing Plan of the Medical Staff.

19. GOVERNANCE ADVISORY COUNCIL ("GAC") means the group, as chaired by the Chancellor, which facilitates the governance of the LPPH Medical Staff and oversees the quality of patient care, treatment and services provided at Langley Porter Psychiatric Hospital.

20. GOVERNING DOCUMENTS means the documents that create a system of rights, responsibilities, and accountability between the Medical Staff and the Governing Body, and between the Medical Staff and its members. The Governing Documents of LPPH Medical Staff include the Medical Staff Bylaws, the Credentialing and Performance Plan, Organizational Plan, the Investigation, Corrective Action and Fair Hearing Plan, the Medical Staff Rules and Regulations, and Policies and Procedures.

21. HE/SHE means an individual person regardless of gender. Unless the context otherwise requires, a reference to one gender shall include reference to other genders.

22. INTERVIEW means, in the context of an investigation by the MSEC, or a committee of the Medical Staff or its designee, the discussion with a Member or others regarding the subject(s) of the investigation. Such discussion does not constitute a formal hearing, and no formal hearing rights apply. There is no Member right to legal representation during an interview.

23. LPPH or HOSPITAL means Langley Porter Psychiatric Hospital for the purposes of these Bylaws. In the event a Medical Staff Member holds membership or privileges at more than one UCSF location, the controlling Medical Staff Bylaws and/or governance documents of the location at which the subject event(s) occurred will apply.

24. MEDICAL STAFF means the organizational component of the Hospital as defined above that includes all physicians (M.D. or D.O.), clinical psychologists, and other professionals allowed by the state to practice independently and approved by the MSEC and the Governance Advisory Council, who have been granted recognition as Members pursuant to these Bylaws. The term Medical Staff shall also be deemed to refer to the "organized medical staff," as that terminology may be used in various laws and regulations, and in any applicable standards of The Joint Commission.

25. MEDICAL STAFF YEAR means the period from July 1 through June 30.

26. MEMBER means any physician (M.D. or D.O.), clinical psychologist, or other professional allowed by the state to practice independently and within his/her defined professional scope of practice and approved by the MSEC and the Governance Advisory Council, who has been appointed to the Medical Staff.

27. NOTICE unless otherwise specified, means a written communication delivered personally to the addressee or a communication delivered electronically on an approved secure platform or sent by United States mail, first-class postage prepaid, addressed to the addressee at the last physical address/email address as it appears in the official records of the Medical Staff or the Hospital.

28. PHYSICIAN means an individual with a M.D. or D.O. who is currently licensed to practice medicine or otherwise permitted to practice medicine by the Medical Board of California.

29. POLICIES refer to the Medical Staff Policies adopted in accordance with these Bylaws, unless otherwise specified.

30. PRACTITIONER means, unless otherwise expressly limited, any currently licensed or registered or permitted physician (M.D., D.O.), or clinical psychologist.

31. PRESIDENT means the person who has been elected by the Medical Staff to act on its behalf.

32. PRESIDENT-ELECT means the person who shall become the president after the President's term concludes and who has been elected by the Medical Staff.

33. PRIVILEGES means the permission granted to Medical Staff Members or Advanced Practice Providers to render specific patient services.

34. PLANS, POLICIES, RULES AND REGULATIONS refers to the Medical Staff Plans, Policies, Rules and Regulations adopted in accordance with these Bylaws, unless otherwise specified.

35. SCHOOL OF MEDICINE means UCSF School of Medicine.

36. SERVICE CHIEF or CHIEF OF CLINICAL SERVICE means the applicable Chair of the Department of the UCSF School of Medicine or one or more designee(s) of the Chair, responsible for safe and competent clinical care provided to patients evaluated or treated under that Service.

37. SEXUAL MISCONDUCT refers collectively to the commission of any act of sexual abuse, misconduct, or relations with a patient, client, hospital staff, medical staff or trainee, or any other unprofessional contact or communication of a sexual nature. In the case of any doubt, please refer to the UCOP Policy on Sexual Violence and Sexual Harassment.

38. SPECIAL NOTICE means the transmission of information that is deemed conveyed when sent by overnight delivery and/or USPS Priority mail with delivery receipts, or when personally delivered.

39. STANDARD OF CARE means the reasonable degree of skill, knowledge and care, based on credible scientific evidence published in current peer-reviewed medical literature, and ordinarily possessed and exercised by members of a person's profession and specialty under similar circumstances. The Standard of Care encompasses whether and under what circumstances a procedure, modality or methodology is utilized and the manner in which it is performed.

40. STANDARDIZED PROCEDURES means the scope of services granted to APPs based upon review by the Credentials Committee, and final approval by the MSEC.

41. THE REGENTS means The Regents of the University of California pursuant to Article IX, Section 9 of the California Constitution.

42. TRAINEES means individuals who are pursuing post graduate training pursuant to an approved or accredited course of study (e.g., ACGME, ABMS and APA-approved programs) at UCSF under the supervision of the Medical Staff.

ARTICLE 1 NAME AND DESCRIPTION OF MEDICAL STAFF ORGANIZATION

1.1 Name

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

1.2 Relationship Between Medical Staff, LPPH and UCSF School of Medicine.

1.2.1 These Bylaws describe the roles, rights, and responsibilities of the Medical Staff and its Members, in their capacity delivering and overseeing care, treatment, and services to patients. The Organizational Plan of the Medical Staff further defines the structure, roles, responsibilities, and processes of the Medical Staff, including the Medical Staff Executive Committee and the committees of the Medical Staff.

1.2.2 LPPH operates as a teaching hospital to support the educational activities for UCSF training programs. Members of the Medical Staff have clinical roles and responsibilities subject to the Bylaws, Plans, Rules, Regulations, and Policies of the LPPH Medical Staff and may concurrently participate in teaching, administrative and/or approved research activities under the auspices of the UCSF School of Medicine.

1.2.3 These Bylaws relate solely to responsibilities of Medical Staff Members in their capacity as clinicians delivering and overseeing the delivery of patient care. As such, all activities conducted on behalf of the Medical Staff shall have, as their overriding purpose, the delivery of safe, effective, and high-quality patient care.

1.2.4 To accomplish these purposes, each Member is assigned to a medical staff category. The rights, responsibilities, and prerogatives of each staff category are described in these Bylaws and in the Credentialing Plan.

1.2.5 Each Clinical Department is subject to oversight by a Department Chair. Each Clinical Department has at least one Chief of Clinical Service, which may be the Chair. The Chief of Clinical Service will have the responsibilities enumerated herein and in the Organizational Plan.

1.2.6 Medical Staff committees oversee activities of the Clinical Departments and Clinical Services, such as, but not limited to credentialing and peer review, oversight of quality, safety and appropriateness of care, treatment, and services. Additionally, these committees participate on behalf of the Medical Staff in the formulation and/or review of Medical Staff Bylaws and policies and Hospital policies, within the purview of the respective committees' responsibilities.

1.2.7 The Medical Staff Executive Committee, which is comprised of elected and appointed officials of the Medical Staff and the Hospital, oversees the quality of patient care, treatment and services through Medical Staff committees and Clinical Department activities. All Medical Staff committees and Clinical Departments report to the Medical Staff Executive Committee.

1.2.8 The Chief Medical Officer is the Vice President for Adult Behavioral Health Services and serves as a liaison between the Hospital and the Medical Staff.

1.2.9 The Medical Staff Executive Committee reports to the Governance Advisory Council, chaired by the Chancellor.

ARTICLE 2 PREROGATIVES AND PURPOSES

2.1 Prerogatives and Purposes of the Medical Staff Organization

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

2.1.1 To provide a system for Medical Staff self-governance and accountability to the Governance Advisory Council for patient care, whereby patients treated at LPPH shall receive the level of care consistent with the generally recognized standards of the profession.

2.1.2 To ensure that all patients of LPPH 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, status as a covered veteran, 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 considering the patient's total circumstances.

2.1.3 To initiate and maintain Bylaws, Plans, Rules, Regulations, and Policies for self-governance.

2.1.4 To account to the Governance Advisory Council for the quality of patient care and professional conduct of all Members authorized to practice in the Hospital through the following measures:

2.1.4.1 Review and evaluation of the quality of patient care provided through valid and reliable patient care evaluation procedures;

2.1.4.2 Implement mechanisms that allow on-going monitoring of professional conduct and patient care practices;

2.1.4.3 Employ mechanisms of appointment, reappointment, and the matching of clinical privileges to be exercised or specified services to be performed with the verified credentials and current demonstrated performance of the Medical Staff applicant or Member;

2.1.4.4 Enable continuing education based at least in part on needs demonstrated through the medical care evaluation program; and

2.1.4.5 Conduct utilization review to provide for the appropriate use of all medical services.

2.1.5 Recommend to the Governance Advisory Council actions with respect to appointments, reappointments, staff category, department assignments, clinical privileges and corrective actions.

2.1.6 Establish and enforce, subject to the Governance Advisory Council approval, professional standards related to professional conduct and the delivery of health care within the Hospital.

2.1.7 Initiate and pursue corrective action with respect to Medical Staff Members when warranted.

2.1.8 Establish and amend from time to time as needed Medical Staff Bylaws, Plans, Rules, Regulations, and Policies for the effective performance of Medical Staff responsibilities, as further described in these Bylaws.

2.1.9 Select and remove Medical Staff Officers.

2.1.10 Recommend assessment of Medical Staff dues and utilize these dues to support Medical Staff functions.

2.1.11 Ensure that all Medical Staff Members demonstrate quality in their performance of professional duties through the appropriate delineation of clinical privileges that he/she/they may exercise in the Hospital.

2.1.12 Work collaboratively with Hospital administrative leadership in ensuring that the Hospital is fiscally sound.

2.1.13 Foster education and research programs of the University of California in an integrated manner with the clinical programs of the Hospital.

2.1.14 Facilitate professional education and community health education and support services.

2.1.15 Foster cooperation with other community health facilities and/or educational institutions or efforts.

2.1.16 Ensure that the Medical Staff and its Members exercise their rights and responsibilities in a manner that does not jeopardize the hospital license, Medicare and Medi-Cal provider status, accreditations, or mission as an academic medical center.

2.1.17 Approve Medical Staff Bylaws, Plans, Rules, Regulations, and Policies, and seek approval of the Governance Advisory Council as required.

ARTICLE 3 MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES

3.1 Medical Staff Membership

Each Member of the Medical Staff shall be assigned to a Medical Staff category based upon the qualifications outlined below. The Members of each category shall have the prerogatives and shall carry out the duties defined in these Bylaws. Action may be initiated to change a Medical Staff category or to terminate the membership of any Member who fails to meet the qualifications or fulfill the duties described herein. There are no grounds for the hearing rights set forth in the Fair Hearing Plan when changing a category or reassigning a category due to the Hospital's or Department's need that is unrelated to a medical disciplinary cause or reason as defined in California Business and Professions Code Section 805.

3.2 Eligibility and Qualifications for Medical Staff Membership

Eligibility and qualifications for Medical Staff Membership are addressed in the Credentialing and Performance Plan.

3.3 Categories of Medical Staff Membership

3.3.1 Attending Staff.

Definition: Physicians, clinical psychologists, or other professionals allowed by the state to practice independently, who are involved in patient care and/or in the supervision of trainees in their involvement with patient care or contact, must meet the criteria for membership, and be approved by the Medical Staff Executive Committee and the Governance Advisory Council as members of the Attending Staff. Members of the Attending Staff who have not been involved in patient care at the Hospital and/or who have not been involved in the clinical supervision of trainees at the Hospital for a period of two (2) years shall automatically be transferred to Courtesy Status and/or be subject to a period of Focused Professional Practice Evaluation in order to maintain membership and privileges.

Prerogatives and Responsibilities: Members of the Attending Staff are eligible to vote and hold office and are expected to participate in the activities of the Medical Staff through membership on its committees and attendance at its meetings.

3.3.2 Courtesy Staff.

Definition: Physicians who admit patients of a minimal acceptable number as determined by the MSEC may apply for appointment to the Courtesy Staff. Members of the Courtesy Staff who have not met the minimum acceptable number of admissions or have not been involved in patient care at the Hospital and/or who have not been involved in the clinical supervision of trainees for a period of two (2) years shall be subject to a period of Focused Professional

Practice Evaluation in order to apply for or maintain membership and privileges.

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

3.3.3 Teaching Only Staff.

Definition: The Teaching Only Medical Staff shall consist of those UCSF School of Medicine faculty members who volunteer their clinical input and knowledge only for teaching at LPPH.

Prerogatives and Responsibilities: Teaching Only members may only participate in the care of patients when incident to performing clinical teaching responsibilities.

Teaching Only Medical Staff may not admit patients to the hospital. Teaching Only members have limited privileges specific to performing their clinical teaching responsibilities. When required, temporary privileges may be extended on a time limited basis. Members of this category shall have no voting rights and may not hold office in any standing committees or subcommittees of the Medical Staff Executive Committee unless so specified at the time of credentialling. Members of this category must meet the general responsibilities of membership, but are exempt from the requirement of federal program participation (such as Medicare/Medi-Cal.) Teaching Only members must comply with the Medical Staff and UC policies including but not limited to the Code of Conduct and Sexual Violence and Sexual Harassment Policy. Members of this category must satisfy the requirements of the service in which they are a member, including participation in committee meetings or departmental meetings as requested.

Since Teaching Only staff appointment is dependent upon having a faculty appointment, the Medical Staff appointment in this category ceases when the faculty appointment is terminated.

3.3.4 Courtesy-Associate Staff.

Definition: Physicians or clinical psychologists who do not provide care for a minimal acceptable number of patients as determined by the LPPH Medical Staff Executive Committee sufficient to meet Courtesy status may apply for appointment instead as Courtesy-Associate Staff. Membership in this category shall be considered for by appointment only by recommendation of the Service Chief and/or President of the Medical Staff.

Prerogatives and Responsibilities: Such Members may serve on committees, may vote, and may hold office. Courtesy-Associate staff must:

a) Be those serving in leadership roles and retained to and charged with assisting the Hospital/School of Medicine with carrying out institutional administrative and operational functions;

b) Meet all of the basic qualifications for Medical Staff membership;

c) Are determined to adhere to the policies of UCSF Health, the ethics of their professions and work cooperatively with others so as not to adversely affect their judgment in carrying out their leadership duties for performance improvement and patient safety functions, and properly perform those responsibilities to the satisfaction of the Medical Staff.

ARTICLE 4 INITIAL APPOINTMENT AND REAPPOINTMENT

4.1 Application Initial Appointment and Reappointment

The Medical Staff shall consider each application for appointment, reappointment, and clinical privileges, and each request for modification of Medical Staff category, using the procedure and criteria and standards for Membership and Privileges in the LPPH Bylaws and the LPPH Medical Staff Credentialing and Performance Plan. By applying to the Medical Staff for appointment or reappointment, the applicant agrees that he or she shall comply with the responsibilities of Medical Staff membership and with the Bylaws, Plans, Rules, Regulations and Policies as they exist and as they may be modified from time to time, as well as Hospital and UC Policies as may be modified from time to time.

4.2 Procedure for Initial Appointment and Reappointment

The verification and processing procedures of applications for appointment and reappointment are set forth in the LPPH Medical Staff Credentialing and Performance Plan.

4.3 Burden on Applicant

Applicants for membership appointment, reappointment, and/or clinical privileges shall have the burden of producing adequate information for a proper evaluation of their qualifications for membership or clinical privileges, including documentation of their general competencies regarding their experience, background, training, board certification or re-certification status, health status, and their ability to provide their patients with care at the generally recognized level of quality. Neither the Medical Staff nor Governance Advisory Council shall have any obligation to review or consider any application until it is complete, as outlined in these Bylaws and the Credentialing and Performance Plan. If further information is required, review and/or action upon an application can be deferred at the discretion of the Credentials Committee or the MSEC. The applicant shall provide accurate, up-to-date information on the application form, and shall be responsible for ensuring that all supporting information and verifications are provided as requested. It shall be the responsibility of the applicant to ensure that any required information from his/her training programs, peer references, or other facilities is timely submitted directly to the Office of Medical Staff Affairs and Governance by such sources. Untimely or incomplete applications will not be processed.

4.3.1 Applicant's Responsibilities.

The applicant shall be responsible for resolving any doubts regarding the application. If during the processing of the application, the Hospital or the Medical Staff or any committee or representative thereof, determines that additional information or verification or an interview with the applicant is needed, further processing of the application may be stayed or deferred, and the application may not be considered complete until such additional

information or verification is received, or the interview is conducted. The Credentials Committee, MSEC or Governance Advisory Council may request that the applicant appear for an interview with regard to the application. Failure to appear at the requested time and location will cause the application to be deemed incomplete.

4.4 Incomplete Applications.

4.4.1 A practitioner whose appointment or reappointment application is not fully completed as defined above shall not be entitled to a credentialing recommendation from any Clinical Service or Committee. If the practitioner fails to complete the application within one hundred eighty (180) days of initial submission or renewal deadline, or within thirty (30) days of a request for additional information, whichever is later, the credentialing process may be terminated at the discretion of the Credentials Committee. The applicant may be given an opportunity to be heard, either in writing or in person, if so determined by the Credentials Committee. Termination of the credentialing process pursuant to this section shall not entitle the practitioner to a hearing described in the Fair Hearing Plan.

4.4.2 If the applicant has not provided a complete application within the 180-day period, the credentialing process may be terminated at the discretion of the Credentials Committee, as provided above. The applicant may apply again no more than twice in the same twelve (12) month period, and any information gathered during the initial process may be used if still valid and timely.

4.4.3 An applicant may be given an opportunity to render an incomplete application complete as described above. However, it is the applicant's responsibility to review the application carefully and verify that the information provided in it is accurate and complete before it is submitted. Any substantial misrepresentation or misstatement in or omission from an application shall, itself alone, constitutes cause for denial of the application, without hearing rights. Similarly, in the event that any substantial misrepresentation or misstatement in, or omission from, an application is discovered after the application has been approved; it shall constitute cause for summary action and/or immediate revocation of Medical Staff membership and/or all clinical privileges. This provision may be invoked by the MSEC, at its discretion, after giving the applicant an opportunity to address the issues in writing or at a meeting.

4.4.4 Until notice is received from GAC regarding final action on an application for appointment, reappointment or new clinical privileges, the applicant shall be responsible for keeping the application current and complete by informing the Office of Medical Staff Affairs and Governance in writing of any material change in the information provided or of any new information that might reasonably have an effect on the applicant's candidacy. Failure to meet this responsibility will be grounds for denial of the application, nullification of an

approval if granted, and/or immediate termination of Medical Staff membership

4.5 Term of Appointment

4.5.1 Appointments shall be effective on approval by the Governance Advisory Council and shall extend for a period not to exceed two (2) years, depending upon the membership category.

4.5.2 Initial appointments or the granting of new privileges shall be subject to Focused Professional Practice Evaluation for a period of up to twelve (12) months, and extensions may be considered for good cause as determined by the applicable Department Chair, Service Chief or Credentials Committee.

4.5.3 Reappointments will be for a period not to exceed two (2) years, depending upon membership category.

ARTICLE 5 CLINICAL PRIVILEGES

5.1 Delineation of Privileges in General

5.1.1 Exercise of Privileges.

Except as otherwise provided in these Bylaws, Plans, Rules, Regulations and Policies, every Member or Advanced Practice Provider providing direct clinical services at this Hospital shall be entitled to exercise only those privileges specifically granted to him/her/them.

5.1.2 Requests for Privileges.

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific privileges desired by the applicant. A request for a modification of privileges must be supported by documentation of training and/or experience supportive of the request.

5.1.3 Basis for Medical Staff Member or Advanced Practice Provider Privilege Determination.

Requests shall be evaluated based on the Medical Staff Member or Advanced Practice Provider's current clinical competence and scope of practice as defined under California law. Please refer below and to the Credentialing and Performance Plan for specific privilege determination.

5.1.4 Privileges for Medical Staff for physician Members shall generally require Board certification or Board eligibility at the time of initial appointment, an active California professional license, DEA certificate, and residency program training that encompasses the requested privileges; however, the Departments may establish alternative or additional criteria for specific clinical privileges for physicians and non-physicians, provided such criteria are approved by the MSEC and the Governance Advisory Council

5.1.4.1 For a Medical Staff Members or Advanced Practice Providers, general competencies obtained from other sources, peer references (especially when there are insufficient peer review data available) and information from other institutions and health care settings where a Member or Advanced Practice Provider exercises privileges; and

5.1.4.2 Assessment of education, training, experience, demonstrated professional competence and judgment, and evidence of physical and mental ability to perform the requested privileges. The review will include available documented results of patient care and other performance metrics, and documented performance of sufficient numbers of procedures applicable to the privileges requested.

5.1.5 For Medical Staff Members and Advanced Practice Providers, evaluation of criteria, including but not limited to the following: challenges to any licensure or registration, involuntary restriction, suspension or termination of privileges or membership at any other organization; voluntary termination of privileges or membership from any medical staff after investigation or to avoid investigation for a medical disciplinary cause or reason; involuntary relinquishment of any license or registration; voluntary relinquishment of any license or registration after notice of investigation for a medical disciplinary cause or reason; any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a settlement or final judgment against the applicant, charges or convictions for criminal activity bearing upon patient safety or public safety.

5.1.6 The processing of applications for clinical privileges is further described in the Credentialing and Performance Plan.

5.2 Categories of Privileges

5.2.1 Visiting Privileges.

5.2.1.1 Visiting Privileges: In circumstances in which patients or an academic program require the services of a provider who is not a Member of the Medical Staff or Advanced Practice Provider Staff, visiting privileges may be granted by the MSEC on a case-by-case basis to fulfill an important patient care need.

5.2.1.2 Visiting privileges do not include admitting privileges. No person shall receive more than two (2) visiting privileges appointments in a twelve (12) month period and each visiting privilege appointment shall be granted for no more than sixty (60) days. Providers with visiting privileges are not eligible to vote or hold office.

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

5.2.1.3.1 Current licensure;

5.2.1.3.2 Relevant education and experience;

5.2.1.3.3 Current competence;

5.2.1.3.4 Ability to perform the privileges requested; and

5.2.1.3.5 Other criteria listed in the Medical Staff Credentialing Policy and Procedures for visiting privileges.

5.2.2 Temporary Privileges.

5.2.2.1 Temporary privileges may be granted to fulfill an important patient care, treatment and service need. Temporary privileges may also be granted when a new applicant for Medical Staff membership or Advanced Practice Provider privileges, with a Complete Application, approved by the MSEC, is waiting for approval by the Governance Advisory Committee. Additionally, temporary privileges may be granted when an existing Member in good standing is requesting one or more additional privileges. Temporary privileges are time limited and may be granted for renewable sixty (60) day periods up to one hundred and twenty (120) days.

5.2.2.2 Temporary privileges may be granted after the applicant completes the Medical Staff membership application and the primary source verification of the following is verified by the Office of Medical Staff Affairs and Governance as follows:

5.2.2.2.1 Current licensure;

5.2.2.2.2 Relevant education/training and experience;

5.2.2.2.3 Current competence;

5.2.2.2.4 Ability to perform the privileges requested; and

5.2.2.2.5 Other criteria listed in the LPPH Medical Staff Credentialing Policy and Procedures for initial appointments.

5.2.3 General Conditions and Termination of Visiting or Temporary Privileges.

5.2.3.1 All requests for visiting or temporary privileges shall include a letter from the Department Chair providing the clinical rationale supporting the needed urgency for the privileges.

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

5.2.3.3 The applicant has:

5.2.3.3.1 Filed a complete application with the Office of Medical Staff Affairs and Governance;

5.2.3.3.2 Demonstrated no current or previously successful challenge to licensure or registration exists;

5.2.3.3.3 Not been subject to voluntary or involuntary termination of membership and/or privileges for medical disciplinary cause or reason at another organization; and

5.2.3.3.4 Not been subject to restriction of clinical privileges for a cumulative total of thirty (30) days or more for any twelve (12) month period for a medical disciplinary cause or reason at another organization.

5.2.3.4 There is no right to visiting or temporary privileges. Accordingly, visiting or temporary privileges should not be granted unless the available information supports, with reasonable certainty, a favorable determination regarding the requesting applicant's qualifications, ability and judgment to exercise the privileges requested.

5.2.3.5 If the available information is inconsistent or casts any reasonable doubt on the applicant's qualifications, action on the request may be deferred until the doubts have been satisfactorily resolved.

5.2.3.6 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.

5.2.3.7 Providers granted visiting or temporary privileges shall be subject to Focused Professional Practice Evaluation and supervision specified by the Department, or as described in these Bylaws, Plans, Rules, Regulations, and Policies.

5.2.3.8 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, Plans, Rules, Regulations and Policies.

5.2.3.9 Visiting or temporary privileges may be terminated with or without cause at any time by the President of the Medical Staff, the responsible Department Chair, or the Chief Medical Officer after conferring with the President of the Medical Staff or the responsible Department Chair. A person shall not be entitled to the procedural rights afforded by the Fair Hearing Plan unless the reason for termination must be reported to the Medical Board of California under Business and Professions Code Section 805.

5.2.3.10 Whenever visiting or temporary privileges are terminated, the appropriate Department Chair or his/her or designee shall assign a Member to assume responsibility for the care of the affected physician's patient(s).

5.2.3.11 All persons requesting or receiving visiting or temporary privileges shall be bound by the Medical Staff Bylaws, Plans, Rules, Regulations, and Policies.

5.2.3.12 As to Advanced Practice Providers, visiting or temporary privileges may be granted by the President of the Medical Staff and/or the Chair of the Credentials Committee for Medical Staff Members or the Chair of the Committee on Interdisciplinary Practice (CIDP) for Advanced Practice Providers (or their designees) on the recommendation of CIDP, and if sought by CIDP, with input from the Department Chair (s) where the privilege(s) will be exercised.

5.2.4 Disaster Privileges.

Disaster privileges may be granted when the Hospital's emergency management plan has been activated and the organization is unable to handle the immediate patient needs. A medical disaster occurs when the destructive effects of natural or man-made forces overwhelm the ability of the Hospital to meet the demand for health care services. Disaster privileges are granted pursuant to the Disaster Privileges Policy (Medical Center Administrative Manual: Policy 1.02.13). HICS director or designee has the authority to grant privileges once the Hospital Incident Command System (HICS) is activated.

5.2.5 Emergency Situations.

In the event of an emergency, and whether or not the emergency management plan has been activated, any Member of the Medical Staff or any credentialed Advanced Practice Providers 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 Advanced Practice Providers shall promptly yield such care to a member with the appropriate privileges when one becomes available.

ARTICLE 6 CORRECTIVE ACTIONS AND AUTOMATIC SUSPENSION OR LIMITATION

6.1 Investigations and Corrective Actions

Investigations, and formal and informal corrective actions are set forth in the Medical Staff Investigations, Corrective Actions and Fair Hearing Plan.

6.2 Fair Hearing Procedure

The grounds for a hearing, hearing procedures, and appellate procedure are set forth in the Medical Staff Investigations, Corrective Actions and Fair Hearing Plan.

6.3 Automatic Suspension or Limitation (Administrative)

The President of the Medical Staff or designee shall approve all recommended automatic or administrative suspensions or limitations. A Member's Medical Staff membership and/or privileges shall be automatically suspended or limited as described below. Such automatic suspensions do not entitle the Member or practitioner to hearing rights.

Unless otherwise stated, for each matter listed below, an automatic suspension or limitation which remains in effect for longer than ninety (90) days will result in voluntary withdrawal of membership and privileges from the Medical Staff, unless otherwise extended by the Medical Staff Executive Committee (MSEC). Thereafter, reinstatement to the Medical Staff shall require a new application and compliance with the appointment procedures applicable to initial applicants. The MSEC does not consider an automatic suspension or limitation based on one of the categories listed below a suspension based on a "medical disciplinary cause or reason," as that term is defined in California Business and Professions Code Section 805.

Unless otherwise expressly stated, any corrective action, automatic suspension or administrative action taken upon a Member's membership and/or clinical privileges at the Hospital shall apply equally to the Member's clinical activities across and throughout LPPH facilities , as determined by the facility medical staff's governing body.

6.3.1 Action Taken on License or Certification.

6.3.1.1 License Revocation, Suspension and Expiration: Whenever a Member's or APP's license or other legally authorized practice in this state is revoked, suspended, or expired by/with the applicable licensing authority, Medical Staff membership and clinical privileges shall be automatically revoked or suspended as of the date such action becomes effective and throughout its term, until reinstated fully by the applicable licensing authority, if reinstatement is requested by the Member/APP and approved by the MSEC.

6.3.1.2 Restriction or Limitation of License, Certificate or Permit: Whenever a Member's or APP's license or other legally authorized practice in this state is limited or restricted by the applicable licensing authority, any clinical privileges which the Member/APP has been granted, which are within the scope of said limitation or restriction, shall automatically be subject to nothing less than the same limitations or restrictions as of the date such action becomes effective and throughout its term. Nothing in this provision shall require the Medical Staff to continue the Member/APP's ability to practice while under any restriction or limitation of license, if in the MSEC's sole discretion, the restriction and/or limitation adversely affect(s) hospital operations, patient care or safety.

6.3.1.3 Terms, Conditions of Probation of License or Certificate: Whenever a Member or APP is placed on probation or mandatory terms/conditions by the applicable licensing or certifying authority, his/her membership status and/or clinical privileges shall automatically be subject to nothing less than the same terms and conditions of the probation as of the date such action becomes effective and throughout its term. Nothing in this provision shall require the Medical Staff to continue the Member/APP's ability to practice while under any condition of probation, if in the MSEC's sole discretion, the probationary term(s) adversely affect(s) hospital operations, patient care or safety.

6.3.2 Action Taken on Drug Enforcement Administration (DEA) Certificate.

6.3.2.1 Revocation, Limitation, Suspension and Expiration: Whenever a Member's DEA certificate is revoked, limited, suspended, or expired, and such is required to exercise the privileges the Member/APP holds, the Member/APP shall be automatically and correspondingly divested of the right to prescribe, dispense, or administer medications covered by the certificate as of the date such action becomes effective and throughout its term.

6.3.2.2 Probation of DEA certificate: Whenever a Member's DEA certificate is subject to probation, the Member/APP's right to prescribe, dispense, or administer such medications and such probation affects the Member/APP's ability to exercise the privileges the Member/APP holds, the Member/APP shall automatically become subject to the same terms of the probation as of the date such action becomes effective and throughout its term.

6.3.3 Cancellation of Professional Liability Insurance.

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 and Risk Management Department thirty (30) days prior to cancellation or termination shall constitute automatic suspension of all privileges and membership on the Medical Staff. The suspension shall be effective until appropriate coverage is reinstated, including coverage of any acts or potential liabilities that may have occurred or arisen during the period of any lapse in coverage. A failure to provide sufficient evidence of appropriate coverage within six (6) months after the date of automatic suspension shall be deemed a voluntary resignation of the Member from the Medical Staff.

6.3.4 Delinquent Medical Records.

6.3.4.1 With regard to documentation of treatment records, if after notice to the Member of delinquent treatment records, incomplete treatment records, or open encounters, the Member repeatedly fails to comply with LPPH Hospital Medical Records Policy or LPPH Medical Staff Rules and Regulations /Medical Records Policy, the Member will be subject to any or all of the following: FPPE, mandatory education for Medical Record-keeping at the Member's expense, automatic suspension or termination of the Member's medical staff membership and/or privileges.

The LPPH Rules and Regulations and relevant LPPH Policies dictates the number of suspension days before a Member is deemed automatically and voluntarily terminated from the Medical Staff. Unless required by law, such automatic actions do not entitle the Member to hearing rights under the Fair Hearing Plan.

A Member who has been so terminated may not reapply for Medical Staff 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 or actions pursuant to the Policies, Rules and Regulations where circumstances warrant. Nothing in the foregoing shall preclude the implementation by the MSEC of a monetary fine for delinquent medical records.

6.3.5 Failure to Comply with Government and Other Third-Party Payor Requirements.

6.3.5.1 The MSEC shall be empowered to determine that compliance with certain specific third-party payor, government agency, and professional review organization rules or policies is essential to Hospital and/or Medical Staff operations and that compliance with such requirements can be objectively determined. The rules may authorize the automatic suspension of a Member or APP who fails to comply with such

requirements. The suspension shall be effective until the Member or APP complies with such requirements.

6.3.5.2 If a Member or APP 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 APP'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 automatically be suspended with no applicable hearing rights, and the Member's right to admit new patients shall also be immediately and automatically suspended. The Member or APP shall be permitted to complete providing services to other current Hospital patients through the patient's discharge. Once such Member's or APP's participating provider status is fully restored and in good standing, then the Member or APP may apply for reinstatement of full privileges, which reinstatement shall be at the discretion of the MSEC.

6.3.5.3 A Member or APP is required on an ongoing basis to advise the President of the Medical Staff and the Chief Executive Officer in writing immediately upon any de-listing, exclusion, suspension, or change in status of the Member's or APP's participating provider status in a federal health care program or any investigation by a governmental or licensing agency relating to the Member's or APP's licensure, certificate or 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.

6.3.6 Electronic Health Record Security.

6.3.6.1 Whenever a Member fails to comply with the requirements for utilization of the electronic health record (EHR) or other data systems in accordance with relevant LPPH Policy, or fails to maintain the security of individual access rights (e.g., sharing passwords) or the confidentiality and security of patient information (e.g., access, use or disclosure of patient information without authorization), the Member's clinical privileges will be automatically suspended and access to and/or use of the EHR system will be limited. At the discretion of the MSEC, in concert with the Chair of the Member's department, the Member's patients will be reassigned until the Member completes additional EHR security training, at the Member's expense.

6.3.7 Failure to Undergo Evaluation when Requested by the Medical Staff Executive Committee.

6.3.7.1 Whenever a member fails to timely undergo a medical, neuropsychological, cognitive, mental health evaluation or drug/alcohol testing when requested by the MSEC, the member's clinical privileges

will be automatically suspended until the requested evaluation is completed and reported to the MSEC.

6.3.8 Failure to Satisfy Request for Information or Special Appearance Requirement.

A Member who fails without good cause to provide requested information or appear when summoned or requested to appear in connection with a peer review matter or investigation, shall automatically be suspended from exercising all or such portion of privileges as the MSEC specifies. The automatic suspension shall remain in effect until the Member has provided the requested information to the satisfaction of the MSEC and/or satisfied the special attendance requirements to the satisfaction of the MSEC, or provided good cause to the satisfaction of the MSEC. If the individual does not comply with the request for information or attend the special meeting as requested, the member will be deemed to have voluntarily resigned from the Medical Staff.

6.3.9 Failure to Pay Dues or Fines.

If the Member fails to pay required dues or fines within thirty (30) days after written warning of delinquency, his/her Medical Staff membership and privileges shall be automatically suspended and shall remain so suspended until the Member pays the delinquent dues. If after sixty (60) consecutive days of suspension, the Member remains suspended, the Member will be considered to have voluntarily resigned from the Medical Staff.

6.3.10 Felony.

If any Member of the Medical Staff is convicted or pleads no contest to a felony, his/her Medical Staff membership and privileges will be immediately and automatically terminated. If the Member is charged with a felony related to public safety, the MSEC may automatically revoke or suspend membership and privileges.

6.3.11 Incomplete Proctoring.

Failure to comply with Medical Staff Proctoring Policy and Proctoring Guidelines, and in the case of APPs the Peer Review Policy, in the required timeframe without good cause will result in automatic suspension or revocation of Medical Staff membership and/or clinical privileges.

6.3.12 Failure to Satisfy Testing and Immunization Requirements.

Members and Advanced Practice Providers are required to comply with all Infection Control testing and immunization requirements upon initial application and annually thereafter for selected requirements. Failure or refusal to comply with these requirements after notice of non-compliance will

result in withdrawal of initial application or administrative suspension of current privileges until such requirements have been met. See Rules and Regulations, Section Article: Communicable Diseases and Infection Control.

6.3.13 Failure to Meet Minimum Activity Requirements.

Practitioners and applicants shall not be entitled to the hearing and appellate review rights if their membership or privileges are denied, restricted or terminated or their Medical Staff categories are changed or not changed because of a failure to meet the minimum activity requirements set forth in the Medical Staff Bylaws, Plans, Rules, Regulations and Policies. In such cases, the only review shall be provided by the MSEC through a subcommittee consisting of at least three MSEC Members. The subcommittee shall give the Practitioner or applicant notice of the reasons for the intended denial or change in membership, privileges, and/or category and shall schedule an interview with the subcommittee to occur no less than thirty (30) days and no more than one hundred (100) days after the date the notice was given. At this interview with the subcommittee, the Practitioner or applicant may present evidence concerning the deficiencies, and thereafter the subcommittee shall render a written decision within forty-five (45) days after the interview. A copy of the decision shall be sent to the Practitioner or applicant, MSEC and Governance Advisory Council. The subcommittee decision shall be final unless it is reversed or modified by the MSEC within forty-five (45) days after the decision was rendered, or the Governance Advisory Council within ninety (90) days after the decision was rendered.

6.4 Scope of Automatic Suspension or Corrective Action

Unless otherwise expressly stated, and subject to final determination by the Medical Staff of other UCSF Health sites and facilities, any automatic suspension or corrective action of a Member's clinical privileges under this Article shall apply to the Member's clinical activities across and throughout the UCSF Health, its clinical sites and system affiliates, as defined herein and in the Investigation, Corrective Action and Fair Hearing Plan.

6.5 Automatic Actions and Procedural Rights

Members whose privileges are automatically suspended and/or who have been deemed to have automatically resigned their Medical Staff membership shall not be entitled to a hearing under the Fair Hearing Plan, unless the suspension must be reported to the Medical Board of California pursuant to Business and Professions Code, Section 805.

6.5.1 Notice of Automatic Suspension or other Administrative Action.

Special notice of an automatic suspension or action shall be given to the affected Member, and regular notice of the automatic suspension shall be given to the MSEC, President of the Medical Staff and Governance Advisory Council, but such notice shall not be required for the automatic suspension to become effective. Patients affected by an automatic suspension shall be assigned to another Member by the Department Chair or President of the Medical Staff. The wishes of the patient and affected Member shall be considered, where feasible, in choosing a substitute Member.

6.5.2 Reinstatement.

Except as otherwise provided in the Corrective Action and Fair Hearing Plan, the President of the Medical Staff or designee may reinstate the Member when the reason for the automatic suspension no longer exists. If the Member's appointment to the Medical Staff has expired during the term of automatic suspension and he/she is seeking reappointment, the President of the Medical Staff may, in accordance with these Bylaws, Plans, Rules, Regulations and Policies, grant the person Temporary Privileges or interim privileges for a period not to exceed the period ending with action on the application for reappointment.

6.5.3 Other Corrective Action.

In addition to automatic actions imposed pursuant to this Article, the MSEC may review the circumstances surrounding the action, conduct or delegate 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, if so requested, pursuant to the Investigation, Corrective Action and Fair Hearing Plan, but only if such corrective action(s) must be reported pursuant to California Business and Professions Code, Section 805.

6.5.4 Automatic Action Based Upon Actions Taken By Another UCSF Health Affiliated Peer Review Body.

6.5.4.1 The MSEC shall be empowered to automatically impose any adverse action that has been taken by another University of California San Francisco ("UCSF") affiliated peer review body (as that term is used in Business & Professions Code Section 809, et seq.) upon completion of the peer review hearing by that review body, if any, including any internal appeal if applicable. Such an adverse action taken by the original peer review body, may include, but is not limited to, (a) denying membership and/or privileges, (b) restricting privileges, or (c) terminating membership and/or privileges. The action by the other UCSF affiliated peer review body that will be the basis for the automatic action here shall have become final at that location within the past thirty-six (36) months. The automatic action may be taken by the MSEC only if the original peer review body acted based upon standards that are

essentially the same as those in effect at this Hospital at the time the automatic action will be taken. The action before this body may be taken once the Member has completed the hearing with the other peer review body and internal appeal, if any, to the other peer review body; however, it is not necessary to await a final disposition in any judicial proceeding that may be brought challenging the action. Nothing in this Article prevents the MSEC from investigating the Member who is or was a subject of adverse action by a different UCSF peer review body and taking action as it deems necessary to protect patients.

6.5.4.2 In such instances, as described above, the Member shall not be entitled to any hearing or appeal unless the MSEC takes an action that is more restrictive than the final action taken by the original peer review body. Any hearing and appeal that is requested by the Member shall not address the merits of the action taken by the original peer review body, which were already reviewed at the original peer review body's hearing, rather, shall be limited to only the question of whether the automatic action is more restrictive than the original peer review body's action. The Member shall not otherwise be entitled to challenge the automatic peer review action unless he or she successfully overturns the original peer review action.

6.5.4.3 Nothing in this Article shall preclude the Medical Staff or Governance Advisory Council from taking a more restrictive action than another UCSF affiliated peer review body based upon the same facts or circumstances.

6.6 Matters Involving Faculty Appointments and Responsibilities

Matters involving faculty appointments and responsibilities are not governed by these Bylaws, rather they are subject to other University policies including the Faculty Code of Conduct. However, matters that are relevant to a Medical Staff Member's status, both as a Medical Staff Member and as a faculty member, are subject to oversight by the responsible Department Chair and the President of the Medical Staff, who together will determine what appropriate action will be taken under these Bylaws and other University policies. If matters are unresolved at this level, Academic Affairs and Medical Staff leadership will determine further appropriate action.

ARTICLE 7 ORGANIZATION

7.1 Departments

7.1.1 The Medical Staff shall be organized into the following Departments. Each Member of the active Medical Staff must belong to at least one of the following Departments: Psychiatry, Medicine, Anesthesia.

7.1.2 Additional Departments may be created, or existing Departments may be combined or eliminated by a three-fourths (3/4) affirmative vote of the MSEC provided only that such action shall parallel similar departmentalization in the Schools of Medicine.

7.1.3 Assignment to Departments: Each Member shall be assigned membership in at least one Department but may also be granted clinical privileges in other Departments consistent with the practice privileges granted.

7.2 Chiefs of Clinical Service/Service Chiefs

The terms Chief of Clinical Service and Service Chief are interchangeable. The Chair of each Department may also serve as its Chief of Clinical Service at LPPH or may appoint one or more Chiefs of Clinical Service. Chiefs of Clinical Service have several responsibilities for oversight of Clinical Service activities, including credentials review, peer review, quality of care and utilization review.

7.2.1 Qualifications.

Each Chief of Clinical Service shall be an active Member of the Medical Staff and a member of the Service, and shall be qualified by training, experience, and demonstrated current ability in clinical care provided by that Service, and able to discharge the functions of his or her office.

7.2.2 Roles and Responsibilities of each Chief of Clinical Service.

7.2.2.1 Assist in the development and implementation of expectations and requirements for clinical performance for that Service;

7.2.2.2 Determine and manage the clinically related and administrative activities within the clinical Service;

7.2.2.3 Assist in the formulation and execution of programs to carry out the quality review, evaluation, and monitoring functions assigned to that Service;

7.2.2.4 Continuously assess and improve the quality of care, treatment and services, and maintain quality improvement programs as appropriate;

7.2.2.5 Assist in developing and enforcing the Medical Staff Bylaws, Plans, Rules, Policies, and the Hospital's Policies that guide and support the provision of patient care, treatment, and services;

7.2.2.6 Communicate to the appropriate individuals or committee, the Service's recommendations concerning appointment, reappointment, delineation of clinical Privileges, and disciplinary action with respect to the Members of the Service;

7.2.2.7 Monitor the quality of patient care and professional performance rendered by Members holding Privileges in the Service through a planned and systematic process, including but not limited to ongoing peer review and Ongoing Professional Practice Evaluations (OPPE), and Focused Professional Practice Evaluation functions (FPPE);

7.2.2.8 Oversee and monitor functions delegated to the Service by the MSEC in coordination and integration with organization-wide quality assessment and improvement activities;

7.2.2.9 Coordinate with UCSF/LPPH Physician Well Being Committee (PWBC) and UCSF/LPPH Committee on Professionalism (COP) in identifying and monitoring Members of the Service who would benefit from or are involved in programs of the PWBC and the COP;

7.2.2.10 Undertake or delegate preliminary peer review investigations of Members of the Service and submit recommendations to the MSEC if further action is needed;

7.2.2.11 Perform such other duties commensurate with the office as may from time to time be reasonably requested by the School of Medicine Department Chair, the President of the Medical Staff, or the MSEC; and

7.2.2.12 Implement within the Service actions taken by the MSEC.

7.2.3 Term of Office.

Each Chief of Clinical Service shall serve in such capacity for a period of time to be determined by the Department Chair.

7.2.4 Removal of Chiefs of Clinical Service.

When a Department Chair has appointed a Chief of Clinical Service, removal of the Chief of Clinical Service from office may occur by the School of Medicine Department Chair. If the Chief of Clinical Service is the Chair, removal from office may occur per majority vote of the MSEC with concurrence by the Dean of the School of Medicine.

7.3 Committees of the Medical Staff

The Standing Committees of the Medical Staff are outlined in the Organizational Plan of the Medical Staff, with the exception of the Medical Staff Executive Committee, which is described in the LPPH Bylaws.

ARTICLE 8 OFFICERS OF THE MEDICAL STAFF

8.1 Officers and Their Duties

8.1.1 Election, Term of Office, Removal of Officers.

Election of Medical Staff Officers, term of office and removal of officers is addressed in the Organizational Plan of the Medical Staff.

8.1.2 Identification.

There shall be the following general officers of the Medical Staff:

8.1.2.1 President

8.1.2.2 Immediate Past-President

8.1.2.3 President-Elect

8.1.3 President.

The President shall serve as the Chief Officer of the Medical Staff and is responsible for the organization and conduct of the Medical Staff, including but not limited to:

8.1.3.1 Calling, preparing the agenda for, and presiding over meetings of the MSEC and Medical Staff.

8.1.3.2 Appointing chairs and Members of the Medical Staff committees with the approval of the MSEC. Establishing and disbanding special committees of the Medical Staff, subject to approval of the MSEC.

8.1.3.3 Promoting quality of care to patients by Members of the Medical Staff.

8.1.3.4 Serving as an ex-officio Member of all Medical Staff committees.

8.1.3.5 Oversight of clinical work performed by the various departments, divisions, and sections.

8.1.3.6 Enforcing compliance with the Medical Staff Bylaws, Plans, Rules, Regulations, Policies, and compliance with procedural safeguards.

8.1.3.7 Representing the Medical Staff for the purpose of receiving and acting upon policies of the Hospital, University, Campus and UC Health.

8.1.3.8 Reporting as requested to the Chancellor on the performance and quality of delegated responsibilities for the provision of patient care services.

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

8.1.3.10 Participating in corrective actions as outlined in the LPPH Investigation, Corrective Action and Fair Hearing Plan.

8.1.4 President-Elect.

8.1.4.1 When the President is unable to perform his or her duties for any reason, the President-Elect shall, in the absence of the President, assume all the duties, responsibilities, and the authority of that office.

8.1.4.2 After serving in office, the President-Elect shall succeed to the office of President. Should the President leave office before expiration of his/her 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 these Bylaws.

8.1.5 Immediate Past President.

The immediate past president shall in the absence of the President Elect, assume all duties and responsibilities in the event of the President Elect is unavailable, absent, ill or as otherwise delegated by the President Elect.

ARTICLE 9 MEDICAL STAFF EXECUTIVE COMMITTEE (MSEC)

9.1 Membership

9.1.1 The majority of the Medical Staff Executive Committee (MSEC) must be physicians (MD, MBBS, MBChB, and DO). The MSEC shall consist of the following Members who may have voting rights in certain circumstances, as further detailed below:

9.1.1.1 The Service Chiefs/Chiefs of Clinical Services specified in these Bylaws, or designees

9.1.1.2 DPBS Chair/ LPPH CEO

9.1.1.3 President of the Medical Staff

9.1.1.4 President-Elect of the Medical Staff

9.1.1.5 Immediate Past President of the Medical Staff

9.1.1.6 The Executive Director of Clinical Operations/ Director of Nursing

9.1.1.7 LPPH CMO

9.1.1.8 Chair of LPPH Credentials Committee

9.1.1.9 Chair of LPPH Pharmacy and Therapeutics Committee

9.1.1.10 Chair of LPPH Patient Safety and Quality Committee

9.1.2 Non-Voting Ex-Officio Members.

9.1.2.1 On the recommendation of the Associate Dean for Graduate Medical Education, and approval of the President, post graduate trainees may sit on the MSEC without vote.

9.1.3 Members who are unable to attend meetings may send a substitute. Substitutes do not have a vote.

9.1.4 A quorum shall consist of three (3) voting Members of the MSEC.

9.1.5 Voting Authority.

9.1.5.1 All Board Members may vote on any committee actions with the following exceptions:

9.1.5.1.1 Disciplinary Actions

For votes concerning disciplinary actions, Credentials Committee reports, or Committee on Professionalism reports, only MSEC members who are current LPPH Medical Staff members in good standing have voting authority. Good standing constitutes the lack of any adverse action or pending investigation for a medical disciplinary cause or reason as defined in Business and Professions Code section 805. This voting may be performed in a closed session where all others are excused at the discretion of the President of the Medical Staff.

9.2 Duties of the Medical Staff Executive Committee

The duties are as follows:

9.2.1 To recommend and enforce Rules and Regulations of the Medical Staff and Hospital policies consistent with the purposes delineated in these Bylaws.

9.2.2 To coordinate the activities and general policies of the various departments, divisions, sections, and services, and to be responsible for the quality of patient care provided by them.

9.2.3 To review and make recommendations regarding Hospital policies that apply to or affect the performance or responsibilities of the Medical Staff.

9.2.4 To establish such committees as may be necessary to govern clinical activities at the Hospital and to receive and act on reports from these committees.

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

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

9.2.7 To recommend to the Governance Advisory Council, after considering the recommendations of the Department Chair and the Credentials Committee, clinical privileges for Medical Staff Members and Advanced Practice Providers.

9.2.8 To oversee the Ongoing Professional Practice Evaluation (OPPE) of Medical Staff Members and Advanced Practice Providers exercising clinical privileges, to make recommendations for improvement, and to initiate Focused Professional Practice Evaluations (FPPE) and to delegate or undertake investigations or corrective actions as circumstances may warrant.

9.2.9 To apprise Hospital leadership on the sources of the hospital's services that are provided by consultation, contractual arrangements, or other agreements.

9.2.10 To report to the Governance Advisory Council regarding the performance and activities of the Medical Staff Members and Advanced Practice Providers.

9.3 Meetings of the Medical Staff Executive Committee

9.3.1 The MSEC shall meet a minimum of ten (10) meetings per year, and shall hold such additional meetings, at the request of the President or any three (3) Members of the MSEC, as may be necessary to conduct of its business.

9.3.2 Voting Members of the MSEC are required to personally or electronically attend MSEC meetings unless an authorized delegate/substitute attends in their absence. The authorized delegate/substitute is not entitled to vote.

9.3.3 Additional MSEC meetings, as defined above, may be conducted by telephone and/or video conference which shall be deemed to constitute a meeting for the matters discussed in that telephone/video conference. Meetings may also be conducted utilizing other electronic methods that permit the interchange of information prior to the MSEC making recommendations to Governance Advisory Council regarding, without limitation:

9.3.3.1 The approved applications for membership to the Medical Staff by the Credentials Committee Chair (or designee); and

9.3.3.2 Established LPPH and Medical Staff Plans, Policies and Procedures to be approved for revisions only.

9.3.4 A permanent record shall be kept of the minutes of all meetings and a report of MSEC actions shall be made to the Medical Staff at the Annual Meeting.

9.4 Removal from Office/Membership on the MSEC

9.4.1 A Member of the MSEC may be removed from office for failure to carry out the duties of his/her office, gross neglect or misfeasance in office, or serious acts of moral turpitude. An MSEC member will be automatically removed when the Medical Staff disciplinary or corrective action of that Member gives rise to a fair hearing process.

9.4.2 Members of MSEC who lose the ability to serve effectively can be removed from the MSEC by two thirds (2/3) majority of those voting Members of the Medical Staff who submit a vote.

ARTICLE 10 AMENDMENT OF BYLAWS

10.1 Amendment Procedure

10.1.1 Amendments to the Medical Staff Bylaws are reviewed and recommended by the Bylaws Committee and the MSEC prior to being submitted for vote of the Medical Staff provided, however, that upon at least thirty (30) days prior written notice to the MSEC, amendments to the Bylaws may be proposed by petition signed by at least twenty-five percent (25%) of the Members of the voting Medical Staff.

10.1.2 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.

10.1.3 Amendments shall require an affirmative vote of a simple majority of the Members present and eligible to vote or by a majority of the Members who cast mail/electronic ballots, followed by approval by Governance Advisory Council.

10.1.4 Neither the Medical Staff nor Governance Advisory Council may unilaterally amend the Medical Staff Bylaws.

10.1.5 In contrast to the above, the Investigation, Corrective Action and Fair Hearing Plan, the Organizational Plan, and the Credentialing and Performance Plan may be amended as needed through the Bylaws Committee with approval by the MSEC and Governance Advisory Council.

10.2 Interim Amendment and Review of Bylaws

Bylaws may be temporarily amended by two thirds (2/3) affirmative vote at a regular or special meeting of the MSEC and subsequent approval by Governance Advisory Council. 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 the Organizational Plan. Review of these Bylaws, Plans, Rules, Regulations, and Policies shall occur at least once every two (2) years and revisions made as may be necessary and appropriate.

10.3 Technical and Editorial Amendments

The MSEC 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 Governance Advisory Council within ninety (90)

days after adoption by the MSEC. The action to amend may be taken by motion and acted upon in the same manner as any other motion before the MSEC. Such approved amendments shall be communicated in writing to the Medical Staff at the next Annual Meeting, or sooner if deemed necessary by the MSEC or Governance Advisory Council.

10.4 Urgent Amendments of Plans, Rules, Regulations, Policies and Procedures

10.4.1 In cases of a documented need for an urgent amendment to Plans, Rules, Regulations, Policies or Procedures necessary to comply with law or regulation, there is a process by which the MSEC, if delegated to do so by the voting Members of the organized Medical Staff, may provisionally adopt and the Governance Advisory Council may provisionally approve an urgent amendment without prior notification of the Medical Staff. In such cases, the Medical Staff will be immediately notified by the MSEC. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment.

10.4.2 If there is no conflict between the Medical Staff membership and the MSEC, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the Medical Staff membership and the MSEC is implemented. If necessary, a revised amendment is then submitted to the Governance Advisory Council for action.

ARTICLE 11 CONFIDENTIALITY AND IMMUNITIES

11.1 General

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 patient's file or of the general Hospital 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 MSEC or its designee and the President/Chief Executive Officer of LPPH.

11.2 Duty of Confidentiality

Inasmuch as effective credentialing, performance improvement, peer review, and consideration of the qualifications of Medical Staff Members, Advanced Practice Providers, 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 Hospital's operations. If it is determined that such a breach has occurred, the MSEC may undertake such corrective action as it deems appropriate. In the event a Member of the Medical Staff will testify in any criminal or civil matter involving another UCSF practitioner, the Member is obligated to inform the acting Director of Risk Management prior to testifying.

11.3 Immunity and Releases

11.3.1 Immunity from Liability for Providing Information or Taking Action.

Each representative of the Medical Staff and Hospital and all third parties shall be exempt from liability to an applicant, physician, clinical psychologist, Advanced Practice Providers, or other professionals allowed by the state to practice independently and approved by the MSEC and the Governance Advisory Council, for damages or other relief by reason of providing information to a representative of the Medical Staff, Advanced Practice Provider staff, LPPH, UCSF Medical Center, or any other health-related organization concerning such person who is, or has been, an applicant to or Member of the Medical Staff or who did, or does exercise privileges or provide services at LPPH or UCSF Medical Center or by reason of otherwise

participating in a Medical Staff or Hospital credentialing, performance improvement or peer review activities for LPPH or in concert with UCSF Medical Center.

11.3.2 Activities and Information Covered.

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

11.3.2.2 Applications for appointment, privileges or specified services;

11.3.2.3 Periodic reappraisals for reappointment, privileges, or specified services;

11.3.2.4 Corrective action;

11.3.2.5 Hearings and appellate reviews;

11.3.2.6 Performance improvement review, including patient care audit;

11.3.2.7 Peer review;

11.3.2.8 Utilization reviews;

11.3.2.9 Morbidity and mortality conferences;

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

11.3.2.11 A Member's and APP's professional qualifications, clinical ability, judgment, physical or mental health, emotional stability, professional conduct, professional ethics, or other matters that might directly or indirectly affect patient care or Hospital operations.

11.3.3 Cumulative Effect.

Provisions in these Bylaws, the Plans of the Medical Staff 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.

11.3.4 Indemnification.

11.3.4.1 The Hospital shall indemnify, defend, and hold harmless the Medical Staff and its individual Members ("Indemnitee(s)") from and against losses and expenses (including reasonable attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities including, but not limited to:

11.3.4.1.1 As a Member of or witness for a Medical Staff, clinical service, committee, or hearing committee;

11.3.4.1.2 As a Member of or witness for the Governance Advisory Council or any LPPH task force, group or committee; and

11.3.4.1.3 As a person providing information to any Medical Staff or LPPH, UCSF Medical Center group, officer, Governance Advisory Council Member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a Medical Staff Member or applicant.

11.3.4.1.4 LPPH shall retain responsibility for the sole management and defense of any such claims, suits, investigations or other disputes against Indemnitees, including, but not limited to, selection of legal counsel to defend against any such actions. The indemnity set forth herein is expressly conditioned on Indemnitees' good faith belief that their actions and/or communications are reasonable and warranted and in furtherance of the Medical Staff's peer review, quality assessment or quality improvement responsibilities, in accordance with the purposes of the Medical Staff as set forth in these Bylaws and in the Plans of the Medical Staff. In no event will LPPH /UCSF Medical Center indemnify an Indemnitee for acts or omissions taken in bad faith or in pursuit of the Indemnitee's private economic interests.

11.3.5 Releases.

Each practitioner physician, Advanced Practice Provider, clinical psychologist, or other professionals who are licensed by the state to practice independently and approved by the MSEC and the Governance Advisory Council shall, upon request of the Medical Staff, execute general and specific releases in accordance with the tenor and import of these Bylaws and the Plans of the Medical Staff. However, execution of such releases shall not be

deemed a prerequisite to the effectiveness of these Bylaws or the Medical Staff Plans.

11.3.6 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 MSEC may deem appropriate.

11.4 Conflict of Interest

11.4.1 In any instance where an officer, committee Chair, or committee member has, or reasonably could be perceived to have a conflict of interest, as defined in these Bylaws and in UCSF Health Policy Number 135, or to be biased in any matter involving another Medical Staff Member or any other matter that comes before such individual or committee, or in any instance where any such individual who brought a complaint against that individual, such individual shall not participate in the discussion or voting on the matter and shall be excused from any meeting during that time, although that individual may be asked and may answer any questions concerning the matter before leaving. As a matter of procedure, the Chair of that committee designated to review the matter shall inquire, prior to any discussion of the matter, whether any committee member has a conflict of interest or bias. The existence of a conflict of interest or bias on the part of any committee member may be called to the attention of the Chair by any committee member with knowledge of the matter.

11.4.2 Assurance of a conflict of interest or bias, or the lack thereof, can be determined by a majority vote of the members of the committee where a quorum is present.

11.4.3 If an individual is requested to abstain or recuse himself/herself and refuses to do so, the potential conflict of interest issue will be reviewed and resolved by the MSEC.

11.4.4 For the purposes of these Bylaws and the Plans of the Medical Staff, practicing in the same specialty or direct economic competition, without more, will not be a conflict of interest for the purposes of engaging in quality review and credentialing activities.

ARTICLE 12 OTHER RIGHTS AND RESPONSIBILITIES OF THE MEDICAL STAFF

12.1 History and Physical Examination Requirements

The requirements for performing and documenting medical histories and physical examinations for inpatients of LPPH are determined by the Medical Staff and are specified in policies, Rules and Regulations of the Medical Staff and policies of the Hospital. The medical history and physical examination are performed and documented by a physician in accordance with applicable laws, regulations and accreditation standards.

For inpatients of LPPH, who will undergo surgery or a procedure requiring anesthesia services, and except in the case of emergencies, a history and physical examination requires compliance with the LPPH Assessment of Patients Policy.

12.2 Members' Conduct Requirements

12.2.1 As a condition of membership and privileges, a Medical Staff Member shall continuously meet the requirements for professional conduct established in these Bylaws. APPs will be held to the same conduct requirements as Members.

12.2.2 Disruptive and Inappropriate Conduct.

Disruptive and inappropriate Medical Staff Member conduct affects or could affect the quality of patient care at the hospital as described in the UC Code of Conduct Policy and LPPH Code of Conduct. The following conduct is prohibited and includes without limitation:

12.2.2.1 Harassment by a Medical Staff Member against any individual involved with the hospital (e.g., against another Medical Staff Member, trainee, hospital employee or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, gender or sexual orientation, or gender expression;

12.2.2.2 "Sexual harassment" is defined in the UCOP Policy on Sexual Harassment and Sexual Violence and includes unwelcome verbal or physical conduct of a sexual or gender-based nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters). Sexual harassment also includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation,

retention, promotion, or other aspects of clinical duties; or (2) this conduct substantially interferes with the individual's responsibilities or employment or creates and/or perpetuates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct which indicates that advancement is conditioned upon acquiescence in sexual activities;

12.2.2.3 Aggressive, disrespectful, unprofessional, or demeaning conduct toward a patient, patient family member, Hospital employee, team member or colleague. Deliberate physical, visual or verbal intimidation or challenge, including verbal or physical threats or pushing, grabbing or striking another person on hospital premises; and

12.2.2.4 Inappropriate access and unauthorized release of protected health and patient information.

12.3 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.

12.4 Dues

The MSEC shall have the power to establish reasonable annual dues, if any, for each category of Medical Staff membership, and to determine the manner of expenditure of such funds received. However, such expenditures must be appropriate to the purposes of the Medical Staff and shall not jeopardize the nonprofit tax-exempt status, if applicable, of the Hospital.

12.5 Disputes with the Governance Advisory Council

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

ARTICLE 13 ADOPTION OF THESE BYLAWS

These Bylaws, as distinguished from the separate and individual Medical Staff Plans, 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 Governance Advisory Council, which shall not be unreasonably withheld. If approval of the Governance Advisory Council is withheld, the reasons for doing so shall be specified by the Governance Advisory Council in writing, and shall be forwarded to the President, the MSEC, and the Bylaws Committee.