

SAN FRANCISCO GENERAL HOSPITAL

MEDICAL STAFF

BYLAWS

2011-2012

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PREAMBLE

WHEREAS, San Francisco General Hospital is a public hospital organized under the laws of the State of California and the Charter of the City and County of San Francisco; and

WHEREAS, its purpose is to serve as a general hospital providing patient care, research, and undergraduate and postgraduate education in the health sciences; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital Governing Body, and that the cooperative efforts of the Medical Staff, the Hospital Administration and the Governing Body are necessary to fulfill the Hospital's obligations to its patients.

THEREFORE, the physicians, dentists, clinical psychologists and podiatrists practicing in the Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws and Rules and Regulations. These Bylaws and Rules and Regulations provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Body, and relations with applicants to and members of the Medical Staff.

DEFINITIONS

Academic Year

Refers to the period from July 1 to June 30.

Affiliated Professional

Defined in these Bylaws. Affiliated Professionals are not eligible for Medical Staff Membership.

Associate Dean

Refers to the Associate Dean of the Medical School, University of California, San

Francisco and San Francisco General Hospital.

Attending Faculty (Supervisor)

Physicians, dentists, clinical psychologists or podiatrists who have been deemed qualified to supervise House Staff by the Department and who have a faculty appointment at UCSF.

Bylaws

Refers to these Bylaws and the accompanying Rules and Regulations.

Chief of Clinical Service

Refers to the head of a Clinical Service appointed pursuant to the Bylaws.

Chief of Staff

Refers to the Chief of Medical Staff of the Hospital who is elected pursuant to the Bylaws.

Clinical Privileges or Privileges

Refers to the permission granted to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services currently offered at the hospital.

Community Primary Care Service (CPC)

Refers to the Service which is comprised of Medical Staff members who work in the community-based clinics owned and operated by the San Francisco Department of Public Health and under the authority of the Governing Body.

Date of Receipt

Refers to the date any Notice, Special Notice or other communication was delivered personally; or if such Notice, Special Notice or communication was sent by mail, it shall mean 72 hours after the Notice, Special Notice or communication was deposited, postage prepaid, in the United States mail.

Department Chair

Refers to the Chair of the Department at the University of California. The Associate

Dean in San Francisco General Hospital will serve as "Department Chair" for those clinical services not represented by a Department Chair at the University of California. For the Community Primary Care Service, (CPC), the Director of Public Health will act as the "Department Chair".

Director of Health

Refers to the individual who serves as the chief executive officer of the Governing Body and who appoints the Executive Administrator.

DPH

Refers to the San Francisco Department of Public Health.

Ex officio

Refers to service by virtue of office or position held.

Executive Administrator

Refers to the individual appointed by the Director of Health to manage the Hospital and to support its issues and goals.

Governing Body

Refers to the San Francisco Health Commission. When the Governing Body has delegated authority to the Director of Health to make determinations regarding appointments, reappointments, termination of appointments, and the granting or revision of Clinical Privileges, the term "Governing Body" shall refer to the Director of Health.

House Staff

Physicians, dentists, clinical psychologists or podiatrists in a training program that leads to eligibility for either general certification or subspecialty certification by an approved American Board of Medical Specialties (ABMS) or in a training program where ABMS Board Certification has not been created.

Hospital

Refers to San Francisco General Hospital.

Investigation

Refers to a process specifically instigated by the Medical Executive Committee (MEC) to determine the validity, if any, of a concern or complaint raised against a member of the Medical Staff. The term investigation does not include the usual activities of the Medical Staff Well Being Committee.

Licensed

Refers to physicians, dentists, clinical psychologists or podiatrists licensed to practice medicine, dentistry, clinical psychology or podiatry in the State of California or qualified under California law to practice with an out-of-state license.

MEC

Refers to the duly elected Executive Committee of the Medical Staff as described in these Bylaws.

Medical Record

Refers to the official written medical record, and any patient specific information stored electronically for purposes of patient care.

Medical Staff

Refers to all physicians (M.D. or D.O.), dentists, clinical psychologists and podiatrists who meet the licensure requirements as set forth in Article 2.2 of these bylaws and who are privileged to provide care for patients in this Hospital.

Medical Staff Year

Refers to the period from July 1 through June 30.

Notice

Refers to a written communication delivered personally to the addressee or sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the Medical Staff or the Hospital.

Physician

Refers to an individual with an M.D. or D.O. degree who is currently licensed to practice medicine.

Practitioner

Refers to, unless otherwise expressly limited, any physician, dentist, podiatrist or clinical psychologist who is applying for Medical Staff membership and/or Clinical Privileges or who is a Medical Staff member and/or exercises Clinical Privileges in this Hospital.

Proctoring

Refers to the verbal and written procedures by which Medical Staff members are evaluated for clinical competence in the areas in which he/she has Privileges.

Special Notice

Refers to a Notice sent my personal delivery or certified mail, return receipt requested.

University

Refers to the University of California San Francisco.

Other

The terms "Chief of Staff," "Chief of Clinical Service," "Executive Administrator," "Associate Dean" and "Director of Health" shall include any persons designated to act on his/her behalf in his/her absence.

ARTICLE I: NAME AND PURPOSES

1.1 Name

The name of this organization shall be the Medical Staff of San Francisco General Hospital (SFGH).

1.2 Purposes and Responsibilities

The Medical Staff's purposes and responsibilities are to:

1.2-1 Collaborate

Collaborate with Hospital Administration to improve the services provided to patients;

1.2-2 Patient Care

Assure that all patients admitted to or treated in any of the facilities, departments or services of the Hospital receive care at a level of quality and efficiency consistent with generally accepted standards and attainable within the Hospital's means and circumstances;

1.2-3 Professional Performance

Assure a high level of professional performance of all Practitioners authorized to practice in the Hospital through the appropriate delineation of the Clinical Privileges that each Practitioner may exercise in the Hospital and through a continuing review and evaluation of each Practitioner's performance in the Hospital;

1.2-4 Educational Setting

Provide an appropriate educational setting for continuing education of the Medical Staff and for the education of both undergraduate and graduate students in the health sciences;

1.2-5 Community Health Education

Organize and support community health education and support services;

1.2-6 Self-Governance

Develop and maintain Bylaws for self-governance of the Medical Staff;

1.2-7 Communication

Provide a means whereby issues of mutual concerns to the Medical Staff and Hospital Administration may be discussed by the Medical Staff with the Governing Body, the Executive Administrator; and the Director of Health;

1.2-8 Continuous Quality Assessment

Incorporate the principles of continuous quality assessment and improvement in the provision of clinical care.

ARTICLE II: MEDICAL STAFF MEMBERSHIP

2.1 General Qualifications

Membership on the Medical Staff of San Francisco General Hospital, (SFGH) is a privilege which shall be extended only to those Practitioners who are professionally competent and continuously meet the qualifications, standards and requirements set forth in these Bylaws. Only those currently licensed physicians, dentists, clinical psychologists and podiatrists whose experience, training, ethics and demonstrated competence assures, in the judgment of the Medical Staff and the Governing Body, that any patient treated by them in SFGH will receive the best possible medical care, may qualify for membership. Members of the Medical Staff shall conduct themselves in the highest ethical traditional and in a manner consistent with the Code of Ethics of the American Medical Association, the American Dental Association, the American Psychological Association or the American Podiatric Medical Association. Individuals in administrative positions who desire Medical Staff membership or clinical privileges are subject to the same procedures as all other applicants for memberships or privileges.

2.2 Basic Qualifications for Consideration of Application Active and Courtesy Medical Staff

A Practitioner must demonstrate compliance with all the basic standards set forth in this Section 2 in order to have an application for Member Staff Membership accepted for review. The practitioner must:

2.2-1 Licensure

Qualify under California law practice with an out-of-state license or be licensed as follows:

- A. Physicians must (1) be licensed to practice medicine by the Medical Board of California or Board of Osteopathic Examiners of the State of California or (2) comply with all of the requirements of California Business and Professions Code Section 2113 or Section 2168 et seq., including possession of a valid and current Certificate of Registration under those code sections and approval by the UCSF Dean, School of Medicine and the Associated Dean at SFGH.
- B. Dentists must be licensed to practice dentistry by the Dental Board of California.
- C. Podiatrists must be licensed to practice podiatry by the California Board of Podiatric Medicine.
- D. Clinical psychologists must be licensed to practice clinical psychology by the California Board of Psychology of the Medical Board of California.

2.2-2 DEA

If practicing clinical medicine, dentistry or podiatry in an area in which the practitioner provides controlled substances or supervises others who prescribe or furnish controlled substances, have a valid federal DEA number.

2.2-3 Board Certification

- A. Basic Requirements

Be certified, or be progressing towards certification by (1) boards, which are duly organized and recognized by an American Board of Medical Specialties member board, or (2) a board or association with equivalent requirements approved by the Medical or Dental Board of California, or (3) a board or association with an Accreditation Council for Graduate Medical Education-approved postgraduate training that provides complete training in that specialty or subspecialty.

Applicants/re-applicants who are progressing toward board certification must become board certified within six years of the initial granting of Medical Staff membership, unless extended for good cause by the Medical Executive Committee.

B. Waivers

A Clinical Service Chief may submit a written request for waiver of the certification requirement to the Medical Executive Committee for persons who demonstrate that his/her education, training, experience, ability, judgment and medical skills make them sufficiently qualified to serve as Medical Staff members. The Medical Executive Committee and the Governing Body will consider each request or a waiver and determine whether approval is in the best interest of the patients and of the Hospital. Such waivers are not required for Practitioners who were members of the Medical Staff as of October 16, 2000.

C. Not Applicable

The certification requirement does not apply to dentists, podiatrists, clinical psychologists, or UCSF physicians practicing medicine with approval of the Medical Board of California under California Business and Professions Code 2113 or 2168.

2.2-4 Professional Liability Insurance

Individuals who are not members of the faculty of the University are not employed by the City and County of San Francisco, shall maintain professional liability insurance in an amount not less than \$1 million each occurrence, \$3 million aggregate and if applicable, with an insurance carrier acceptable to the Executive Administrator. Each such member shall upon acceptance of the Medical Staff and thereafter at any time requested by the Credentials Committee, provide the Credentials Committee with written evidence of

conforming coverage. Each such member shall promptly report to the Credentials Committee any reduction, restriction, cancellation for termination of the required insurance coverage or, if applicable, change insurance carrier.

A Practitioner who does not meet these basic qualifications is ineligible to apply for Medical Staff membership, and the application shall not be accepted for review. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic qualifications is not entitled to the procedural rights set forth in these Bylaws, but may submit comments and a request for reconsideration of the specific qualifications, which adversely affected such Practitioner. Those comments and requests shall be reviewed by the MEC and the Governing Body, which shall have the sole discretion to decide whether to consider any changes in the basic qualifications or to grant a waiver as permitted in this Section 2.4 of the Bylaws.

2.2-5 Participation in Medicare, Medicaid and Other Federal Health Care Programs

- A. Be eligible to participate in the Medicare, Medi-Cal, and other federal health care programs;
- B. Obtain a National Provider Identification, (NPI); and
- C. Enroll in Medicare and receive an enrollment confirmation letter, excluding dentists whose professional services are not reimbursed by Medicare.

2.3 Qualifications for Membership

In addition to meeting the basic qualifications, the practitioner must:

2.3-1 Experience, Education and Training

Document his/her (1) adequate experience, education, and training in the requested privileges; (2) current professional competence; (3) ability to perform the privileges

requested; (4) good judgment; and (5) adequate physical and mental health to demonstrate to the satisfaction of the Medical Staff that he/she is professionally and ethically competent so that patients can reasonably expect to receive the generally recognized high professional level of care for this community; and

2.3-2 Ethics

Be determined (1) to adhere to the lawful ethics of his/her profession; (2) to be able to work cooperatively with others in the Hospital setting so as not to adversely affect patient care or Hospital operations; and (3) to be willing to participate in and properly discharge Medical Staff responsibilities.

2.4 Condition and Duration of Appointment

2.4-1 Governing Body Action

Initial appointment and reappointment to the Medical Staff shall be made by the Governing Body. The Governing Body shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Staff provided in these Bylaws.

2.4-2 Duration

Initial appointments and reappointments to the Medical Staff shall each be for a period of not more than two years.

2.4-3 Clinical Privileges

Appointments to the Medical Staff shall confer on the appointee only such Clinical Privileges as have been granted by the Governing Body, in accordance with these Bylaws.

2.4-4 Provide Care

Every Medical Staff member shall provide care and supervision of his/her patients, abide by the Medical Staff Bylaws, accept committee assignments and, when appropriate, provide emergency service care and except consultation assignments.

2.4-5 Shall Not Discriminate

Medical Staff members shall not discriminate in the provision of care to patients based on race, religion, color, national origin, ancestry, age, disability, medical status, sex, gender or sexual orientation, or any other arbitrary basis.

2.4-6 Division of Fees

The practice of division of fees under any guise whatsoever shall be prohibited and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff.

2.5 Harassment Prohibited

Harassment by Medical Staff member against any individual (e.g., against another Medical Staff member, House Staff, Hospital employee or patient) on the basis of race, religion, color, national origin, ancestry, age, disability, marital status, sex, gender or sexual orientation shall not be tolerated.

All allegations of harassment will be investigated according to policies adopted by the City/County of San Francisco and/or University of California.

2.6 Nondiscrimination

No aspect of Medical Staff membership or Clinical Privileges shall be denied on the basis of race, religion, color, national origin, ancestry, age, disability, marital status, sex, gender or sexual orientation. The credentialing and recredentialing processes will be conducted in a non-discriminatory manner and members responsible for credentialing decisions will be required to sign an affirmative statement that they will make decisions

in a non-discriminatory manner. Additionally, the Medical Staff shall not discriminate with respect to staff privileges or the provision of professional services against a licensed physician and surgeon or podiatrist on the basis of whether the physician and surgeon or podiatrist holds an M.D., D.O., or D.P.M.

2.7 Effect of Other Affiliations

No person shall be entitled to membership on the Medical Staff or to the exercise of particular Clinical Privileges merely because the person holds a certain degree, is licensed to practice in this or any other state, is a member of any professional organization, is certified by any Clinical Board, or because such person had, or presently has, staff membership or privileges at another health care facility.

2.8 Basic Responsibilities of the Medical Staff

Each Medical Staff Member and each practitioner exercising temporary privileges, shall continuously meet all of the following responsibilities:

- A. Provide his or her patients with care that is of a generally recognized professional level of quality and efficiency.
- B. Abide by the Medical Staff Bylaws and Rules and Regulations and all other lawful standards and policies of the Medical Staff and the Hospital.
- C. Abide by applicable laws and regulations of government agencies, standards of The Joint Commission, and the CMS Conditions of Participation: and
- D. Discharge such Medical Staff, Clinical Service, committee and service functions for which he or she is responsible by appointment, election or otherwise.

ARTICLE III: CATEGORIES OF THE MEDICAL STAFF

The Medical Staff shall be divided into Active and Courtesy Staff categories.

3.1 Active Medical Staff

The Active Medical Staff shall consist of physicians, dentists, clinical psychologists and podiatrists qualified for Medical Staff membership who regularly treat patients in a location under the direction of a Clinical Service of the Medical Staff at SFGH. He/she will assume all the functions and responsibilities of membership on the Active Medical Staff. Members of the Active Medical Staff shall be appointed to a specific Clinical Service, shall be eligible to vote, to hold Medical Staff offices and to serve on Medical Staff committee's. Active Medical Staff members are required to participate in Clinical Service conferences, meetings and continuous quality improvement.

3.2 Courtesy Medical Staff

The Courtesy Medical Staff shall consist of physicians, dentists, clinical psychologists, and podiatrists qualified for Medical Staff membership who do not regularly treat patients in a location under the direction of a Clinical Service of the Medical Staff at SFGH. Courtesy Medical Staff members shall be appointed to a specific Clinical Service and may serve on Medical Staff Committees. Courtesy Medical Staff members shall not be eligible to hold Medical Staff Offices or to vote on amendments to these Bylaws and Rules and Regulations. Courtesy Medical Staff members are encouraged but not required, to participate in Clinical Service conferences and meetings; eligibility to vote at such conferences and meetings is at the discretion of the Chief of the Clinical Service.

ARTICLE IV: APPOINTMENT AND REAPPOINTMENTS

4.1 General

4.1-1 Application Process

All applications for appointment and reappointment to the Medical Staff must be in writing, signed by the applicant, and submitted to the Medical Staff Services Department

(öMSSDö) on a form approved by the Governing Body, upon recommendation of the Credentials Committee.

4.1-2 Application Content

Every applicant for appointment or reappointment must furnish a fully completed application, and shall have the burden of producing accurate and adequate information for a proper evaluation of his/her current clinical competence, character and ethics.

Information in applications shall include:

- A. Previously successful or currently pending challenges to any licensure or registration (State or District, Drug Enforcement Administration) or the relinquishment (voluntary or involuntary) of such licensure or registration;
- B. Voluntary or involuntary termination of Medical Staff membership, or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital or other health care organization;
- C. A factual synopsis of all pending and resolved professional liability actions, made within five (5) years of the date of the application, in which the applicant provided or supervised the patient care at issue; and
- D. For many resolved professional liability actions, a description of the judgment, arbitration award, settlement or other disposition.
- E. Attestation questions regarding the following issues:
 - Reason for an inability to perform essential functions of the position;
 - History of chemical dependence for substance abuse;
 - Violations of any criminal law or statutes;

- Denial, revocation, suspension, reduction, limitation, probation, loss or relinquishment of licensure;

- Disciplinary activity or limitation of privileges and/or Medical Staff status;

4.1-3 Completion of Application

An application is "completed" when the applicant has supplied all of the requested information and all necessary verifications have been obtained - including current license, licensing board disciplinary records, specialty Board Certification status, National Practitioner Data Bank (NPDB) information, DEA certificate, if appropriate, training and practice from professional school through the present, current malpractice liability insurance and history, and reference letters.

4.1-4 Application Misrepresentation or Omission

Any significant misrepresentation or omission by an applicant for appointment or reappointment may be grounds for denial of the application or other appropriate corrective action, including revocation of Clinical Privileges and Medical Staff Membership.

4.1-5 Effect of Application

By applying for appointment or reappointment to the Medical Staff, each applicant

- A. signifies his/her willingness to appear for interviews with the medical staff;
- B. authorizes the Medical Staff to consult with Medical Staff members of other health care facilities with which the applicant has been associated and who may have information bearing on the applicant's competence, character, ethical qualifications, relevant mental and physical health, and any claims history;
- C. consents to the Medical Staff's inspection of all records and documents pertinent

to the applicant's current licensure, specific training, experience, current clinical competence and ability to perform the privileges requested and other matters that may be material to an evaluation of professional qualifications for Medical Staff membership:

- D. releases from any liability the Hospital, the Medical Staff, Affiliated Professionals, House Staff, the Governing Body, and his/her directors, officers, agents, representatives and employees, for his/her acts performed in good faith and without malice in connection with evaluating the applicant's credentials; and
- E. certifies that he/she shall promptly report to the MSSD any changes in the information submitted on the application form which may subsequently occur.

4.1-6 Applicant's right to be informed

Each applicant has the right to be informed of the status of their credentialing or recredentialing application upon request.

4.2 Initial Appointment Process

4.2-1 Applicant's Receipt of Medical Staff Information

As soon as reasonably practicable, the applicant shall be provided with a copy of or access to, the Medical Staff Bylaws and Rules and Regulations, as well as the Clinical Service Rules and Regulations governing the applicant's specialty.

4.2-2 Completed Application

The completed application for initial appointment shall include detailed information concerning the applicant's professional qualifications, including, but not limited to, education, professional training, experience, licensure, relevant physical and mental health, disciplinary history, claims history, information regarding possible involvement in

professional liability actions, biographical data, request for Clinical Privileges, peer references, health care facility affiliations, current professional insurance coverage, documentation of additional appropriate licenses, certificates, or registrations required by law and/or the Medical Staff Bylaws and Manuals and the appropriate Clinical Service Rules and Regulations, specialty board status, University faculty appointment status and employee status; a signed agreement that the applicant has read and shall abide by the Medical Staff Bylaws and Manuals and the appropriate Clinical Service Rules and Regulations; a release from liability for all parties engaging in good faith peer review, commencing with the credentialing process; a signed statement of respect for the confidentiality of all Medical Staff proceedings.

4.2-3 Incomplete Application

An incomplete application will not be processed, and if an applicant fails to complete the application within two (2) months after the date of initial submission, it will be considered voluntarily withdrawn. Such withdrawal shall not entitle the applicant to the rights set forth in these Bylaws. The Credentials Committee may, for a good cause, extend the time for completion of the application.

4.2-4 Recommendation for Medical Staff Membership and Clinical Privileges

When the Medical Staff Services Department (MSSD) has received all necessary verifications, the completed application and all supporting documentation and other relevant information (the "file") shall be submitted to the Division/Service Chief for review and recommendations regarding membership and Privileges. The Division/Service Chief's written recommendations shall then be forwarded to the Credentials Committee.

4.2-5 Credentials Committee Review and Action

The Credentials Committee shall review the completed application and file and the Service Chief's final recommendations at the next regularly scheduled Credentials Committee meeting. The Credentials Committee, or a subcommittee thereof, may personally interview the applicant. The Credentials Committee shall then submit to the Medical Executive Committee (MEC) its written report and recommendations as to membership and Privileges.

4.2-6 Medical Executive Committee Review and Action

At its next regularly scheduled meeting after receipt of the written report and recommendations of the Credentials Committee, the MEC shall review the Credentials Committee's report and recommendations and make a recommendation to the Governing Body, through the Director of Health, that the application be approved, deferred for further consideration, or denied. All recommendations to approve an application must also specifically recommend the Clinical Privileges to be granted and any special conditions or limitations relating to such Privileges. When the recommendations are adverse to the applicant, the MEC shall document the reasons for such recommendations.

- A. When the recommendation of the MEC is favorable to the applicant, it shall be forwarded to the Governing Body, through the Director of Health.
- B. When the recommendation of the MEC is to defer the application for further consideration, a subsequent recommendation for approval or denial must be made by the MEC within forty-five (45) days of the deferral.
- C. When the recommendation of the MEC is adverse to the applicant in respect to appointment or Clinical Privileges, the Chief of Staff shall promptly notify the Division/Service Chief. The Chief of Staff shall also notify the applicant by Special Notice, in accordance with Section 7.3 of these Bylaws. The Governing

Body shall be generally informed of the recommendation for informational purposes, but it shall not act on it until after the applicant has exercised, or has been deemed to have waived, his/her procedural rights set forth in Articles VI and VII of these Bylaws.

4.2-7 Governing Body Review and Action

The Governing Body shall act upon favorable recommendation at its next regularly scheduled meeting and notify the applicant of its decision. If the Governor Body's decision is adverse to the applicant in respect to appointment or Clinical Privileges, the Chief of Staff, upon receiving notice of the Governing Body's decision, through the Director of Health, shall promptly notify the applicant of such adverse decision by Special Notice, in accordance with Section 7.3 of these Bylaws. Such adverse decision shall be held in abeyance until the applicant has exercised, or has been deemed to have waived, his/her procedural rights under Articles VI and VII by these Bylaws.

- A. The fact that the adverse recommendation or decision is held in abeyance during the hearing and appellate review shall not confer Privileges where none existed before.
- B. In the event the Governing Body wishes to defer action, it may do so by referring the matter back to the MEC with a statement of its reasons for doing so. Any such referral back shall set a time limit (not to exceed two (2) months) within which the MEC is to provide additional information or recommendations or take further action.
- C. The final decision of the Governing Body shall be made within forty-five (45) days of its initial consideration of a decision contrary to the recommendation of the MEC. This final decision shall be promptly forwarded to the MEC and the

applicant.

- D. The time periods set forth in this section are guidelines only, and are not directives which create any right for a Practitioner to have an application processed within these precise periods. When no time periods are specified, all parties shall act as soon as reasonably practicable.

4.3 Reappointment Process

4.3-1 Frequency

The Medical Staff shall reevaluate Practitioners at least every two (2) years for the purpose of determining its recommendations for reappointment to the Medical Staff and the continuation of Clinical Privileges.

4.3-2 Reappointment Application Process

On or before four (4) months before the expiration of a Medical Staff member's appointment, the MSSD shall mail the member a reappointment application. Within one (1) month of the date the application was mailed, the member must return the completed and signed application to the MSSD, along with all required information and materials.

4.3-3 Recommendation for Reappointment

Each Service Chief in which the Medical Staff member requests or has exercised Privileges shall review the member's completed application and file and forward his/her written recommendations to the Credentials Committee. The recommendations shall include a statement that the recommendations are based on information provided by the Quality Management Department, including the Clinical Service's quality information about the Medical Staff member, any professional liability claims, the member's clinical activity, education, and training, and any other pertinent information. At the time of reappointment, if a member has not participated in clinical activity for a period of two

years that member's Medical Staff membership shall automatically expire. Such an individual may apply for a new appointment to the Medical Staff.

4.3-4 Additional Considerations for Reappointment

In addition to the items listed in subsection 4.3-3 above, each recommendation concerning reappointment of a Medical Staff member, and the Clinical Privileges to be granted upon reappointment, shall be based upon such member's current professional performance, evidence of progression towards Board Certification or re-certification (if applicable), current competence, clinical or technical skills and judgment in the treatment of patients, ongoing provider specific continuous quality improvement evaluations, ethical conduct, attendance at Medical Staff meetings and participation in Medical Staff affairs, compliance with these Bylaws and Rules and Regulations, voluntary or involuntary loss and/or relinquishment of Privileges or licensure, a response to the National Practitioner Data Bank inquiry, and mental or physical health that permits the member to carry out the essential functions of his/her Medical Staff category or Privileges, with or without reasonable accommodation.

4.3-5 Credentials Committee Action

The Credentials Committee shall review the completed reappointment application and file and the Clinical Service Chief's final recommendations at the next regularly scheduled Credentials Committee Meeting. The Credentials Committee, or a subcommittee thereof, may professionally interview the applicant. The Credentials Committee shall then submit to the MEC its written report and recommendations as to reappointment and Privileges.

4.3-6 Medical Executive Committee Action

At its next regularly scheduled meeting after receipt of the written report and recommendations of the Credentials Committee, the MEC shall review the Credentials Committee's report and recommendations, and make recommendations to the Governing Body, through the Director of Health, that the application be deferred for further consideration, approved, or denied. When the recommendations include a denial of reappointment and/or a reduction in category or Clinical Privileges, the MEC shall document the reasons for such recommendations. Thereafter, the procedures set forth in Section 4.2 above shall apply.

4.3-7 Term of Reappointment

Reappointments to any Medical Staff category shall be for a maximum of two (2) years.

4.3-8 Failure to Return a Completed Reappointment Application

Failure of a Practitioner to return a completed application for reappointment at least four (4) months prior to the expiration of his/her current term shall result in automatic termination of the Practitioner's privileges and prerogatives effective on the date the Practitioner's current term expires. Prior to termination, the Practitioner shall be sent at least one (1) letter by Special Notice warning of the impending termination. The respective Clinical Service Chief shall be notified in writing of the delinquent reappointment and pending termination. If an application for reappointment is not received in fully completed four (4) months before the current term expires, the Practitioner shall be deemed to have resigned his/her Medical Staff membership effective the date his/her current term expires. Practitioners who automatically resign under this section will be processed as a reinstatement should he/she wish to apply within one (1) month after his/her term has expired.

4.3-9 Reinstatement

Practitioners who automatically resign under 4.3-8 above shall be required to complete a reinstatement form to reapply for membership. Reinstatement shall be processed in a manner parallel to the reappointment process outlined in 4.3 above. Reinstatement application forms shall be accepted within one (1) month from the date of Practitioner membership expires.

All Practitioners, whose membership has expired longer than one (1) month, shall be required to complete the initial appointment process outlined in 4.2 above in order to apply for membership.

4.4 Access to Own Credentials File

Medical Staff member shall be granted access to his/her own credentials file, subject to the following provisions:

- A. Timely notice of a request for access shall be made by the member to the Chief of Staff or designee;
- B. The member may review, and receive a copy of, only those documents provided by or addressed personally to the member.
- C. A summary of all other information, including but not limited to peer review committee findings, letters of reference, proctoring reports and complaints, shall be provided to the member, in writing, by the designated Officer of the Medical Staff, at the time the member reviews the credentials file or within a reasonable period of time after receipt of a request for such summary, as determined by the

MEC. Such summary shall disclose the substance, but not the source, of the information summarized;

- D. The review by the member shall take place in the Medical Staff office, during regular working hours, with an Officer or designee of the Medical Staff present.

4.5 Right to Request Corrections/Additions

Medical Staff members may exercise the right to request the corrections or appropriate additions to credentials file information following the below listed protocol.

- A. After reviewing the file, a member may address a written request to the Chief of Staff asking for correction or deletion of information in the credentials file. Such request shall include a statement of the basis for the action requested.
- B. The Chief of Staff shall review such a request within a reasonable time and shall recommend to the MEC, after such review, whether or not to make the correction or deletion requested.
- C. The MEC, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote.
- D. The member shall be notified promptly, in writing, of the decision of the MEC.
- E. In any case, members shall have the right to add to his/her own credentials file, upon written request to the MEC, a statement responding to any information contained in the file.

4.6 Reapplication After Adverse Decision

An applicant or member, who has received a final adverse decision regarding appointment, reappointment, membership, or Privileges, or who has resigned after notice of an adverse

recommendation or a final adverse decision, shall not be eligible to reapply to the Medical Staff for a period of two (2) years from the date of the final adverse decision or resignation. Any such reapplication shall be processed as an initial application, and the applicant must submit such additional information as may be required to demonstrate that the basis for the earlier adverse decision or recommendation no longer exists.

4.7 House Staff

House Staff are not eligible for Medical Staff membership.

4.8 Affiliated Professionals

4.8-1 General

A. Affiliated Professionals are individuals who

- (1) Are employees of the City and County of San Francisco or the University,
- (2) Provide health services, requiring them to exercise independent judgment within the area of his/her professional competence and the limits established by the Governing Body, the Medical Staff, and the applicable practice laws,
- (3) Do not qualify for Medical Staff membership because they are not licensed as physicians, dentists, clinical psychologists, or podiatrists, and may not vote on amendments to the Bylaws and Rules and Regulations; and
- (4) Belong to a professional category that has been accepted for practice at the Hospital by the Governing Body after appropriate consultation.

At present, the following categories have been so accepted:

Certified Nurse Midwives

Certified Registered Nurse Anesthetists

Nurse Practitioners

Physician Assistants

Pharmacists (PharmD)

Optometrists

- B. Although not eligible for Medical Staff membership, Affiliated Professionals shall be credentialed through the Medical Staff and shall be subject to general Medical Staff oversight and to the individual direction of Medical Staff members, as set forth below.
- C. The clinical responsibilities of each Affiliated Professional shall be set forth in standardized procedures developed by the Committee on Interdisciplinary Practice and approved by the Credentials Committee, Medical Executive Committee, and Joint Conference Committee.

4.8-2 Role of Medical Staff

- A. The work of each Affiliated Professional shall be conducted with oversight of a physician member who shall be available either physically or electronically. A Medical Staff member can supervise no more than four Affiliated Professionals at one time.
- B. Affiliated Professionals may practice within the scope of his/her licensure, as limited by any relevant Hospital and Medical Staff policies and procedures.
- C. As employees of either the City and County of San Francisco or the University, Affiliated Professionals shall be recruited and hired through the usual personnel processes of each entity. Any offer of employment shall be contingent upon Medical Staff approval following the procedures set forth below.

4.8-3 Appointment

- A. Each Affiliated Professional who has been provisionally hired shall submit an application to the MSSD for appointment to Affiliated Professional status on a form provided for that purpose. The applicant shall furnish all information required on the application form or reasonably requested by the appropriate Medical Staff committee. The applicant shall have the burden of producing adequate information for a proper evaluation of competency, character, and ethics. An applicant who fails to provide all requested information within one (1) month of the date of being notified of any deficiencies shall be deemed to have withdrawn the application.
- B. A Practitioner who is on the Office of Inspector General (OIG) Exclusion List is not eligible for appointment as an Affiliated Professional.
- C. A Practitioner must possess a National Provider Identifier (NPI) or must have submitted an application for a NPI in order to be considered for appointment or reappointment to the Medical Staff.
- D. Practitioner must have enrolled in Medicare and received an enrollment confirmation letter, excluding PharmDs whose professional services are not reimbursed by Medicare and Nurse Practitioners hired prior to April, 2004 without a master's degree.
- E. Nurse Practitioners who were not hired by the City or University prior to April, 2004 must have a master's degree or higher in nursing and be board eligible.
- F. The MSSD shall forward the completed application to the Chair or Co-Chair of the Interdisciplinary Practice Subcommittee of the Credentials Committee. The Interdisciplinary Practice Subcommittee shall review the application and shall

forward the application together with its recommendation to the Credentials Committee.

- G. The Governing Body shall review the recommendation of the MEC and shall make a decision on behalf of the Hospital concerning whether to admit the Affiliated Professional or Affiliated Professional status and to permit the Affiliated Professional to perform the functions contained in the proposed job description.
- H. If the Governing Body denies the applicant admission to Affiliated Professional status or declines to permit the applicant to perform all of the functions contained in the proposed job description, the applicant shall be limited to the remedies set forth in the Grievance Procedures in the applicable Memorandum of Understanding. The applicant shall not be entitled to any of the procedural rights set forth in these Bylaws.
- I. An Affiliated Professional who has been hired and who have submitted an application as set forth below, may perform functions at the Hospital on a temporary basis while the Medical Staff is considering the completed application. However, services that require a standardized procedure may not be performed until the applicant's credentials and a standardized procedure have been approved by the Medical Staff.
- J. An Affiliated Professional who is admitted to Affiliated Professional status shall be subject to a period of proctoring/evaluation under rules and procedures established by the relevant clinical service.
- K. By applying for appointment, an applicant agrees to the same provisions that

apply to applicants for Medical Staff membership set forth in Sections 4.1-3, 4.1-4 and 4.1-5 of these Bylaws.

- L. Any material misrepresentation by an applicant may be grounds for disapproval of the application or for termination of Affiliated Professional status.
- M. An Affiliated Professional may not perform any functions that require a standardized procedure, as determined by the Committee on Interdisciplinary Practice, unless the standardized procedure has been approved by the Medical Staff.

4.8-4 Reappointment

- A. The initial appointment to Affiliated Professional status shall last for a maximum period of two (2) years.
- B. Each subsequent reappointment shall be for a maximum two (2) year period.
- C. Prior to the end of each appointment or reappointment period, the MSSD shall provide the Affiliated Professional with an application or reappointment, which shall be submitted and processed according to the same procedures as for the application for initial appointment.

4.8-5 Corrective Action

- A. Any corrective action against an Affiliated Professional shall be in accordance with the procedures set forth in the applicable Memorandum of Understanding. The applicant shall not be entitled to any of procedural rights set forth in these Bylaws.
- B. In the event that immediate action is necessary to prevent imminent danger to the

health of any individual, the Affiliated Professional's right to perform some or all duties set forth in the Job Description may be suspended immediately, in accordance with the procedures set forth in the applicable Memorandum of Understanding. The applicant shall not be entitled to any of the procedural rights set forth in these Bylaws.

ARTICLE V: CLINICAL PRIVILEGES

5.1 Clinical Privileges

5.1-1 Process

Every Practitioner practicing at this Hospital by virtue of Medical Staff membership shall, in connection with such practice, be entitled to exercise only those Clinical Privileges specifically granted to him/her by the Governing Body, except as provided in Sections 4.2 of these Bylaws. The granting of Privileges depends upon an individual's documented experience in categories of diagnostic and treatment areas and current competence as judged by ongoing continuous quality improvement reviews. Every hospitalized patient shall have a physician member of the Medical Staff responsible for his/her care.

5.1-2 Education, Training and Experience

Every initial application for Medical Staff appointment must contain a request for specific Clinical Privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's documented education, training, experience and demonstrated competence, University faculty appointment (if applicable), references, and other relevant information, including a recommendation by the Clinical Service in which such Privileges are sought.

The applicant shall have the burden of establishing qualifications and competency in the requested Clinical Privileges.

5.1-3 Evaluation

Periodic re-determination of Clinical Privileges and the increase in, or curtailment of same, shall be based upon direct observation of care provided, review of records of patients treated in this Hospital, and/or review of records of the Medical Staff which document the evaluation of the member's provision of professional care.

5.2 Temporary Privileges

5.2-1 Pending Application for Permanent Medical Staff Membership

- A. Temporary Privileges may be granted on a case-by-case basis to meet an important patient care need when an applicant has submitted a complete application, which on its face does not suggest any irregularities or concerns, and is awaiting the review and approval of the Credentials Committee, Medical Executive Committee and the Governing Body.
- B. No person with Temporary Privileges may vote or hold office.
- C. Temporary Privileges may be granted for a period not to exceed four months.

5.2-2 Application and Review

The Chief of Staff, or his/her designee, with the concurrence of the Executive Administrator, may grant Temporary Privileges after the following has been completed:

- A. The Medical Staff Services Department has confirmed that the applicant has

submitted a complete application, which on its face does not suggest any irregularities or concerns;

- B. The National Practitioner Data Bank report has been received and evaluated;
- C. Current California licensure has been verified; and
- D. The appropriate Chief of Service, or designee, (or Chiefs of Services, or designees, if the applicant is seeking privileges in more than one Clinical Service) has interviewed the applicant and contacted at least one person who has recently worked with the applicant, directly observed the applicant's professional performance over a reasonable period of time, and can provide reliable information regarding the applicant's current professional competence to perform the privileges requested, ethical character, and ability to work well with others so as not to adversely affect patient care.

5.2-3 General Conditions

- A. There is no right to Temporary Privileges. Such privileges will not be granted unless available information supports, with reasonable certainty that a favorable determination will be made on the individual's Medical Staff application. A determination to grant Temporary Privileges shall not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff.
- B. If the available information is inconsistent or casts any reasonable doubt on the applicant's qualifications, action on the request for Temporary Privileges will be deferred until the doubt has been satisfactorily resolved.
- C. Temporary Privileges shall automatically terminate at the end of four (4) months

unless terminated earlier.

- D. In exercising Temporary Privileges, the applicant shall act under the supervision of the Chief of Service, or designee, to whom he/she is assigned and shall be proctored and monitored in accordance with the Clinical Service Rules and Regulations and the proctoring provisions set forth in these Bylaws.
- E. All requests for Temporary Privileges shall include a clinical rationale from the appropriate Chief of Service supporting the needed urgency of the privileges.
- F. Temporary Privileges shall not be granted unless the applicant has an academic appointment with the University, is an employee of the City and County of San Francisco, or provides documentation of professional liability coverage in accordance to Section 2.2-4 of these Bylaws.
- G. Temporary Privileges shall not be granted unless the applicant signs an acknowledgment that he/she has received or been given access to a copy of the Medical Staff Bylaws and agrees to be bound by the terms thereof.
- H. The Chief of Staff may use his/her discretion to restrict, suspend, or terminate any or all of the Temporary Privileges granted. In such an event, the Practitioner shall not be entitled to the procedural rights set forth in Article VI of these Bylaws, or to any other procedural rights, unless such action requires the filing of a report to either the Medical Board of California or the National Practitioner Data Bank.

5.3 Visiting Privileges

5.3-1 To Meet a Specific Need

- A. Visiting Privileges may be granted for a specified period of time on a case-by-

case basis when a patient(s) of a Clinical Service require the services of a physician, dentist, podiatrist, or clinical psychologist who is not a member of the Medical Staff.

- B. No person with Visiting Privileges shall vote, or hold office.
- C. The Chief of Staff or his/her designee, with the concurrence of the Executive Administrator, may authorize Visiting Privileges if:
 - (1) The person has submitted a completed application for Visiting Privileges;
 - (2) The Chief of Staff or his/her designee reasonably believes that the person has the qualifications, ability, and judgment required for Medical Staff membership; and
 - (3) The Chief of the Clinical Service requiring a person's services recommends the person.

5.3-2 General Conditions

- A. In exercising Visiting Privileges, the applicant shall act under the supervision of the Chief of Service, or designee, to which he/she is assigned.
- B. All requests for Visiting Privileges shall include a clinical rationale from the appropriate Chief of Service supporting the need for granting such privileges.
- C. Visiting Privileges shall not be granted unless the applicant has an academic appointment with the University, is an employee of the City and County of San Francisco, or provides documentation of professional liability coverage in accordance with Section 2.2-4 of these Bylaws.

- D. Visiting Privileges shall not be granted unless the applicant signs an acknowledgment that he/she has received or been given access to a copy of the Medical Staff Bylaws and agrees to be bound by them.
- E. The Chief of Staff may use his/her discretion to restrict, suspend, or terminate the Visiting Privileges. In such an event, the Practitioner shall not be entitled to the procedural rights set forth in Article VI of these Bylaws, or to any other procedural rights, unless such action requires the filing of a report to either the Medical Board of California or the National Practitioner Data Bank.
- F. The Chief of Staff shall inform the Governing Body that Visiting Privileges were granted for a patient care need that could not be met by a member of the Medical Staff.

5.4 Emergency Situations

5.4-1 Medical Staff Members and Credentialed Affiliated Professionals

In the event of an emergency, any member of the Medical Staff or affiliated professionals, as well as any other licensed health care professional, shall be permitted to do everything reasonable to save the life of a patient or to save a patient from serious harm. The member, affiliated professional, or other licensed health care professional shall promptly yield such care to a more qualified member of the Medical Staff when one becomes available.

5.5 Disaster Privileges

5.5-1 In the event that the Emergency Management Plan has been activated and the Hospital is unable to handle the immediate patient needs, Disaster Privileges may be granted by the Executive Administrator, the Chief of Staff, or his/her

designee(s) upon presentation of the following:

- A. A valid government issued photo identification card such as a driver's license or a passport, and at least one of the following:
 - (1) A copy of a current license to practice medicine.
 - (2) Primary Source verification of licensure.
 - (3) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps. (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group.
 - (4) Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances, or
 - (5) Confirmation by a licensed independent practitioner currently privileged by the Hospital, or by a staff member, with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

5.5-2 During the disaster, the Medical Staff shall oversee the performance of each physician who has been granted disaster privileges. Based on its oversight of such physicians, the Medical Staff shall determine within 72 hours of the physician's arrival if the disaster privilege should continue.

5.5-3 Primary source verification of licensure shall occur as soon as the disaster is

under control or within 72 hours from the time the physician presented him/herself to the Hospital, whichever comes first. If primary source verification can not be completed within 72 hours due to extraordinary circumstances, the following shall be documented:

- (1) The reason(s) it could not be performed within 72 hours;
- (2) Evidence of the physician's demonstrated ability to continue to provide adequate care, treatment, and services; and
- (3) Evidence of the Hospital's attempt to perform primary source verification as soon as possible.

5.5-4 Primary source verification of licensure is not required if the physician has not provided care, treatment or services under the disaster privileges.

5.6 Proctoring

5.6-1 General

All new appointees to the Medical Staff and existing members requesting additional privileges, regardless of specialty or category of membership so long as direct patient care is involved, shall be assigned a Proctor by the Clinical Service Chief or designee and complete a period of proctoring, as defined in 5.5-4 "Proctoring Duration" below.

The Proctor must have unrestricted privileges to perform the evaluation(s) that he/she will proctor. The Clinical Service Chief will submit a form to the Credentials Committee attesting to the satisfactory completion of proctoring. Documentation of the proctoring will reside in the Clinical Service Office.

5.6-2 Function and Responsibility of the Proctor

- A. The Proctor shall be responsible for evaluating the Practitioner's clinical competence for the requested privileges.
- B. The Proctor's primary responsibility is to evaluate the Proctoree's performance. However, if the Proctor believes intervention is warranted in order to avert harm to a patient he/she may take any action he/she finds reasonably necessary to protect the patient.

5.6-3 Responsibility of the Proctoree

The Proctoree shall be responsible for notifying one of the assigned Proctors for each patient whose care is to be evaluated. For surgical or invasive medical procedures that will be observed, the Proctoree shall be responsible for arranging the time of the procedure with the Proctor.

5.6-4 Proctoring Duration

Proctoring shall be deemed successfully completed when the Proctoree completes the proctoring as determined in the Clinical Service Rules and Regulations. Proctoring should commence upon granting of medical privileges, be completed within the first six (6) months of initial granting of new privileges and must be completed within the first year (12 months) of initial granting of new privileges.

For privileges that are infrequently performed by the Medical Staff member, the Clinical Service Chief may submit a written request to the Credentials Committee to expand the proctoring period, or to have the proctoring occur at another accredited hospital so long as the Proctor is a member of the SFGH Medical Staff in good standing. These privileges shall be voluntarily

relinquished or withdrawn if proctoring is not completed within twenty-four (24) months of the initial granting of the infrequently required privileges.

5.6-5 Reciprocal Proctoring

Reciprocal proctoring is proctoring that is performed by non-SFGH Medical Staff Members at sites other than the Hospital. This situation becomes necessary when no SFGH Medical Staff Members who possess the necessary expertise are available to proctor a specific skill or procedure. Only such specific skills or procedures may be reciprocally proctored; all other elements of the Practitioner's practice shall be proctored by a Medical Staff Member of SFGH. Requirements for reciprocal proctoring are as follows:

- A. The reciprocal Proctor is an active member of the Medical Staff at an accredited hospital;
- B. The reciprocal Proctor possesses unrestricted privileges to perform the procedure for which the proctoring is being performed; and
- C. The reciprocal proctoring arrangement and the reciprocal Proctor have been approved by the Chief of the Clinical Service.

For each case that is reciprocally proctored, the reciprocal Proctor shall complete SFGH proctoring form and submit it to the Clinical Service. The Clinical Service shall submit an evaluation summary to the Credentials Committee.

ARTICLE VI: ROUTINE MONITORING AND EDUCATION AND CORRECTIVE ACTION

6.1 Routine Monitoring and Education, Including Verbal and Written Counseling

6.1-1 Responsibilities of the Chiefs of the Clinical Services

The Chiefs of the Clinical Services are responsible for ensuring the quality of patient care rendered by their service and maintaining professional standards of behavior among members of their service.

6.1-2 Quality of Patient Care - Education, Monitoring and Investigation and Response to Concerns Identified

The Chiefs of Clinical Services are responsible for carrying out delegated peer review and quality improvement functions for their service. The Chief of the Clinical Service may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the Practitioner is only required to provide reasonable notice of admissions and procedures) in the course of carrying out their duties without initiating formal corrective action. Comments, suggestions, and warnings may be issued orally or in writing. The Practitioner shall be given an opportunity to respond in writing and to discuss the matter with the Chief of the Clinical Service. Documentation of any informal actions, monitoring, or counseling shall be maintained by the Chief of the Clinical Service.

6.1-3 Professional Standards of Behavior

The Chiefs of Clinical Services are responsible for monitoring the professional behavior of members of their service and addressing disruptive and inappropriate behaviors as described in the SFGH institution-wide Code of Professional Conduct Policy.

A. Expected Behaviors of Members of the Medical Staff

All members of the Medical Staff are expected to treat patients and their families, as well as other providers, nurses, and ancillary staff, in a courteous, dignified,

and currently respectful manner.

B. Examples of Disruptive and Inappropriate Behaviors include, but are not limited to, the following:

- (1) Shouting or using vituperative language.
- (2) Use of profanity directed at an individual.
- (3) Slamming or throwing objects.
- (4) Physical or verbal intimidation and harassment.
- (5) Hostile, condemning, or demeaning communications.
- (6) Derisive, insulting, or demeaning criticism of performance.
- (7) Deliberate failure to abide by Hospital, Medical Staff, departmental or committee bylaws, policies and procedures, or directives, including refusal to comply with required duties.
- (8) Behavior disruptive to the delivery of quality patient care, and an environment free of harassment and violence.
- (9) Retaliation against any person who addresses or reports incidents of unacceptable behavior.

Expressing contrary opinions is not disruptive conduct, nor is expressing concern regarding constructive criticism of existing policies or procedures or questioning, potentially unacceptable performance or conditions, if it is done in good faith, in an appropriate time, place and manner, and with the aim of improving the environment of care rather than personally attacking any

individual.

6.1-4 Investigation in Response to Alleged Disruptive and Inappropriate Behavior

- A. Alleged violation of the Code of Professional Conduct may be reported by any hospital personnel using the confidential and 1157-protected Unusual Occurrence (UO) reporting form designed for this purpose. Confidentiality will be maintained throughout the investigation of the alleged behavior and for any counseling, warning, or disciplinary action resulting from the investigation. The person allegedly demonstrating Disruptive or Inappropriate Behavior will be informed of the UO by the Chief of the Clinical Service Staff or designee and have the opportunity to respond to or refute the allegations. If the investigation finds that the allegation does not meet the level of Disruptive and Inappropriate Behavior as defined by this Code, the report will be closed and dismissed. Dismissed reports will not be considered determination of recurrent Disruptive and Inappropriate Behaviors.
- B. The Chief of the Clinical Service or designee shall conduct initial investigation within one (1) week of being notified by Risk Management of a Code of Professional Conduct UO Report or otherwise becoming aware of the issue. When the Chief of Clinical Service is the subject of the alleged behavior, the Chief of Staff or designee will conduct the investigation. The Chief of Clinical Service or designee may discuss each UO report with the affected Member, the Chief of Service, Chief of Staff, or designee will take appropriate action based on the following guidelines:

(1) **Dismissed/No Action:** The alleged behavior does not meet the level of

Disruptive and Inappropriate Behavior as defined in these Bylaws. The Chief of Service will report this outcome to Risk Management, including a brief explanation of why the alleged behavior did not meet the level of behavior as defined by these Bylaws. The UO report will be recorded as "dismissed". No further action shall be taken.

- (2) **Meeting for Resolution:** The behavior is relatively minor, had low potential to adversely affect patient care, and likely can be resolved by a meeting of the involved parties. The Chief of Service will convene and facilitate a face-to-face Meeting for Resolution between the Member and the affected party. The Chief of Staff may help identify an alternative facilitator/mediator upon request. The Chief of Service will notify Risk Management of the satisfactory outcome of the Meeting for Resolution.
- (3) **Verbal Counseling:** The behavior had the potential to adversely affect patient care and is a first confirmed Disruptive or Inappropriate Behavior event for the Member. The Chief of Service shall verbally counsel the Member when an instance of Disruptive and Inappropriate Behavior warrants such counseling. The Verbal Counseling shall emphasize the particular conduct that is inappropriate and stress that future similar conduct may result in more formal action under the Corrective Action procedures. A record of the Verbal Counseling will be kept by the Chief of Service and will include expectations, the action plan, and the consequences of repeat behavior of a similar nature (which will include Written Counseling). A Member also may be directed by the Chief of Service to issue an apology to the involved party or parties. The Chief of the Clinical Service shall maintain documentation of the counseling and notify Risk Management of this outcome.

(4) **Written Counseling:** The behavior had the potential to adversely affect patient care and is sufficiently serious to make Verbal Counseling insufficient, inappropriate, or it represents recurrent Disruptive and Inappropriate Behavior that previously was addressed with Verbal Counseling. The Chief of Service will meet with the Member and write a formal letter that sets forth the serious nature of the Disruptive and Inappropriate Behavior, reiterates any previous Verbal Counseling in relation to similar Disruptive and Inappropriate Behavior exhibited by the Member, emphasizes the responsibility of Medical Staff Members to treat all persons at the Hospital courteously, respectfully, and with dignity, and informs the Member that future similar conduct may result in referral of the matter to the Medical Executive Committee for possible Corrective Action. The letter will include expectations, the action plan, and the consequences of repeat behavior of a similar nature. The Member also may be directed by the Chief of Service to issue an apology to the involved party or parties. A copy of the Written Counseling shall be sent to the Chief of Staff, the Associate Dean, and the Medical Staff Services Office for inclusion in the Members peer review (credentials) file. The Medical Staff Member may submit a letter of rebuttal that will be placed in the Member's peer review file. The Chief of Service will report this outcome to Risk Management.

(5) **Action Plans** may include remedial education, referral for psychological evaluation and treatment, referral for anger management counseling, or other professional assistance programs. The Chief of Staff is encouraged to consult freely with the Chief of Staff, Associate Dean, Chief Medical Officer and/or Executive Administrator in determining the appropriate plan of action.

The level of action may be revised by the Chief of Service, in consultation with the Chief of Staff, Associate Dean, Chief Medical Officer and/or Executive Administrator as appropriate, after further information is obtained in the course of investigation and counseling.

- (6) **Risk Management** will log Code of Professional Conduct UO reports and outcomes, track trends, and report aggregate data to the Performance Improvement and Patient Safety Committee (PIPS) twice annually. The identity of individual Members will not be disclosed in these reports.

6.1-5 Medical Executive Committee Approval is not Required and Procedural Rights are not Triggered

The approval of the Medical Executive Committee (MEC) is not required for actions taken by the Chief of the Clinical Services as set forth in Section 6.1 herein nor do such actions give rise to procedural rights for the Medical Staff Member as set forth in Article VII herein.

6.2 Criteria for Initiation of Corrective Action

A corrective action investigation may be initiated whenever reliable information indicates that a member may have exhibited acts, demeanor, or conduct, either within or outside of the Hospital, that are reasonably likely to be

(a) detrimental to patient safety or to the delivery of quality patient care within the Hospital;

(b) unethical;

(c) contrary to the Medical Staff Bylaws and Rules and Regulations;

(d) below applicable professional standards;

(e) disruptive of Medical Staff or Hospital operations or the delivery of quality patient care;

(f) a documented pattern of Disruptive and Inappropriate Behavior as defined as more than two (2) incidents warranting Verbal or Written Counseling within a two (2) year period.

6.3 Initiation

- A. Any person who believes that corrective action may be warranted may provide information to the Chief of Staff, any other Medical Staff officer, any Clinical Service Chief, the Governing Body, or the Executive Administrator.
- B. If the Chief of Staff, any other Medical Staff officer, any Clinical Service Chief, the Governing Body, or the Executive Administrator determines that Corrective Action may be warranted under this Section 6.2 of these Bylaws, that person or entity may request the initiation of a formal Corrective Action Investigation or may recommend particular Corrective Action. Such requests must be conveyed to the MEC in writing. The MEC may conduct an informal review of the matter to determine whether an investigation is warranted.
- C. The Chief of Staff shall notify the Executive Administrator, or his/her designee in his/her absence, and the MEC, and shall continue to keep them fully informed of all action taken. In addition, the Chief of Staff shall immediately forward all necessary information to the committee or person that will conduct any Investigation; provided, however, the Chief of Staff or the MEC may dispense with further Investigation of matters deemed to have been adequately investigated by a committee pursuant to Section 6.4 of these Bylaws, or otherwise.

6.4 Formal Investigation

If the MEC concludes that an Investigation is warranted, it shall direct an Investigation to be undertaken. The MEC may conduct the Investigation itself or may assign the task to an appropriate officer or standing or ad hoc committee. The affected Practitioner shall be given an opportunity for an interview to discuss or refute the charges. Such an interview shall not constitute a "hearing" as the term is used in Article VII of these Bylaws, and none of the procedural rights under Article VII of these Bylaws shall apply. A record of the matters discussed and the findings resulting from an interview shall be made. If the Investigation is delegated to an officer or committee other than the MEC, such officer or committee shall proceed with the Investigation in a prompt manner and shall forward a written report of the Investigation to the MEC as soon as practicable. The report shall include findings of fact and recommendations for appropriate corrective action. If the MEC concludes action is indicated, but no further Investigation is necessary, it may proceed to take action.

6.5 Medical Executive Committee Action

As soon as practicable after the conclusion of the Investigation, the MEC shall take action that may include, without limitation:

- A. Determining no corrective action be taken, and if the MEC determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's file;
- B. Deferring action for a reasonable time when circumstances warrant;
- C. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude department or committee chairs from issuing informal written or oral warnings outside of the mechanism for Corrective

Action. In the event, such letters are issued, the affected member may make a written response that shall be placed in the member's file;

- D. * Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of Clinical Privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring;
- E. * Recommending reduction, modification, suspension or revocation of Clinical Privileges. If suspension is recommended, the terms and duration of the suspension and the conditions that must be met before the suspension is ended shall be stated;
- F. * Recommending suspension, revocation or probation of Medical Staff membership. If suspension or probation is recommended, the terms and duration of the suspension or probation and the conditions that must be met before the suspension or probation is ended shall be stated; and
- G. Taking other actions deemed appropriate under the circumstances.

* Actions reported to the Medical Board of California and entered into the National Practitioner Database.

6.6 Procedural Rights

- A. If the MEC determines that no corrective action is required or that only a letter of warning, admonition, reprimand, or censure should be issued, the decision shall be transmitted to the Governing Body. The Governing Body may affirm, reject, or modify the action. The Governing Body shall give great weight to the MEC's decision and initiate further action only if the failure to act is contrary to the

weight of the evidence that is before it, and then only after it has consulted with the MEC and the MEC still has not acted. The decision shall become final if the Governing Body affirms it or takes no action on it within seventy (70) days after receiving the Notice of Decision.

- B. If the MEC recommends an action that is a ground for a hearing under Section 7.2 of these Bylaws, the Chief of Staff shall give the Practitioner Special Notice of the adverse recommendations and of the right to request a hearing in accordance with Section 7.3 of these Bylaws. The Governing Body may be informed of the recommendation, but shall take no action until the member has either waved his/her right to a hearing or completed the hearing.

6.7 Initiation of Governing Body

If the MEC fails to investigate or take corrective action, contrary to the weight of the evidence, the Governing Body may direct the MEC to initiate investigation or corrective action, but only after written notice to the MEC. If the MEC fails to take action in response to the Governing Body's direction, the Governing Body may initiate investigation and corrective action, but this corrective action must comply with these Medical Staff Bylaws. The Governing Body shall inform the MEC in writing of what it has done.

6.8 University

Nothing in this article or elsewhere in these Bylaws is intended to limit the University's ability to take appropriate action with respect to University faculty members.

6.9 Criteria for Initiation

- A. Whenever the Practitioner's conduct is such that a failure to take action may result in imminent danger to the health or safety of any individual, the Chief of

Staff, the MEC, the Executive Administrator or the Chief of Clinical Service in which the member holds Privileges may summarily restrict or suspend the Medical Staff membership or Clinical Privileges of such member.

- B. Unless otherwise stated, such summary restriction or suspension (summary action) shall become effective immediately upon imposition, and the person or body responsible shall promptly give written Special Notice generally describing the reasons for the action to the member, and Notice to the MEC, the Executive Administrator and the Governing Body.
- C. The summary action may be limited in duration and shall remain in effect for stated period or until resolved as set forth herein. Unless otherwise indicated by the terms of the summary action, the Chief of the involved Clinical Service shall make the necessary arrangements to provide alternate coverage for proper and necessary patient care during the period of restriction or suspension.
- D. The notice of the summary action given to the MEC shall constitute a request to initiate corrective action and the procedures set forth in Article VI of these Bylaws shall be followed.

6.10 Medical Executive Committee Action

The affected Practitioner may request an interview with the MEC. The interview shall be convened as soon as reasonably practicable under the circumstances but in no event less than seven (7) days after the summary action was taken and shall be informal and not constitute a hearing, as that term is used in these Bylaws and none of the procedural rights under Article VII of these Bylaws shall apply. The MEC may thereafter continue, modify, or terminate the terms of the summary action. It shall give the Practitioner written Special Notice of its decision, which shall include the information specified in

Section 7.3 of these Bylaws, if the action is adverse.

6.11 Procedural Rights

Unless the MEC terminates the summary action, it shall remain in effect during the completion of the corrective action and hearing and appellate review process. When a summary action is continued, the affected Practitioner shall be entitled to the procedural rights set forth in Article VII these Bylaws, but the hearing may be consolidated with the hearing on any corrective action that is recommended so long as the hearing commences within two (2) months after the hearing on the summary action was requested.

6.12 Initiation by the Governing Body

- A. If no one authorized under Section 6.9 of these Bylaws is available to take a summary action to summarily restrict or suspend a member's membership or Privileges, the Governing Body (or its designee) may immediately suspend or restrict a member's Privileges if failure to do so may result in imminent danger to the health of any individual, provided that the Governing Body (or its designee) has made reasonable attempts to contact the Chief of Staff and the MEC, and the Chief of the Service to which the member is assigned before acting.
- B. Such summary action is subject to ratification by the MEC. If the MEC does not ratify such summary action within two (2) working days of its imposition, excluding weekends and holidays, the summary action shall terminate automatically.

6.13 Licensure

Automatic suspension or termination of Privileges or memberships may occur:

- A. Whenever a member's license or other legal credential authorizing practice in this state is revoked, suspended, or expires. Medical Staff membership and

Privileges shall be automatically suspended as of the date such action becomes effective.

- B. Whenever a member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority. Any Privileges which are within the scope of such limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
- C. Whenever a member is placed on probation by the applicable licensing or certifying authority, his/her membership status and Privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

6.14 DEA Certificate

- A. Whenever a member's DEA certificate is revoked, limited, or suspended, or expires, the member shall automatically and correspondingly be divested of the right to prescribe or supervise prescription of medications covered by the certificate as of the date such action becomes effective throughout its term.
- B. Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation as of the date such action becomes effective and throughout its term.

6.15 Medical Records

Medical Staff members are required to complete medical records within the time prescribed by the MEC. Failure to timely complete medical records shall result in an

automatic suspension after notice is given. Such suspension shall apply to the Medical Staff member's right to admit, treat, or provide services to new patients in the Hospital, but shall not affect the right to continue to care for a patient the Medical Staff member has already admitted or is treating. The suspension shall continue until the medical records are completed.

6.16 Procedural Rights

Practitioners, whose Privileges are automatically suspended and/or who have been deemed to have automatically resigned his/her Medical Staff membership shall be entitled to the procedural rights set forth in Article VII of these Bylaws only if the suspension is reportable pursuant to California Business and Professions Code Section 805.

6.17 Notice of Automatic Suspension and Transfer of Patients

Special Notice of an automatic suspension shall be given to the suspended individual, and Notice of the suspension shall be given to the appropriate Chief of Service, MEC, Executive Administrator, and Governing Body, but such notices shall not be required for the suspension to become effective. Patients affected by an automatic suspension shall be assigned to another member of the Clinical Service Chief or Chief of Staff.

6.18 Automatic Termination

If a Practitioner is suspended for more than six (6) months, his/her membership (or the affected Privileges, if the suspension is a partial suspension) shall be automatically terminated. Thereafter, reinstatement to the Medical Staff shall require application and compliance with the appointment procedures applicable to initial applicants.

ARTICLE VII: HEARINGS AND APPELLATE REVIEWS

7.1 General Provisions

Except as otherwise provided in these Bylaws, the following definitions shall apply under this Article.

- A. "Body Whose Decision Prompted the Hearing" refers to the MEC in all cases when the MEC or authorized Medical Staff officers, members or committees took the action or rendered the decision which resulted in a hearing being requested. It refers to the Governing Body in all cases where the Governing Body or its authorized officers, directors or committees took the action or rendered the decision, which resulted in a hearing being requested.
- B. "Petitioner" as used in this Article, refers to the Practitioner who has requested a hearing pursuant to Section 7.3-2 of these Bylaws.
- C. Technical, insignificant or non-prejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken.
- D. If an adverse action described in Section 7.2 of these Bylaws is taken or recommended, the Petitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action.

7.2 Grounds for Hearing

Except as otherwise specified in these Bylaws, any one or more of the following actions or recommended actions shall be deemed an actual or potential adverse action and constitute grounds for a hearing:

- A. Denial of Medical Staff appointment, reappointment, granting of initial Clinical Privileges, of renewed/revised Clinical Privileges.
- B. Revocation, suspension, restriction, involuntary reduction of Medical Staff membership and/or Privileges.
- C. Involuntary imposition of significant consultation or proctoring.
- D. Any other corrective action or recommendation that must be reported pursuant to Business and Professions Code Section 805.

Removal from a position as Chief of a Clinical Services or as an Officer of the Medical Staff, or termination from the Medical Staff following the two (2) years of inactive status, or termination from the Medical Staff following a resignation or lay off from employment with the University or the City and County of San Francisco shall not constitute grounds for a hearing.

7.3 Requests for Hearing

7.3-1 Notice of Action for Proposed Action

The Petitioner shall be notified by Special Notice of any recommendations or action which would constitute grounds for a hearing. The notice shall inform Petitioner:

- A. What action has been proposed against the Petitioner;
- B. Whether the action, if finally adopted, will be reported under Business and Professions Code Section 805 and to the National Practitioner Data Bank;
- C. The reasons for the action or proposed action;
- D. That the Petitioner may request a hearing;

- E. That hearing must be requested within one (1) month; and
- F. That the Petitioner has the hearing rights described in the Medical Staff Bylaws.

7.3-2 Request for Hearing

The Petitioner shall have one (1) month following receipt of notice of such action or proposed action to request a hearing. The request shall be in writing, addressed to the Chief of Staff with a copy to the Executive Administrator. If the Petitioner does not request a hearing within the time and manner described, the Petitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. Such final recommendation shall be considered by the Governing Body, within seventy (70) days and shall be given great weight by the Governing Body, although it is not binding on the Governing Body.

7.3-3 Hearings Prompted by Governing Body Action

If the hearing is based upon an adverse action by the Governing Body, the Chair of the Governing Body shall fulfill the functions assigned in this Section to the Chief of Staff.

7.3-4 Time and Place for Hearing

Upon receipt of a timely request for a hearing made by the Petitioner, the Chief of Staff shall notify the Executive Administrator and the MEC, appoint a Judicial Review Committee, and shall schedule and arrange for a hearing before the Judicial Review Committee. The Chief of Staff shall give Special Notice of the hearing within one (1) month after receipt of a request for it. The notice shall state the time, place, and date of the hearing. The date of the commencement of the hearing shall be not less than one (1) month or more than two (2) months from the date the Chief of Staff received the hearing request.

7.3-5 Notice of Charges

As part of, or together with, the notice of place, time and date of the hearing, the Chief of Staff shall state in writing the reasons for the final proposed action taken or recommended, the acts or omissions with which the Petitioner is charged, and a list of the charts in question, when applicable. The Petitioner shall be provided with a summary of the rights to which he/she is entitled at the hearing. A supplemental notice of charges may be issued at any time, provided the Petitioner is given sufficient time to prepare.

7.3-6 Judicial Review Committee

The Chief of Staff shall appoint, a Judicial Review Committee composed of not less than three (3) unbiased members of the Active Medical Staff who shall gain no direct financial benefit from the outcome and who have not acted as accuser, investigator, fact finder, initial decision-maker, or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. The Chief of Staff will appoint one of these members to serve as Chair. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Judicial Review Committee. Such appointment shall include designation of a Chair. In the event it is not possible to appoint all Judicial Review Committee members from the Active Medical Staff, the Chief of Staff may appoint a member or members from other Staff categories or Practitioners, who are not members of the Medical Staff. When feasible, the Judicial Review Committee shall include at least one (1) member who has the same healing arts licensure as the Petitioner and who practices in the same specialty as a Petitioner. The Chief of Staff may appoint alternates who meet the standards described above and who can serve if a Judicial Review Committee member becomes unavailable.

7.4 The Hearing Procedure

7.4-1 The Hearing Officer

The Chief of Staff shall appoint a Hearing Officer to preside at the hearing. The Hearing Officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, but an attorney regularly utilized by the Hospital for legal advice regarding its affairs and activities shall not be eligible to serve as Hearing Officer. The Hearing Officer shall not be biased for or against any party, shall gain no direct financial benefit from the outcome, and must not act as a prosecuting officer or as an advocate. The Hearing Officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have authority and discretion to make all rulings on questions which pertain to matters of law, procedure, or the admissibility of evidence that are raised prior to, during or after the hearing, including deciding when evidence may not be introduced, granting continuances, ruling on disputed discovery requests, and ruling on challenges to Judicial Review Committee members or himself or herself serving as the Hearing Officer. If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as seems warranted by the circumstances. The Hearing Officer should participate in the deliberations of the Judicial Review Committee and be a legal advisor to it, but the Hearing Officer shall not be entitled to vote.

7.4-2 Representation

- A. The Petitioner shall, upon request to, and approval by, the Judicial Review Committee, be entitled, at his/her own expense, to be represented by an attorney at law, or by a Physician licensed to practice in the State of California, at such hearing. If the Petitioner is represented by legal counsel, the MEC may also be represented by legal counsel. The MEC shall not be represented by legal counsel if the Petitioner is not so represented. The Judicial Review Committee shall determine the role of legal counsel and may eject any such counsel, whose activities at the hearing are, in the judgment of the Presiding Officer, disruptive to the proper conduct of the hearing proceedings. The Body Whose Decision Prompted the Hearing shall appoint a representative from the Medical Staff to present the recommendation and evidence in support thereof in to examine witnesses.
- B. The Petitioner shall state, in writing, his/her intentions with respect to attorney representation at the time he/she file the request for a hearing. Notwithstanding the foregoing and regardless of whether the Petitioner elects to have attorney representation at the hearing, the parties shall have the right to consult with legal counsel to prepare for a hearing or an appellate review.
- C. Any time attorneys will be allowed to represent the parties at a hearing, the Hearing Officer shall have the discretion to limit the attorneys' role to advising his/her clients, rather than presenting the case.

7.4-3 Postponements and Extensions

Postponements and extensions of the time beyond those expressly permitted in these Bylaws may be requested by anyone but shall be granted upon agreement of the parties or by the Hearing Officer on a showing of good cause.

7.4-4 Failure to Appear or Proceed

Failure without good cause of the Petitioner to personally attend and proceed at a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved and such actions shall be taken immediately.

7.4-5 Discovery

A. Rights of Inspection and Copying

The Petitioner may inspect and copying (at his/her own expense) any documentary information relevant to the charges that the Body Whose Decision Prompted the Hearing has in its possession or under its control. The Body Whose Decision Prompted the Hearing may inspect and copy (at its expense) any documentary information relevant to the charges that the Petitioner has in his/her possession or under his/her control. The request for discovery shall be fulfilled as soon as practicable. Failure to comply with reasonable discovery requests a least one (1) month prior to the hearing shall be good cause for a continuance of the hearing.

B. Limits on Discovery

The Hearing Officer shall rule on discovery disputes the parties cannot resolve. Discovery may be denied when justified to protect peer review or in the interest

of fairness and equity. Further, the right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable Practitioners other than the Petitioner nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information.

C. Ruling on Discovery Disputes

In ruling on discovery disputes, and factors that may be considered include:

- (1) Whether the information sought may be introduced to support or defend the charges;
- (2) Whether the information is exculpatory or inculpatory in nature;
- (3) The burden on the party in possession of producing the requested information; and.
- (4) What other discovery requests the party has previously submitted resisted.

7.4-6 Objections to Introduction of Evidence Previously Not Produced for the Medical Staff

The Body Whose Decision Prompted the Hearing may object to the introduction of evidence that was not provided during an appointment or initial privilege application review despite the requests of the Medical Staff for such information. The information will be barred from the hearing by the Hearing Officer unless the Petitioner can prove he/she previously acted diligent and could not have submitted the information.

7.4-7 Pre-Hearing Document Exchange

At the request of either party, the parties shall exchange copies of all documents that will be introduced at the hearing. The documents must be exchanged at least ten (10) days before commencement of the hearing. A failure to do so is good cause for a continuance.

7.4-8 Witness Lists

At the request of either party, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that party at the hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as he/she becomes aware of the possible participation of such additional witnesses. The failure to have provided the name of any witness at least ten (10) days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

7.4-9 Procedural Disputes

- A. It shall be the duty of the parties to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.
- B. The parties shall be entitled to file motions as deemed necessary to give full effect to rights established by the Bylaws and to resolve such procedural matters as the Hearing Officer determines may properly be resolved outside the presence of the Judicial Review Committee. Such motions shall be in writing and shall specifically state the motion, all relevant factual information, and any supporting authority for the motion. The moving party shall deliver a copy of the motion to the opposing party, who shall have five (5) working days to submit a written response to the Hearing Officer, with a copy to the moving party. The Hearing Officer shall determine whether to allow oral argument on any such motions.

The Hearing Officer's ruling shall be in writing and shall be provided to the parties promptly upon its rendering. All motions, responses and rulings thereon shall be entered into the hearing record by the Hearing Officer.

7.4-10 Record of Hearing

A shorthand reporter shall be present to make a record of the hearing proceedings. The cost of a shorthand reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. The Hearing Officer may, but shall not be required to, order that oral evidence shall be taken on oath or affirmation.

7.4-11 Rights of the Parties

Within reasonable limitations, the Petitioner may ask the Judicial Review Committee members and Hearing Officer questions which are directly related to evaluating his/her qualifications to serve and for challenging such members or the Hearing Officer. Both sides may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, receive all information made available to the Judicial Review Committee, and to submit a written statement at the close of the hearing, as long as these rights are exercised in an efficient and expeditious manner. The Petitioner may be called by the Body Whose Decision Prompted the Hearing or the Judicial Review Committee and examined as if under cross-examination. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

7.4-12 Rules of Evidence

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing

conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

7.4-13 Burdens of Presenting Evidence and Proof

- A. At the hearing, the Body Whose Decision Prompted the Hearing shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The Petitioner shall be obligated to present evidence in response.
- B. An initial applicant for membership and/or Privileges shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that he/she is qualified for membership and/or the denied Privileges. The Petitioner must produce information which allows for adequate evaluation and resolution of reasonable doubts concerning his/her current qualifications for membership and Privileges.
- C. Except as provided above for initial applicants for membership and/or Privileges, throughout the hearing, the Body Whose Decision Prompted the Hearing shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, and its action or recommendation is reasonable and warranted.

7.4-14 Adjournment and Conclusion

The hearing officer may adjourn the hearing and reconvene the same at the convenience of the participants without Special Notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Judicial Review Committee shall

thereupon, outside of the presence of any person, conduct its deliberations and render a decision and accompanying report.

7.4-15 Basis for Decision

The decision of the Judicial Review Committee shall be based on the evidence and written statements introduced at the hearing, including all logical and reasonable inferences from the evidence and testimony.

7.4-16 Decision of the Judicial Review Committee

Within one (1) month after final adjournment of the hearing, the Judicial Review Committee shall render a written decision. If the Petitioner is currently under suspension, however, the time for the decision and report shall be fifteen (15) days after final adjournment. Final adjournment shall be when the Judicial Review Committee has concluded its deliberations. A copy of the decision shall be forwarded to the Executive Administrator, the MEC, the Governing Body, and to the Petitioner. The report shall contain the Judicial Review Committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Both the Petitioner and the Body Whose Decision Prompted the Hearing shall be provided a written explanation of the procedure for appealing the decision. The decision of the Judicial Review Committee shall be considered final, subject only to such rights of appeal or Governing Body review as described in these Bylaws.

7.5 Appeal

7.5-1 Time for Appeal

Within one (1) month after receipt of the decision of the Judicial Review Committee, either the Petitioner or the Body Whose Decision Prompted the Hearing may request an appellate review of the Governing Body. Said request shall be delivered to the Chief of

Staff in writing, in person or by certified mail and shall include a brief statement as to the reasons for appeal. If such appellate review is not requested within such period, both sides shall be deemed to have accepted the action involved and it shall thereupon become, pending ratification by the Governing Body, final and shall be effective immediately.

7.5-2 Grounds for Appeal

On appeal, the Governing Body may exercise its independent judgment in determining: (1) whether there was substantial failure of the Judicial Review Committee to comply with the procedures required by these Bylaws so as to deny fair hearing, (2) whether the decision is reasonable and warranted, (3) and whether any bylaw, rule, or policy relied on by the Judicial Review Committee is unreasonable and unwarranted.

7.5-3 Time, Place, and Notice

In the event of an appeal to the Governing Body, the Governing Body shall within one (1) month after receipt of such notice of appeal, schedule and arrange for an appellate review. The Governing Body shall cause the applicant or member to be given notice of the time, place and date of the appellate review. The date of appellate review shall not be less than one (1) month, nor more than two (2) months from the Date of Receipt of the request for appellate review; however, when a request for appellate review comes from a member who is under suspension, the review shall be held as soon as agreements may reasonably be made, but not to exceed ten (10) days from the Date of Receipt of the request. The time for appellate review may be extended by the Chair of the Governing Body for good cause.

7.5-4 Nature of Appellate Review

The proceedings by the Governing Body shall be in the nature of an appellate hearing

based upon the record of the hearing before the Judicial Review Committee, provided that the Governing Body may, at its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Judicial Review Committee hearing. Each party shall have the right to present a written statement in support of his/her position on appeal, to personally appear and make oral argument, and the right to be represented by an attorney. At the conclusion of oral argument, if allowed, the Governing Body may thereupon, at a time convenient to itself, conduct deliberations outside the presence of the appellate and respondent and his/her representatives. The Governing Body may affirm, modify or reverse the decision of the Judicial Review Committee or, at its discretion, refer the matter for further review and recommendation.

7.5-5 Final Decision

Within one (1) month after the conclusion of the proceedings before the Governing Body, the Governing Body shall render a final decision in writing and shall deliver copies thereof to the applicant or member of the Medical Staff and to the Chief of Staff, in person or by certified mail.

7.5-6 Further Review

Except when the matter is referred for further review and recommendation in accordance with Section 7.26-D of these Bylaws (Nature of Appellate Review), the final decision of the Governing Body following the appeal procedures set forth in these Bylaws shall be effective immediately and shall not be subject to further review. If the matter is referred back to the Judicial Review Committee for further review and recommendation, said Committee shall promptly conduct its review and make its recommendations to the Governing Body. This further review process and the report back to the Governing Body shall in no event exceed one (1) month except as the parties may otherwise stipulate.

7.5-7 Right to One Hearing Only

Except as otherwise provided in these Bylaws, no applicant or member shall be entitled as a matter of right to more than one (1) evidentiary hearing and one (1) appellate review on any single matter which may be the subject of an adverse recommendation or action.

7.6 Exceptions to Hearing Rights

7.6-1 Exclusive Use Departments

The procedural rights of these Bylaws do not apply to a Practitioner whose application for Medical Staff membership and Privileges was denied or whose Privileges were terminated on the basis the Privileges he/she seeks are granted only pursuant to an exclusive use policy. Such Practitioners shall have the right, however, to request that the Governing Body review the denial and the Governing Body shall have the discretion to determine whether to review such a request and, if it decides to review the request, to determine whether the Practitioner may personally appear before and/or submit a statement in support of his/her position to the Governing Body.

7.6-2 Hospital Contract Practitioners

The procedural rights of these Bylaws do not apply to Practitioners who have contracted with the Hospital to provide clinical services. Removal of these Practitioners from office and of any exclusive Privileges (but not his/her Medical Staff membership) shall instead be governed by the terms of his/her individual contracts and agreements with the Hospital. The procedural rights of this Article VI and VII of these Bylaws shall apply if an action is taken which must be reported pursuant to Business and Professions Code Section 805 and/or Practitioner's Medical Staff membership status or Privileges which are independent of the Practitioner's contract are removed or suspended.

7.6-3 Affiliated Professionals, House Staff, Medical Students and Trainees

Affiliated Professionals, House Staff, Medical Students and Trainees are not entitled to the procedural rights set forth in these Bylaws.

7.6-4 Denial of Applications for Failure to Meet the Minimum Qualifications

Practitioners shall not be entitled to the procedural rights of these Bylaws if his/her membership, Privileges, applications or requests are denied because of his/her failure to have a current California license to practice medicine, dentistry, clinical psychology or podiatry; to maintain an unrestricted Drug Enforcement Administration certificate (when it is required under these Bylaws); to maintain professional liability insurance (as required by the Bylaws); or to meet any of the other basic standards specified in Article II of the Bylaws, or to file a complete application.

7.6-5 Automatic Suspension or Limitation of Privileges

A member shall not be entitled to any procedural rights when the member's license or legal credential to practice has been revoked or suspended as set forth in Article VI of these Bylaws. In other cases described in Article VI of these Bylaws, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority or the DEA was unwarranted, but only whether the member may continue to practice in the Hospital with those limitations imposed. Practitioners whose Privileges are automatically suspended and/or who have resigned his/her Medical Staff membership for failing to complete medical records or for failing to maintain malpractice insurance are not entitled under these Bylaws to any procedural rights, except when a suspension for failure to complete

medical records will exceed one (1) month in any twelve (12) month period and it must be reported pursuant to California Business and Professions Code Section 805.

ARTICLE VIII: STRUCTURE OF THE MEDICAL STAFF

8.1 Medical Staff Year

The Medical Staff Year is July 1 through June 30.

8.2 Officers of the Medical Staff

The officers of the Medical Staff shall be the Chief of Staff, Chief of Staff-Elect and Chief of Staff-Past.

8.2-1 Qualifications of Officers

Officers shall be members of the Active Medical Staff at the time of nomination and election and must remain members in good standing during his/her term of office.

8.2-2 Election of Chief of Staff-Elect

The Chief of Staff-Elect of the MEC shall be elected at the Annual Meeting of the Medical Staff in alternate years, for a one (1) year term, unless a vacancy as described in this Article indicates a need to have an additional election to fill positions.

The Nominating Committee shall present a candidate to the voting Active Staff members in attendance at the Annual Meeting of the Medical Staff. Other nominations may be taken from the floor, with the approval of the nominee, prior to the meeting.

If floor nominations are made, a hand vote will be taken to elect the Chief of Staff-Elect.

A simple majority of the Active Medical Staff members attending the meeting shall determine the election. If no floor nominations are made, a vote of acclamation will be requested by the presiding Chief of Staff.

8.2-3 Term of Office

The Chief of Staff shall serve a two (2) year term of office. The Chief of Staff-Elect shall serve a one (1) year term from the beginning of the Medical Staff year and assume the responsibilities of the Chief of Staff at the end of that term. Upon completion of the two (2) year term as the Chief of Staff, he/she shall serve one (1) year as Chief of Staff-Past and be available to serve as Acting Chief of Staff in the first year of the Chief of Staff's two-year term. The Chief of Staff-Elect will be available to serve as Acting Chief of Staff in the second year of the Chief of Staff's two-year term.

8.2-4 Vacancies in Office

If the position of the Chief of Staff becomes vacant during the first year of the two (2) year term, the Chief of Staff-Past shall assume all designated responsibilities through the end of that academic year. If the Chief of Staff-Past is unable to serve, the MEC will appoint an Acting Chief of Staff who will serve until the next Annual Meeting of the Medical Staff. If the vacancy occurs in the second year of the Chief of Staff's elected term, the Chief of Staff-Elect will assume the duties of the office to complete the term and then fill the Chief of Staff's position for the elected full two (2) year term.

In the event of the temporary absence of the Chief of Staff, the Chief of Staff-Elect and the Chief of Staff-Past, the Chief of Staff shall designate an acting Chief of Staff who shall chair the MEC during the absence.

8.2-5 Duties of Officers

A. Chief of Staff

The Chief of Staff Shall:

- (1) Serve as Chief of the Medical Staff;
- (2) Represent the views, policies (including strategic planning and budget

considerations), needs and grievances of the Medical Staff and MEC to the Governing Body, to the Executive Administrator, and to the Associate Dean;

- (3) Receive and interpret to the Medical Staff the policies of the Governing Body;
- (4) Report to the Governing Body of the performance and maintenance of quality with respect to the Medical Staff's delegated responsibilities to provide medical care;
- (5) Be the spokesperson for the Medical Staff and the MEC in its external professional and public relations;
- (6) Present the minutes to the MEC;
- (7) Appoint committee Chairs and approve members to all Medical Staff committees except the MEC;
- (8) Call, preside at, and be responsible for the agenda of all regular and special meetings of the MEC and of the Medical Staff;
- (9) Be responsible for the enforcement of Medical Staff Bylaws, and for implementation of suspension of Clinical Privileges as provided for in these Bylaws;
- (10) Serve as a member of the Joint Conference Committee;
- (11) Serve as a member of the Credentials Committee if neither the Chief of Staff-Past nor Chief of Staff-Elect are members of the committee;
- (12) Report at the Annual Meeting of the Medical Staff;

(13) Serve as an ex-officio member of all other Medical Staff Committees, except Judicial Review Committees.

B. Chief of Staff-Elect

The Chief of Staff-Elect shall perform duties as assigned by the Chief of Staff and, in the absence of the Chief of Staff, shall assume all the duties as assigned and have the authority of the Chief of Staff. The Chief of Staff-Elect shall assume the office of Chief of Staff at the end of the current Chief of Staff's term. The Chief of Staff-Elect shall serve as Chair of the Bylaws Committee and be a member of the Credentials Committee the year prior to assuming the position of Chief of Staff if the officers of the Medical Staff are not represented. The Chief of Staff-Elect shall also serve on the MEC and Joint Conference Committee.

C. Chief of Staff-Past

The Chief of Staff-Past shall perform duties as assigned by the Chief of Staff and shall assume all the duties as assigned and have the authority of the Chief of Staff in the absence of both the Chief of Staff and the Chief of Staff-Elect. The Chief of Staff-Past shall chair the Nominating Committee of the Medical Staff. The Chief of Staff-Past shall also serve on the MEC, Joint Conference Committee and the Credentials Committee if the officers of the Medical Staff are not represented.

8.2-6 Removal of Officers

A Medical Staff Officer may be removed from office for any valid cause, including, but not limited to, failure to carry out the duties of the office, gross neglect or misfeasance in office, or serious acts of moral turpitude. Except as otherwise provided in these Bylaws, removal of Medical Staff officers may be initiated by the MEC or upon the written

request of twenty percent (20%) of the Active Medical Staff. Such removal may be effected by majority vote of the MEC members or by a two-thirds vote of the Active Medical Staff. Voting on removal of an elected office shall be by secret written ballot.

ARTICLE IX: CLINICAL SERVICES

9.1 Organization of Clinical Services

9.1-1 Overall Supervision

Each Clinical Service shall have a Chief who shall be responsible for the overall supervision of the clinical work, teaching, and research within that Clinical Service.

Each Clinical Service may be organized into subsections.

9.1-2 Clinical Services

The Clinical Services are as follows:

- Anatomic Pathology
- Anesthesiology and Peri-Operative Care
- Community Primary Care
- Dentistry/Oral & Maxillofacial Surgery
- Dermatology
- Emergency Services
- Family and Community Medicine
- Laboratory Medicine
- Medicine
- Neurology
- Neurosurgery
- Obstetrics-Gynecology
- Ophthalmology

Orthopedic Surgery
Otolaryngology and Head & Neck Surgery
Pediatrics
Psychiatry
Radiology and Nuclear Medicine
Surgery
Urology

9.2 Qualifications, Selection and Tenure of Chiefs of Clinical Services

9.2-1 Qualifications

- A. All Chiefs shall be board certified or re-certified in the respective specialty. The Chief of the Community Primary Care Service (CPC) shall be board certified or re-certified in a primary care specialty.
- B. Chiefs shall have a University faculty appointment.
- C. Chiefs may be the Chair or Vice Chair of his/her respective University department.
- D. Chiefs shall be members of the Active Medical Staff and Clinical Privileges shall be determined as set forth in Article IV of these Bylaws.

9.2-2 Selection of a Chief

- A. The Chief of Staff, in consultation with the Associate Dean, UCSF Department Chair and Executive Administrator, shall appoint an ad hoc search committee within one (1) month of notification of a position becoming vacant. The search committee shall be chaired by a member of the Active Medical Staff and shall be composed of members of the Active Medical Staff, University faculty, the Associate Dean, or designee, and the Hospital Executive Administrator, or

designee.

- B. The Chief of Staff shall consult with the Director of Health or designee, and the Executive Administrator in appointing the ad hoc search committee for the selection of the Chief of the CPC. The search committee for the CPC Chief shall be chaired by a member of the Active Medical Staff and shall include members of the Active Medical Staff, members of the CPC affiliated staff, the Director of Health or designee, and the Executive Administrator or designee.
- C. The ad hoc search committee shall provide a progress report on his/her deliberations to the Chief of Staff.
- D. The recommendations of the search committee shall be made to the Chief of Staff who shall, with the approval of the UCSF Department Chair in consultation with the Associate Dean, nominate the Chief of Clinical Service. The recommendations of the search committee for the Chief of the CPC shall be made to the Chief of Staff who shall, with the approval of the Director of Health in consultation with the Associate Dean, nominate the Chief of the CPC.
- E. The nomination shall be acted upon by the MEC. Ratification of the nomination shall be accomplished by a two-thirds vote, and shall be forwarded to the Governing Body for approval.
- F. Upon approval of the Governing Body and acceptance of the position by the nominee, the nominee shall assume the office of Chief of the Clinical Service.
- G. If the MEC or Governing Body disapprove the nomination, the Chief of Staff shall reconstitute an ad hoc search committee.

9.2-3 Review

- A. Chiefs of Clinical Services shall be reviewed not less than every four (4) years and continued service as Chief is contingent upon the results of this review.
- B. Reappointment of the Chief shall follow a review by a committee appointed by the Chief of Staff and shall occur upon recommendation of the Chief of Staff, in consultation with the Associate Dean, the UCSF Department Chair, and the Executive Administrator, upon approval of the MEC and the Governing Body. Reappointment of the Chief of the CPC shall occur upon recommendations of the Chief of Staff, in consultation with the Director of DPH and the Executive Administrator. The reappointment review committee shall include members of the clinical service, as well as other members of the Medical Staff, the Associate Dean and the Executive Administrator. Input from Nursing Staff and House Staff shall be sought.

9.2-4 Removal

- A. Request for removal of a Chief may be initiated by:
 - (1) A two-thirds vote of all Active Medical Staff members of the Clinical Service; or,
 - (2) The associate Dean, UCSF Department Chair, Chief of Staff; or,
 - (3) The Executive Administrator, in consultation with the Associate Dean; or,
 - (4) By two-thirds vote of the MEC.
- B. When a request for removal has been initiated, a Review Committee shall be appointed by the Chief of Staff in consultation with the Associate Dean, UCSF Department Chair, and the Executive Administrator. The findings of the Review

Committee shall be acted upon by the MEC.

- C. If the MEC recommends removal by a two-thirds vote, the recommendation shall be forwarded to the Governing Body for approval.

9.2-5 Vacancy

- A. When a Chief of Clinical Service is temporarily absent from the position for more than one (1) month, prompt notification shall be made to the Chief of Staff. Upon receipt of such notice, appointment of an Acting Chief for a Clinical Service shall be made by the Chief of Staff in consultation with the permanent Chief of Clinical Service.

- B. If the Chief of a Clinical Service resigns or intends to resign, the Chief of Staff will appoint the Acting Chief after consultation with the outgoing Clinical Service Chief, if appropriate, the Executive Administrator and the Associate Dean within one (1) month of the vacancy of the position. In the case of the CPC, consultation will be made with the Director of Health and lieu of the Associate Dean.

(1) Appointment for ninety (90) days or less will be effective upon approval of the Chief of Staff.

(2) Appointment for more than ninety (90) days shall require the approval of the MEC, the Associate Dean and the Governing Body.

9.3 Functions of Chiefs of Clinical Services

Each Chief shall:

9.3-1 Credentialing/privileging

- A. Recommend criteria for clinical privileges in the Clinical Service;

- B. Recommend sufficient number of qualified and competent individuals to provide care/clinical services;
- C. Make a report to the Credentials Committee concerning the appointment, reappointment, and delineation of clinical privileges for all applicants seeking privileges in the Clinical Service;
- D. Make recommendations to the Credentials Committee regarding the qualifications and competence of Clinical Service personnel who are affiliated professional staff;
- E. Assist the Hospital, in accordance with the provisions of these Bylaws, with respect to the granting and with the evaluation of requests for temporary privileges;
- F. Be responsible for the evaluation of all new appointees and report thereon to the Credentials Committee.

9.3-2 Performance Improvement

- A. Continuously monitor and evaluate the quality and appropriateness of patient care provided within the clinical service;
 - (1) Recommended for approval by the Credentials Committee and MEC the criteria to be used in conduct of Ongoing Professional Practice Evaluation (OPPE) and conduct OPPE for each member of the Clinical Service at least every six (6) months.
 - (2) Monitor and evaluate the quality and appropriateness of patient care provided by the attending staff;

- (3) Monitor and evaluate the quality and appropriateness of House Staff supervision by attending staff;
 - (4) Monitor and evaluate the quality and appropriateness of patient care provided by House Staff.
- B. Continuously monitor the professional performance of all individuals who have delineated clinical privileges and affiliated professionals in the Clinical Service, and report thereon to the Credentials Committee as part of the reappointment process and at such other times as may be indicated;
- C. Hold regular Performance Improvement Conferences no less than quarterly, to present and discuss specific patient cases and best practices;
- D. Appoint ad hoc committees and working groups as necessary to carry out quality improvement activities;
- E. Conduct a focus review of any individual with privileges in the Clinical Service if there is a reasonable basis to be concerned that the individual's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics or other matters might directly or indirectly affect patient care.
 - (1) The focus review shall consider the individual's overall performance as well as specific cases. Comparison with historical, departmental and external benchmarks may be considered.
 - (2) A peer review panel may be appointed to conduct a focus review.
 - (3) Recommendations from a focus review may be used as the basis for

continued routine monitoring and education or for pursuing formal corrective action.

9.3-3 Education and Research

- A. Be accountable to the Associate Dean and the UCSF Department Chairs for the conduct of graduate and undergraduate medical education and UCSF based research programs conducted in his/her Clinical Service;
- B. Be responsible for the establishment, implementation and effectiveness of the orientation, and supervision of the teaching, education and research programs in the Clinical Service.

9.3-4 Administration

- A. Designate an acting chief when absence of a chief will occur for duration of greater than twenty (24) hours but less than one (1) month. After one (1) month, the process described in Section 9.2-5 will be followed;
- B. Be responsible and accountable to the Governing Body through the MEC for all clinically and administratively related activities within the Clinical Service;
- C. Be a member of MEC, regularly attend the MEC meetings or send a designee when unable to attend, and regularly disseminate decisions made and issues discussed at MEC meetings to the members of the Clinic Service;
- D. Be responsible for the integration of the Clinical Services into the primary functions of the organization;
- E. Be responsible for the coordination and integration of interdepartmental and intradepartmental services;

- F. Review and update the Clinical Service Rules and Regulations at least every two years:
- G. Be responsible for the enforcement of the Medical Staff Bylaws and Rules and Regulations and the Hospital's policies and procedures within the respective Clinical Service;
- H. Ensure adequate input from his/her Clinical Service and Medical Staff committee meetings through attendance by service members;
- I. Be responsible for the orientation of new members and enforcement of the Medical Staff Bylaws and Rules and Regulations in the hospital's policies and procedures within the respective Clinical Service;
- J. Be responsible implementation within the Clinical Service of actions taken by the Governing Body and the MEC;
- K. Participate in the administration of his/her Clinical Service through cooperation with the Nursing Service, Hospital Administration and all personnel involved in matters affecting patient care;
- L. Report and recommend to hospital management when necessary with respect to matters affecting patient care in the Clinical Service, including personnel, space and other resources, supplies, special regulations, standing orders and techniques;
- M. Be responsible for the process of assessing and recommending off-site sources providing patient care services not available at the Hospital.
- N. Assists in the preparation of annual records including budgetary planning, pertaining to the Clinical Service as may be required by the Chief of Staff, the

MEC, the Associate Dean, Executive Administrator, or the Governing Body;

- O. Delegate to a vice chief or other Active Staff member of the Clinical Service such duties as appropriate;
- P. Establish divisions, sections or services within the Clinical Service and appoint Chiefs thereof, subject to the approval of the MEC and the Governing Body;
- Q. Develop and implement policies and procedures that guide and support the provisions of services; and
- R. Maintain quality control programs, as appropriate.
- S. Make a presentation to the MEC at least every two (2) years on the activities of the Clinical Service following a template provided by the Chief of Staff.

9.4 Functions of Clinical Services

- A. Each Clinical Service shall establish written criteria consistent with the policies of the MEC for the granting of Clinical Privileges.
- B. Each Clinical Service shall be responsible for maintaining and supervising a high quality education and training program for graduate and undergraduate education in the health sciences.
- C. Each Clinical Service shall be responsible for the supervision of House Staff and the House Staff training programs.
- D. The Chief of the CPC shall collaborate with the appropriate Chief of Clinical Service and the Associate Dean to maintain and supervise high quality training experiences within the CPC clinical sites for graduate and undergraduate students

in the health sciences.

- E. Each Clinical Service shall develop criteria under which consultation will be required; these shall not preclude a requirement for consultation when the Chief of Clinical Service determines that a patient would benefit from such consultation.
- F. Each Clinical Service shall meet as frequently as necessary but at least quarterly to consider findings from the ongoing monitoring and evaluation of quality and appropriateness of the care and treatment provided to patients. Minutes shall be forwarded to the Medical Staff Services Department. Written summaries and recommendations of any and all new policies or changes in policies shall be submitted to the Medical Executive Committee for its approval.

9.5 Assignment to Clinical Service

The MEC shall, after consideration of recommendations of the Clinical Services as transmitted through the Credentials Committee, recommend initial Clinical Service assignments for all Practitioners with Clinical Privileges. All Medical Staff members shall be assigned to at least one Clinical Service and be granted clinical privileges that are relevant to the care provided in that Clinical Service. The exercise of clinical privileges within any Clinical Service shall be subject to the Medical Staff Bylaws and Rules and Regulations of that Clinical Service and to the authority of the Chief of the Clinical Service.

ARTICLE X: COMMITTEES OF THE MEDICAL STAFF

10.1 Designation

Standing committees, subcommittees and ad hoc committees of the Medical Staff

described in these Bylaws and in the Committee Manual, are created for, and meet the purpose of evaluation and improvement of the quality of care rendered in the Hospital.

Medical Staff functions covered by appropriate committees included, but are not limited to, executive review, credentialing, medical records, tissue review, utilization review, infection control, pharmacy and therapeutics, and assisting the Medical Staff members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services.

10.2 General Provisions

10.2-1 Ad Hoc Committees

As the need arises, the Chief of Staff, with the advice and counsel of the MEC, may appoint ad hoc committees to deal with specific problems including the evaluation and improvement of the quality of care rendered in the Hospital. These ad hoc committees shall keep permanent records of its proceedings and activities and shall render a report of its activities to the MEC.

10.2-2 Parliamentary Procedure

All meetings of all committees and subcommittees of the Medical Staff shall be conducted following Roberts Rules of Order.

10.2-3 Scheduling

Medical Staff committees shall hold regular meetings as specified in these Bylaws, the meeting schedule of which shall be reviewed and/or revised by the Chair at the beginning of each academic year. The members shall be advised in writing, at least one (1) week in advance of scheduled meetings, of any necessary changes to the established meeting schedule. If no meeting schedule is otherwise described in these Bylaws, the committee will meet at least quarterly unless otherwise required in the description for each

committee.

10.2-4 Appointment of Chairs of Committees

Standing committee chairs shall be appointed by the Chief of Staff except when chairs are specified in these Bylaws. Subcommittee chairs of standing committees shall be appointed by the Chairs of his/her respective standing committee. Standing committees of the Medical Staff shall be chaired only by members of the Active Medical Staff.

10.2-5 Membership Appointment

Members of all committees shall be appointed by committee chairs, after consultation with the Chief of Staff or administration, as appropriate. Medical Staff Services Department shall maintain an accurate membership and attendance roster of all committees of the Medical Staff.

Active Medical Staff Members shall have voting prerogatives. Ex-Officio Members who are not members of the Active Medical Staff, Courtesy Staff members and other administrative, nursing and hospital representatives shall be appointed as non-voting members unless the Chair specifies voting prerogatives at the beginning of the Medical Staff year. This shall be documented in committee minutes at the beginning of the Medical Staff year and shall remain in effect for the membership appointment period of one (1) year.

Voting privileges, if issued by the Chair, shall be for all matters before the committee during the course of the year.

10.2-6 Quorum

Unless otherwise stipulated in these Bylaws, a quorum is constructed by at least three (3) members of the Active Medical Staff. For the MEC, a quorum shall consist of at least ten

(10) or more members of the Active Medical Staff.

10.2-7 Manner of Action

Having established a voting quorum, the action of a simple majority of the voting members present at a meeting shall represent the action of the committee. Action may be taken without a meeting by unanimous consent in writing signed by every member entitled to vote.

10.2-8 Attendance Requirements

Excused absences can be issued by Chairs or Chiefs if requests for absences are submitted before the scheduled meeting. Any committee may invite the attendance of any individuals who may be useful to its work.

10.2-9 Notice of Meetings

Chairs are responsible for scheduling meetings and providing adequate notice to committee members.

10.2-10 Minutes and Reporting

- A. Minutes of all meetings, unless otherwise stated, shall be forwarded to the Medical Staff Services Department, which shall serve as the official repository for official business of the Medical Staff.
- B. Minutes of meetings shall include, at a minimum, summaries and recommendations of any and all new policies or changes in policy. Such recommendations shall be submitted to the Medical Executive Committee for its approval.
- C. Each committee shall submit reports to MEC on its activities, including policy recommendations, per the guidelines set forth below. Such reports shall be made

by the committee chair, or designee if not available:

Ambulatory Care.....Every 6 Months.

Bylaws.....As needed to present proposed amendments

Cancer.....Every 6 Months

Credentials.....Every Month

Critical Care.....Every 6 Months

Ethics.....Every 6 Months

Infection Control.....Every 3 Months

Operating Room.....Every 6 months

Pharmacy and Therapeutics.....Every Month

Performance Improvement and Patient Safety.....Every Month

Substance Abuse í í í íAnnually

Medical Staff Well Being.....Every 6 Months

- D. Minutes of all meetings of committees for Clinical Services of the Medical Staff shall be considered confidential and privileged as shall all material caused to be prepared for the use of said committees or Clinical Services. Likewise, any business before these peer review bodies shall be treated with the utmost confidentiality and shall not be discussed or disseminated outside of the protection of the peer review body or organization.

10.2-11 Special Meetings

Special meeting of any committee for Clinical Service may be called or requested by the Chair or Chief thereof, by the Chief of Staff, or by one-third (1/3) of the group's members, but not less than two (2) members. The agenda must be included in the call to meeting. Notice must be given in writing at least two (2) weeks in advance of such called meeting to all voting members of the committee. Only matters included in the agenda may be considered at a special meeting.

10.2-12 Terms of Committee Members

Unless otherwise specified, committee members are appointed for term of one (1) year.

10.2-13 Removal

If a member of a committee ceases to be a member in good standing of the Medical Staff, or loses employment or contract relationship with the Hospital, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the Chair and Chief of Staff.

10.2-14 Vacancies

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made, provided however, that if an individual who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected in the Chair and Chief of Staff.

10.3 Medical Executive Committee

10.3-1 Composition of MEC

The MEC consists of the Officers of the Medical Staff, the Chiefs of the twenty (20) Clinical Services identified in Section 9.1-2 herein, the Director of Health, the Chief Executive Officer, the Associate Dean, the Chief Nursing Officer, the Chair of the

Credentials Committee, the Chief Medical Officer, the Medical Director of Trauma Services, four (4) At-Large Members elected in accordance with Section 10.4-2 herein, and up to three (3) representatives of the House Staff appointed by the Chief of Staff. The Chief of Staff may invite other persons to attend meetings.

10.3-2 Attendance and Voting

- A. It is the expectation that all Ex-Officio members and At-Large Members shall attend MEC meetings and shall provide notice of any absences to the Chief of Staff prior to the meeting.
- B. Each At-Large Member has one vote. When a Chief of a Clinical Service cannot attend a meeting, he/she may designate an alternate to attend and exercise a proxy vote in the Chief's absence.
- C. When a Chief of the Clinical Service also holds the position of an officer of the Medical Staff for Associate Dean, no additional members of the MEC will be named, and that single individual will represent both membership categories and have only one (1) vote.
- D. The three (3) members of the House Staff shall collectively have a single vote.

10.3-3 Officers and At-Large Members

- A. The current or acting Chief of Staff shall serve as the Chair of the MEC.
- B. The Chief of Staff-Elect shall serve a one (1) year term when elected at the annual meeting of the Medical Staff or shall serve for the remainder of the unexpired term of the vacancy he/she fills when elected by the MEC.
- C. The Chief of Staff-Past shall serve a one (1) year term after completion of his/her

year as Chief of Staff.

- D. The four (4) At-Large MEC members who are elected shall not serve more than three (3) consecutive one (1) year terms.
- E. Vacancies in any of the four (4) At-Large members arising during the Medical Staff Year shall be filled by the nomination of a member of the Active Medical Staff by the Chief of Staff and approval by a vote of the MEC.

10.3-4 Duties of MEC

The Medical Staff delegates to the MEC broad authority to oversee the operations of the Medical Staff. Under the leadership of the Chief of Staff, and without limiting this broad delegation of authority, the MEC shall perform in good faith the duties listed below.

- A. Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;
- B. Coordinate the activities of the Medical Staff committees and of the Clinical Services;
- C. Receive and act upon reports and recommendations from Medical Staff Committees and Clinical Services;
- D. Provide a forum in which the Medical Staff leadership can discuss issues and recommendations with the Chief Executive Officer, Chief Nursing Officer, Chief Financial Officer, Chief Medical Officer, and Associate Dean;
- E. Fulfill the Medical Staff's accountability to the Governing Body for the quality of care rendered to patients;

- F. Ensure that the Medical Staff is kept abreast of new laws, regulations, licensing and accreditation standards, and CMS Conditions of Participation;
- G. Review the credentials of all applicants and make recommendations to the Governing Body for Medical Staff appointments, assignments to departments and delineation of Clinical Privileges;
- H. Review the recommendations from the Credentials Committee and make recommendations to the Governing Body for reappointment and renewal or changes in Clinical Privileges;
- I. Ensure the professional and ethical conduct and competent clinical performance of Medical Staff members, including the initiation of investigations and corrective action when warranted;
- J. Review and approve all hospital-wide administrative and environment of care policies and clinical policies proposed by Medical Staff committees, and
- K. Make recommendations directly to the Governing Body for its approval regarding the following:
 - (1) The Medical Staff's structure;
 - (2) The mechanism used to review credentials and to delineate individual clinical privileges;
 - (3) Individuals for Medical Staff Membership and Affiliated Professionals;
 - (4) Delineated Clinical Staff Privileges for each eligible individual;
 - (5) The mechanism for hearing procedures and the mechanism by which

membership on the Medical Staff may be terminated;

(6) The organization of the quality assessment and improvement activities of the Medical Staff.

L. To amend these Bylaws and Rules and Regulations, in accordance with Article XVI, Section 15.5, in the case of a documented need for an urgent amendment necessary to comply with law, regulation, or deficiency issued by The Joint Commission or state or federal regulating body.

M. To take such other actions as may reasonably be deemed necessary in the best interest of the Medical Staff and Hospital.

The authority delegated pursuant to this section 10.3-4, may be removed by amendment of these Bylaws and Rules and Regulations.

10.4 Nominating Committee

10.4-1 Composition

The Committee shall be chaired by the Chief of Staff-Past or, in years in which there is no Chief of Staff-Past, the Chief of Staff. The Chair shall appoint four (4) members from the Active Medical Staff to serve on the committee, and at least one of these appointees shall be from the Community Primary Care Service. The Associate Dean, Chief Medical Officer, and Executive Administrator shall also be members of the committee.

10.4-2 Duties

The committee shall:

A. Nominate a member of the Active Medical Staff to serve as Chief of Staff-Elect prior to the end of the first year of the Chief of Staff's term of office.

- B. Nominate four (4) members of the Active Medical Staff to serve a one-year term as Members-At-Large on the MEC for no more than three (3) consecutive years.
- C. Election of the Chief of Staff-Elect and the MEC Members-At-Large will occur at the Annual Meeting in accordance with Section 8.2-2 herein.

10.4-3 Meetings

The Committee shall meet as needed to carry out these duties, and shall maintain records of its activities and meetings.

10.5 Joint Conference Committee

10.5-1 Composition

The Committee shall consist of at least two (2) representatives of the Governing Body appointed by the President of the Governing Body, the Director of Health, the Chief of Staff, the Associate Dean, the Chief Medical Officer, the Executive Administrator, the Chief Nursing Officer and the Chief Financial Officer. The Chief of Staff-Past shall be a member of the committee and shall remain a member of the Committee for six (6) months following the expiration of the term of office. The Chief of Staff-Elect shall become a member of the Committee six (6) months prior to assuming the responsibilities of Chief of Staff. The Chair of the Committee, in consultation with the Executive Administrator and Chief of Staff, may appoint additional representatives from Hospital administration and the Medical Staff. The President of the Governing Body shall appoint one of the Governing Body representatives to serve as Chair of the Committee and the Executive Administrator shall serve as Secretary.

10.5-2 Duties

The duties of the committee shall be:

The Joint Conference Committee shall provide a forum for effective communication

among the Medical Staff, Hospital Administration, and Governing Body to ensure Medical Staff Representation and participation in deliberations affecting the discharge of Medical Staff responsibilities and an effective means for the Medical Staff to participate in the development of all Hospital Policies.

10.5-3 Meetings

The Joint Conference Committee shall meet monthly at least ten (10) times annually and shall transmit reports of its activities to the MEC through the Chief of Staff. The agenda of each meeting shall be set by the Chair of the Committee, in consultation with the Executive Administrator in the Chief of Staff.

10.6 Ambulatory Care Committee

10.6-1 Composition

This committee shall consist of Medical Staff members from the Clinical Services as follows:

- A. A minimum of one (1) Active physician member of the Medical Staff from the following services: Medicine, Family and Community Medicine, Community Primary Care, Pediatrics, Obstetrics-Gynecology, Emergency Services, Radiology, and Laboratory Medicine.
- B. Members of the Medical Staff from other Clinical Services as deemed appropriate by the Co-chairs and Chief of Staff.
- C. Representatives from Hospital Administration, Nursing, Information Services, Patient Financial Services, Pharmacy, Medical Social Services, and Quality Management.
- D. The committee shall be co-chaired by one Active Member of the Medical Staff

from the Community Primary Care Service and one Active Member of the Medical Staff from one of the other clinical services represented on the Ambulatory Care Committee.

10.6-2 Duties

The committee shall:

- A. Serve as a forum to discuss issues related to the planning, development, quality, and delivery of ambulatory care services.
- B. Participate in the development of Hospital policies, procedures, and practices that are common to department, services, and programs providing ambulatory care services.
- C. Review clinic specific practices to ensure that they are congruent with the Hospital's mission and aligned with the Hospital's operational and organizational systems.
- D. Provide input on quality improvement activities which relate to multiple ambulatory care centers.
- E. Participate in preparation for accreditation surveys.
- F. Advocate for the highest standard of ambulatory care for the people of the City and County of San Francisco.
- G. Identify and promote opportunities to improve the direction and coordination of patient care activities by primary care provider.
- H. Facilitate linkages and collaboration between primary care in the sub-specialty care providers; between hospital based and community based providers; and

between medical providers and other clinical disciplines.

- I. Report to the MEC on activities, including policy recommendations, no less frequently than every six (6) months.

10.6-3 Meetings

This Committee shall meet at least quarterly but as frequently as necessary to carry out its duties and shall maintain records of its proceedings and activities.

10.7 Bylaws Committee

10.7-1 Composition

This Committee shall consist of at least seven (7) members of the Active Medical Staff including the Chief of Staff, Chief of Staff-Elect, Chiefs of Staff-Past, the Chief Medical Officer, one representative from Hospital Administration, one representative from the Dean's Office and one representative from the CPC service. The Chair shall be the Chief of Staff-Elect. In the years without a Chief of Staff-Elect, the Chief of Staff shall appoint a Chair from among the members of the committee.

10.7-2 Duties

The Committee shall conduct an annual review of the Medical Staff Bylaws and Rules and Regulations, and shall submit recommendations for changes to the MEC prior to any required notification of the Active Medical Staff.

10.7-3 Meetings

The Committee shall meet at least annually but as frequently as necessary to carry out its duties and shall maintain records of its proceedings and activities.

10.8 Cancer Committee

10.8-1 Composition

The Cancer Committee shall consist of seven (7) Active Medical Staff members representing General Surgery, Obstetrics and Gynecology, Otolaryngology, Pathology, Medical Oncology, General Internal Medicine, and Radiology. Additionally, a representative from Radiation Therapy at UCSF and the Cancer Liaison Physician shall be members of the Committee. Non-Physician representatives from Nursing, Pain Control, Clinical Research, Nutrition Services, Social Service, Hospital Administration, Quality Management, Medical Records, and the Tumor Registrar shall serve as committee members.

10.8-2 Duties

The Cancer Committee shall:

- A. Actively supervise the Tumor Registry doing quality review of abstracting, staging, and completeness of extent of disease information. This shall include ensuring that the Tumor Registry meets the standards of the American College of Surgeons and Commission on Cancer.
- B. Appoint and oversee the functions of the Tumor Board, a separate, multidisciplinary, weekly consultative and education committee.
- C. Perform continuous quality improvement functions for the Medical Staff with respect to cancer patients. These shall include working with individual Clinical Services and Hospital Administration as well as performing patient care evaluations as mandated by the Commission on Cancer.

- D. Ensure that consultative services from all major disciplines are available for all San Francisco General Hospital cancer patients.
- E. Ensure that educational programs for the Medical Staff include all major cancer treatment sites.
- F. Report to the MEC on its activities, including policy recommendations, no less than every six (6) months.

10.8-3 Meetings

This Committee shall meet at least quarterly and shall maintain permanent records of its proceedings and activities and shall submit reports on its activities, including policy recommendations, no less frequently than every six (6) months.

10.9 Credentials Committee

10.9-1 Composition

The Credentials Committee shall consist of at least eight (8) members of the Active Medical Staff, including an officer of the MEC, one (1) member from the CPC service, and a member of the Interdisciplinary Practice Subcommittee. Two (2) of the members shall be Chiefs or Assistant Chiefs of Clinical Services and at least one (1) member shall be from a clinical area where surgery is practiced (Surgery, Ob/Gyn., Orthopedics, Otolaryngology, or Neurosurgery).

10.9-2 Duties

The Credentials Committee shall:

- A. Review the credentials of applicants and make recommendations for membership and delineation of Clinical Privileges in compliance with these Bylaws;
- B. Make a report to the MEC on each applicant for Medical Staff membership and

privileges, which shall include recommendations from the appropriate Clinical Service Chief;

- C. Review all information available regarding the competence of Medical Staff members and as a result of such review makes recommendations for the granting of Privileges, reappointments, and the assignment of Practitioners to the various Clinical Services as provided in these Bylaws.
- D. Make a report to the MEC regarding approval of Affiliated Professionals, which shall include recommendations from the appropriate Clinical Service Chief.

10.9-3 Meetings

The Credentials Committee shall meet monthly at least ten (10) times per year, and shall maintain a permanent record of its procedures and activities.

10.9-4 Subcommittees

A. Interdisciplinary Practice Subcommittee

(1) Composition

The Subcommittee shall consist of the Director of Nursing, the Executive Administrator or designee, and an equal number of Physicians appointed by the MEC and registered nurses appointed by the Director of Nursing. Licensed or certified health professionals other than registered nurses shall be included in the Subcommittee as necessary.

(2) Duties

This Subcommittee shall:

Review and approve standardized procedures and protocols for patient care activities of the Affiliated Professionals in accordance with the requirements of

Title 22 of the California Code of Regulations governing committees on interdisciplinary practice.

Review, report and forward recommendations to the Credentials Committee on a regular basis regarding approval as an Affiliated Professional.

(3) Meetings

This Subcommittee shall meet at least quarterly and shall maintain permanent record of its proceedings and activities.

10.10 Critical Care Committee

10.10-1 Composition

This Committee shall consist of Active Medical Staff members who are Directors or Assistant Directors of critical care units and the Emergency Department; a nurse, representative from each critical care unit and the Emergency Department; and one (1) representative each from Nursing Administration, Hospital Quality Assurance, Post Anesthesia Recovery and Respiratory Therapy. One (1) House Staff member shall be invited to serve.

10.10-2 Duties

This Committee shall coordinate procedures, practices and equipment in the various emergency areas in critical care units of the Hospital and shall make recommendations to the MEC regarding these and related quality of care matters. The Committee shall submit reports to the MEC on its activities, including policy recommendations, no less than every six (6) months.

10.10-3 Meetings

This Committee shall meet monthly at least ten (10) times a year and shall maintain

permanent records of its proceedings and activities.

10.10-4 Subcommittee

A. Donor Council Subcommittee

(1) Composition

The Subcommittee shall consist of at least one representative from each of the areas responsible: Critical Care, Medical Staff, Attending Neurologist/Neurosurgeon, a nurse representative from each critical care unit, the Emergency Department, the Medical-Surgical, Peri-Operative and Perinatal divisions, a representative from Clinical Laboratory, and a representative from the California Transplant Donor Network (CTDN). A physician shall serve as Chair of this subcommittee.

(2) Duties

The subcommittee shall:

- a. Review data collected by CTDN
- b. Prepare reports on donor statistics for Quality Management and the Critical Care Committee
- c. Review and revise SFGHMC policies, as needed
- d. Review and discuss concerns related to the donor process
- e. Coordinate education activities housewide, as needed.

(3) Meetings

The subcommittee shall meet quarterly and will maintain permanent records of its proceedings and activities.

10.11 Ethics Committee

10.11-1 Composition

The Committee shall consist of no fewer than fifteen (15) members. These members shall include representatives of the Medical and Nursing Staffs, the Critical Care Units, the inpatient and outpatient departments; Hospital Administration, The Continuous Quality Improvement program and an attorney. One (1) member of the House Staff shall be invited to serve.

10.11-2 Duties

The Committee shall educate the Hospital community regarding ethical principles, facilitate interchange in ethical decisions, and help develop ethical guidelines. The Committee shall submit reports to the MEC on his/her activities, including policy recommendations, no less frequently than every six (6) months.

10.11-3 Meetings

The Ethics Committee shall meet monthly at least ten (10) times a year and shall maintain a permanent record of the proceedings and activities.

10.12 Infection Control Committee

10.12-1 Composition

This Committee shall consist of:

- A. Members from the Active Medical Staff from each of the following Clinical Services (with vote):
 - (1) Laboratory Medicine
 - (2) Medicine
 - (3) Medicine, with expertise in Infectious Disease

(4) Medicine, with expertise in Occupational Health

(5) Pediatrics

(6) Surgery

(7) Obstetrics and Gynecology

B. Director of Quality Management (with vote)

C. Director of Health and Safety (with vote)

D. Other representatives (with vote) from:

(1) Infection Control Nurse Practitioners

(2) Nursing Administration

(3) House Staff

(4) Central Processing and Distribution

(5) Operating Room

(6) Nursery

E. Consultative Representatives (without vote) from:

(1) Dietary

(2) Housekeeping

(3) Laundry

(4) Pharmacy

(5) Engineering

(6) Other departments, as requested

10.12-2 Duties

This Committee shall be responsible for directing all phases of the infection control program for the Hospital and its clients. The Committee shall directly supervise the Infection Control staff; establish definitions and guidelines for surveillance of infections and determine whether he/she is nosocomial; determine and report pertinent infection rates; carry out epidemiologic studies of nosocomial infection, when appropriate, determine infection control measures; promote a preventive corrective program designed to minimize infection hazards; establish and monitor precautions, procedures and programs in association with the Employee Health Service for surveillance and prevention of infections in employees; and review and approve infection control policies and procedures, including those for cleaning, waste disposal, disinfection and sterilization. The Infection Control Committee, through its Chair, may institute any appropriate control measures or studies when there is reasonable concern of danger to any patient or personnel. Under supervision of the Committee through the Chair, the Infection Control Practitioners or the Registered Nurse responsible for a patient care unit may initiate cultures and appropriate isolation procedures with notification of the Medical Staff member responsible for the patient. The Committee shall submit reports to the MEC on its activities, including policy recommendations, no less frequently than every three (3) months.

10.12-3 Meetings

This Committee shall meet at least bimonthly, maintain a record of proceedings, and activities and report to the MEC and Governing Body at least quarterly. Infection

Control staff, the Chair, the Infection Control Practitioners and Executive Administrator shall meet as frequently as necessary to carry on the business of the Infection Control function of the Hospital.

10.13 Medical Staff Well Being Committee

10.13-1 Composition

The Medical Staff Well Being Committee shall be comprised of no less than three (3) Active members of the Medical Staff, a majority of which, including the Chair, shall be physicians. Insofar as possible, members of this Committee shall not serve as active participants or other peer review or continuous quality improvement committees.

10.13-2 Duties

The duties of the committee shall be as follows:

- A. To foster and actively support the well-being of Medical Staff Members;
- B. To provide education to members of the Medical Staff about illness and impairment issues specific to physicians;
- C. To facilitate self-referral by a physician and referral by other organization staff;
- D. To facilitate referral of the affected physician to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern;
- E. To provide for the maintenance of the confidentiality of the physician seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the safety of a patient is threatened;
- F. To assure evaluation of the credibility of a complaint, allegation, or concern;

- G. To monitor the affected physician and the safety of patients until the rehabilitation or any disciplinary process is completed;
- H. To assure a reporting to the Medical Staff leadership instances in which a physician is providing unsafe treatment; and
- I. To provide assistance, counseling, and referrals for disruptive physicians.

10.13-3 Meetings

The Committee shall meet as frequently as necessary. It shall maintain only such record of its proceedings and activities as it deems advisable and shall report quarterly on its activities to the MEC.

10.14 Operating Room Committee

10.14-1 Composition

This Committee shall consist of Medical Staff members representing the Clinical Services of Surgery, Orthopedic Surgery, Anesthesiology, Obstetrics and Gynecology; and one (1) representative drawn from each of the following Clinical Services: Neurosurgery, Urology, Ophthalmology, Otolaryngology and Dentistry/Oral and Maxillofacial Surgery. The Chief of the Infection Control Committee, the Director of the Blood Bank, a representative from Hospital Administration, and the Assistant Director of Nursing for the Operating Room shall serve with vote. One (1) member of the House Staff shall be invited to serve.

10.14-2 Duties

The Operating Room Committee shall be responsible for the evolution of the safe, proper, and efficient utilization of Operating Rooms within the Hospital. This Committee shall be responsible for the development of policies and procedures regarding the safe,

proper, and efficient conduct of surgical procedures. The Committee shall submit reports to the MEC on its activities, including policy recommendations, no less frequently than every six (6) months.

10.14-3 Meetings

This Committee shall meet monthly at least ten (10) times a year and maintain permanent records of its proceedings and activities.

10.15 Pharmacy and Therapeutics Committee

10.15-1 Composition

This Committee shall consist of at least five (5) members of the Active Medical Staff including one (1) representative from the CPC service. One (1) House Staff representative shall be invited to serve. In addition, representatives from the Pharmaceutical Service, the Nursing Service, Food Services, Hospital Administration, and other services as appropriate shall serve with vote. The Director of Pharmaceutical Services, or designee, shall serve as Secretary to the Committee.

10.15-2 Duties

This Committee shall be responsible for the development and surveillance of all drug use policies and practices within the Hospital and its clinics. The Committee shall assist in the formation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to pharmaceuticals in this Hospital and its clinics. It shall also perform the following specific functions:

- A. Serve as an advisory group to the Medical Staff and the Department of Pharmaceutical Services on matters pertaining to the choice of available drugs;

- B. Published and maintain the Hospital formulary;
- C. Establish and maintain standards concerning the use and control of investigational drugs and of research in the use of approved drugs;
- D. Make recommendations concerning drugs to be stocked on nursing units and other special services;
- E. Prevent unnecessary duplication in stocking pharmaceuticals;
- F. Evaluate clinical data concerning new pharmaceuticals requested for use in this Hospital and make recommendations to the Medical Executive Committee regarding what pharmaceuticals should be made available and placed on the formulary;
- G. Oversee sample use in clinics;
- H. Shall submit reports on its activities, including policy recommendations to the Medical Executive Committee, no less frequently than quarterly and as needed;
- I. Promote medication use safety;
- J. Report issues to the Performance Improvement and Patient Safety Committee.

10.15-3 Meetings

This Committee shall meet at least quarterly and shall maintain permanent records of its proceedings and activities.

10.15-4 Subcommittees

The Committee shall conduct the bulk of its business through five (5) subcommittees.

The Chair of each subcommittee shall be a member of the Pharmacy and Therapeutics

Committee and shall be appointed by the Chair of the Committee with the approval of the Chief of Staff.

A. Antibiotic Advisory Subcommittee

This Subcommittee shall be responsible for reviewing antibiotics and related therapies. The Subcommittee shall assist the Adverse Drug Reaction and Drug Use Evaluation Subcommittee in conducting drug use evaluations for antibiotic therapy. The Subcommittee will work closely with the Infection Control Committee and the Clinical Laboratories.

B. Formulary Review Subcommittee

This Subcommittee shall be responsible for evaluating all requests for changes to the Formulary including additions of new drugs, new uses for current drugs, and deletions from the Formulary. The Subcommittee shall also conduct periodic reviews of drug classes to assess appropriate use and promulgate guidelines for the use of drugs in clinical areas as appropriate.

C. Medication Use and Safety Subcommittee

This Subcommittee shall maintain a program to detect and concurrently report adverse drug reactions and medication errors and shall evaluate reported adverse effects in a timely fashion. A summary of evaluations shall be presented to the Pharmacy and Therapeutics Committee, and may be reported to the drug manufacturer and/or the Food and Drug Administration when deemed appropriate. The Subcommittee shall evaluate, promote, monitor and present to the Pharmacy and Therapeutics Committee the efforts of the Medical Staff and Hospital departments to accomplish appropriate drug use evaluation as required by accreditation agencies.

D. Nutrition Subcommittee

The Subcommittee shall recommend therapeutic enteral and parenteral nutritional formulations for the Formulary and to monitor and assess nutritional therapies. Additionally, the Subcommittee shall serve to review and approve policies and procedures relating to nutritional therapy of the Food and Nutritional Service, Outpatient Nutrition Service and the Nutritional Support Services, including the Diet Manual.

E. Pain Management Subcommittee

This Subcommittee shall recommend a program for identifying and ameliorating barriers to effective pain management. It will collaborate with the Adverse Drug Reaction and Drug Use Evaluation Subcommittee and the Formulary Subcommittee around pharmaco-therapy of pain. It will review and recommend policies and procedures pertinent to pain management.

F. Moderate Sedation Subcommittee

This Subcommittee shall oversee the administration of moderate or deep sedation and anesthesia. The activities of the Subcommittee shall include physician and registered nursing training and formulating policy and procedures for the administration of moderate or deep sedation and anesthesia by non-anesthesia trained personnel.

10.16 Performance Improvement and Patient Safety Committee

This Medical Staff committee is responsible for implementing the objectives of the organization-wide performance improvement and patient safety program. The committee takes an interdisciplinary and proactive approach to the prevention of adverse events, medical errors and near misses, and promotes patient outcomes/safety and reduction of

health disparities as the core values in providing quality patient care.

10.16-1 Composition

This Committee shall consist of at least seven (7) physician representatives from the Active Medical Staff. It shall also include one (1) representative from Radiology, Clinical Lab, Pharmacy, Infection Control, Nursing and the Behavioral Health Center. The Chief Nursing Officer, Administrative Director of Quality Improvement, the Administrative Director of Utilization Management, and the Patient Safety Officer shall also be members. The Chief Medical Officer shall serve as Chair and the Administrative Director of Quality Management shall serve as Vice-Chair.

10.16-2 Duties

- A. On an annual basis, reviews the effectiveness of Hospital Performance Improvement and Patient Safety Program in meeting the organizational-wide purpose, goals and objectives and revises the program as necessary.
- B. Identifies organization-wide trends, patterns and opportunities to improve aspects of patient care and safety through the review and analysis of data obtained from focused reviews and sentinel events in the Joint Commission Sentinel Event Alerts, patient case reviews, risk management reports, hospital claims, staff patient safety suggestion tool, patient and staff surveys, utilization review data, patient/visitor concerns, clinical service and ancillary/diagnostic department performance improvement reports, ongoing medical record review and other sources as appropriate.
- C. Reviews performance improvement reports from clinical laboratory services, diagnostic radiology services, and dietetic services as part of the annual report.

- D. Formulates and recommends action for improving patient care and safety to clinical services, ancillary/diagnostic departments, and performance improvement committees as appropriate.
- E. Makes recommendations based on an evaluation of the care provided (e.g. efficacy, appropriateness) and how well it is done (e.g. availability, timelines, effectiveness, continuity with other services/practitioners, safety, efficiency, respect, and caring).
- F. Reviews and approves the Hospital Utilization Management plan on an annual basis.
- G. Conducts utilization review studies designed to evaluate the appropriateness of admission to the hospital, lengths of stay, discharge practices, and use of medical and hospital services that may contribute to the effective utilization of services.
- H. Reports and forwards recommendations at least quarterly to the Joint Conference Committee through the Chief Medical Officer, based on the review and recommendations made by the MEC.
- I. Reviews quality, utilization, and patient safety issues relevant to the Tertiary Care Contract and to the care of managed care patients.
- J. Submits an annual report to the MEC.
- K. Facilitates a multidisciplinary, interdepartmental collaborative approach to improving the quality of patient care and safety, and appropriate utilization of resources through the designation of Performance Improvement and Utilization Management subcommittees.

10.16-3 Meetings

The Committee shall meet monthly at least ten (10) times a year. The Committee shall maintain permanent records of its proceedings and activities.

10.16-4 Subcommittees

A. Code Blue Subcommittee

(1) Composition

Physician representatives from Cardiology, Emergency Department, Pulmonary Service, nursing representation from the Quality Improvement Coordinating Committee and Nursing Education, staff representation from Pharmacy Service, Respiratory Therapy Service, the Product Evaluation Committee and the Hospital Quality Management Department. The Chair shall be a physician appointment by the Chief of the Medical Staff.

(2) Duties

Oversee the organization of the Code Blue Team, (e.g., personnel composition, members roles and responsibilities, availability of equipment, scope of service area and communication mechanisms). All findings from codes related to quality improvement activities shall be reported to this committee for evaluation and recommendations.

(3) Meetings

The Code Blue Subcommittee shall meet as needed and shall maintain permanent records of its proceedings and activities.

B. Patient Concern Subcommittee

(1) Composition

The Subcommittee shall consist of at least one (1) representative from each of the

areas designated as responsible for the review and follow up of patient concerns:
SFGH Director of Risk Management, Department of Psychiatry Quality
Improvement Coordinator, Mental Health Rehabilitation Facility QI Coordinator,
UCSF Risk Management, CCSF Risk Management, SFGH/CPC Quality
Management. The Director of Risk Management shall serve as Chair of this
subcommittee.

(2) Duties

The Subcommittee shall:

- a. Review aggregate concern data and analyze trends;
- b. Prepare reports on patient concerns data for PIPS and individual departments;
- c. Forward provider specific data to the Medical Staff Services Department, as requested;
- d. Review and revise SFGH/CPC patient concern policies as needed;
- e. Coordinate the patient concern database;
- f. Review and discuss patient concerns involving multiple departments/sites and develop a response plan;
- g. Report to the PIPS biannually.

(3) Meetings

The Subcommittee shall meet monthly. The Subcommittee shall maintain permanent records of its proceedings and activities.

C. Pediatric Emergency Medicine Subcommittee

(1) Composition

This Subcommittee shall consist of the Director of Pediatric Emergency Medicine; at least one (1) physician and one (1) nurse from the pediatric clinic; the pediatric chief residents; the head nurses in critical care and trauma services; the Director of Pediatric Trauma; and the head nurses from pediatrics and emergency medicine or his/her designates.

(2) Duties

The Subcommittee shall:

Ensure compliance with the City and County of San Francisco Emergency Department Approved for Pediatrics plan.

Ensure ongoing compliance with the standards of the Emergency Department Approved for Pediatrics (EDAP).

Review the Hospital's internal capabilities for emergency pediatrics, not addressed by the EDAP standards, including the inpatient critical care and trauma services. The committee will evaluate current problems, identify resources and establish performance guidelines. This process will include establishment of a quality assurance/quality improvement mechanism.

(3) Meetings

The Subcommittee shall meet at least quarterly and shall maintain permanent records of its proceedings and activities.

D. Risk Management Subcommittee

(1) Composition.

This Subcommittee shall consist of at least eight (8) members of the Active Medical Staff, including representatives from the Clinical Services of Medicine, Surgery, Pediatrics, Family and Community Medicine, Obstetrics and Gynecology, Psychiatry and Emergency Medicine. In addition, representatives from SFGH Risk Management, UCSF Risk Management, Hospital Administration, SFGH Quality and Utilization Management Committee, and the Associate Administrator, Nursing Services shall also serve. The Chair of the Performance Improvement and Patient Safety Committee shall serve as Chief for this Subcommittee.

(2) Duties

The Subcommittee shall:

Identify general areas of potential risk in the clinical aspects of patient care and safety;

Identify and evaluate the specific cases with potential risk in the clinical aspects of patient care and safety;

Recommend corrections for problems in the clinical aspects of patient care and safety identified by risk management activities; and

Design programs to reduce risk in the clinical aspects of patient care and safety.

(3) Meetings

The Subcommittee shall meet monthly at least ten (10) times per year and shall maintain permanent records of its proceedings and activities.

E. Transfusion Subcommittee.

(1) Composition

The Transfusion Subcommittee shall consist of the Head Nurse from the Operating Room, the Surgical Clinical Head Nurse, the Chief Blood Bank Technologists, the Director of the Blood Bank and one (1) member each from the Departments of Anesthesia, Surgery, OB/GYN, Pediatrics, Neonatology, Hematology, Oncology and Emergency Services.

(2) Duties

This Subcommittee shall review transfusion-related issues in the Hospital, including the appropriateness of the use of blood and blood components, incidents of avoided blood wastage and all transfusion reactions. The findings of such reviews shall be reported to the PIPS Committee and Chiefs of the Clinical Services, when appropriate. The Subcommittee shall develop and approve policies and procedures regarding transfusion practices. Make recommendations based on results; Report to PIPS quarterly.

F. Trauma Program Operational Process Performance Subcommittee

(1) Composition

The Subcommittee shall be Co-Chaired by the Trauma Medical Director and Trauma Program manager. The Subcommittee shall consist of the representatives from the Departments of Emergency Medicine, Anesthesia, Neurosurgery, Orthopedics, Radiology, Physical Medicine, Rehabilitation, Respiratory Therapy, Perioperative Services, Laboratory Medicine, and Pediatrics; the Nursing Directors or Managers of the Surgical ICU, Emergency Department, Surgical Nursing, PACU and Operating Room; Neurosurgical, Emergency Department and Surgical CNS representatives, Risk Management and Quality Management Nursing representatives, Trauma PI Coordinators,

Trauma, Orthopedic and Neurosurgical NP representatives, Medical Director of SFFD Emergency Medical Services Division, SFGH Base Hospital Coordinator, EMSA Medical Director and Trauma Coordinator, San Mateo EMS Clinical Coordinator, and other professionals are invited to participate as needed.

(2) Duties

This Subcommittee shall address, assess and correct global trauma program and system issues. The membership shall review all major clinical activities and systems of trauma care and shall;

- a. Evaluate system and medical performance through objective and systematic monitoring;
- b. Identify, analyze and track problems;
- c. Developed and implement plans for improvement, resolution, and modification of current systems of trauma care;
- d. Communicate the results of review and plans of correction to all program related services/departments;
- e. Trend and measure the effectiveness of corrective action;
- f. Document the reporting of patient safety initiatives, and continuous quality improvement activities.

(3) Meetings

This Subcommittee shall meet on a monthly basis at least ten (10) times/year and shall maintain permanent records of its proceedings and activities.

G. Trauma Multidisciplinary Peer Review Committee

(1) Composition

This Subcommittee shall be chaired by the Trauma Medical Director. The Subcommittee shall consist of the Chiefs-of-Service, or their designated representatives, of the following Departments: Surgery, Emergency Medicine, Anesthesia, Neurosurgery, Orthopedic Surgery, Radiology, Laboratory Medicine/Blood Bank, and Pediatrics. Additional members shall include the Co-Directors of Surgical ICU, the SFGH Director of Patient Safety and Performance Improvement, and all members of the Department of Surgery regularly participating in the care of acutely injured patients. Other attendees shall include the Trauma Program Manager and Trauma Performance Improvement staff.

(2) Duties

This Subcommittee shall assure the equality and appropriateness of trauma care at this Hospital as it relates to performance of individual providers and the interaction between providers of different disciplines. The Subcommittee shall review clinical activity and outcomes (deaths, complications, errors) and shall:

- a. Evaluate provider performance through objective and systematic monitoring.
- b. Analyze problems related to provider performance and develop plans for improvement, resolution, and modification of current practices.
- c. Communicate the results of review and plans of correction to all members of the Committee and the Trauma Panel.

- d. Facilitate and direct a development of clinical management guidelines or protocols for the management trauma.
- e. Measure the effectiveness of any corrective action taken or protocols generated.

(3) Meetings

The Subcommittee shall meet on a monthly basis at least ten (10) times/year and shall maintain permanent records of its proceedings and activities.

H. Community Primary Care Subcommittee

(1) Composition

The Community Primary Care subcommittee shall be chaired by the CPC Medical Director for Quality Improvement and The Director of Community Primary Care Nursing. The subcommittee shall consist of at least two (2) Health Center Medical Directors, one staff physician, one nurse practitioner/physician assistant, and one Health Center nurse manager and/or staff nurse. The CPC Health Centers shall be represented on the Committee. The SFGH Primary Care Health Center(s) will be represented on the committee as deemed appropriate by said SFGH Health Center and the Co-Chairs of the CPC QI Committee.

(2) Duties

This Subcommittee will be responsible for monitoring the Quality Improvement activities of the CPC primary care delivery sites. Each CPC Health Center will constitute its own Health Center Quality Improvement Committee, chaired or co-chaired by the Health Center Medical Director, which will direct QI activities at the Health Center and affiliated sites and will report to the Community Primary Care QI Committee. It shall monitor and evaluate the quality and

appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems through the following:

- a. The identification and assessment of problems in the delivery of patient care;
- b. The development and implementation of plans designed to identify opportunities for improvement in patient care;
- c. The creation and implementation of standardized monitoring systems that regularly evaluate indicators of clinical performance; The maintenance of a database that documents the effectiveness of the aforementioned clinical performance indicators; The use of relevant findings for quality reviews to appraise the effectiveness of medical care provided; and efficiency in the delivery of service (to minimize morbidity and mortality as well as to avoid unnecessary delay in care).

(3) Meetings

This Subcommittee shall meet monthly at least nine (9) times a year and shall maintain permanent records of its proceedings and activities.

10.17 Substance Abuse Committee

10.17-1 Composition

The Substance Abuse Committee shall consist of at least ten (10) members of the Medical Staff, Nursing Staff, Pharmacy, Security, and Hospital Administration, representing the full range of services and programs.

10.17-2 Duties

The Committee shall:

- A. Complete needs assessments related to the impact of substance abuse and substance abusers in various Clinical Services, units and programs;
- B. Recommend policies and procedures related to working with substance abuse and substance abusers, including, but not limited to:
 - (1) Detoxification and Management Protocols for substances abuse;
 - (2) Review of the Hospital formulary and guidelines for use of abusable medications;
 - (3) Review of the clinical needs of substance abusers and the ability of the Hospital to meet these needs, including emergency care, management in the Hospital, and outpatient services, and review appropriate use of such services and recommend any additional needed services;
 - (4) Security and Hospital Police Policies in an attempt to limit availability of abusable substances in the Hospital, and limit patients from leaving Hospital grounds with Hospital property;
 - (5) Review the needs of special populations as indicated;
 - (6) Patient contracts for management of substance abusers on the inpatient services.
 - (7) Shall submit reports to the MEC on its activities, including policy

recommendations, no less frequently than every six (6) months.

- C. Recommend approaches to teaching Medical Staff, Nursing Staff, and House Staff officers and medical, nursing, and social work students about substance abuse;
- D. Recommend treatment approaches sensitive to community and ethics/minority needs, including ways to have regular Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Al-Anon, and other relevant meetings in the Hospital or on Hospital grounds;
- E. Established working linkages and accessibility to all programs directly involved in substance abuse on the Hospital campus, as well as reviewing, renewing, and establishing community, neighborhood, and governmental linkages with appropriate services and agencies;
- F. Recommend interventions or ways of working with the substance abuse issues of Hospital staff and Hospital employees (deferring to the Medical Staff Well Being Committee for issues involving Medical Staff members - see section 10.13).

10.17-3 Meetings

The Committee shall meet at least quarterly and shall maintain permanent records of its proceedings and activities.

10.18 Information Systems Committee

10.18-1 Composition

The Information Systems Committee shall be chaired by the Chief Medical Officer (CMO) and the Vice Chair shall be the SFGH Director of Information Systems. Other members of the Medical Staff and Administrative Staff shall be selected by the Chair and

approved by the Chief of Staff.

10.18-2 Duties

The purpose of the Committee is to:

- A. Develop long term information technology goals for San Francisco General Hospital that are consistent with the Hospital's Strategic Goals,
- B. Review, approve and prioritize IS service requests which require significant IS resources or any request which impacts more than a single department,
- C. On an annual basis, discuss capital equipment and capital project requests that have an IS component and assist in the ranking of these requests,
- D. Evaluate information technology needs from as many vantage points as possible, assess implications to the organization as a whole, and determine the best utilization of IS resources,
- E. Serve as a forum for identifying information technology solutions through a collaborative decision-making process, and
- F. Be responsible for reviewing, approving and prioritizing annual above-base requests for IS projects. Projects recommended by this Committee will be submitted to the SFGH Executive Committee for site approval. The SFGH Executive Committee will make recommendations to the DPH IS Executive Oversight Committee for final approval.

10.18-3 Meetings

The Committee shall meet at least quarterly and shall maintain permanent records of its proceedings and activities. The Chair of the Committee will make semi-annual reports to

the SFGH Medical Executive Committee on Committee activities.

ARTICLE XI: MEETINGS OF THE WHOLE MEDICAL STAFF

11.1 Annual Meeting

An annual Medical Staff meeting shall be held within two (2) months of the end of the Medical Staff year.

Each member of the Active Medical Staff is expected to attend the annual meeting of the Medical Staff and special Medical Staff Meetings duly convened pursuant to these Bylaws.

The agenda at the annual Medical Staff meeting shall be:

- A. Call to order
- B. Approval of minutes of previous annual or special meetings of the Medical Staff
- C. Annual Reports
 - (1) Director of Health
 - (2) Executive Administrator
 - (3) Dean, School of Medicine
 - (4) Associate Dean
 - (5) Chief of Staff
- D. Old Business
- E. New Business

F. Adjournment

11.2 Voting

A simple majority of the Active Medical Staff Members attending the meeting shall determined the outcome of the vote.

11.3 Special Meetings

- A. The Chief of Staff may call a special meeting of the Medical Staff at any time. The Chief of Staff shall call a special meeting within ten (10) days after receipt of a written request for same signed by not less than 20 percent (20%) of the Active Medical Staff and stating the purpose for such meeting. The Chief of Staff shall designate the time and place of any special meeting.
- B. A written or printed notice stating place, day and hour of any special meeting of the Medical Staff shall be delivered, whether personally or by mail, to each member of the Active Staff not less than seven (7) days before the date of such meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in a United States mail addressed to each staff member at the address appearing on the records of the Hospital. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.
- C. Twenty-five percent (25%) of the Active Medical Staff shall constitute a quorum.
- D. Agenda will include Reading of the notice of the meeting, Transaction of business for which the meeting was called and Adjournment.

**ARTICLE XII: CONFIDENTIALITY OF INFORMATION;
IMMUNITY AND RELEASES**

12.1 Authorization and Conditions

By applying for or exercising clinical privileges with Hospital, an applicant:

- A. Authorizes representatives of the Hospital and the Medical Staff to solicit, provide and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;
- B. Authorizes persons and organizations to provide information concerning such practitioner to the Medical Staff;
- C. Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital who would be immune from liability under Section 12.2-4 below; and
- D. Acknowledges that the provisions of this Article are express conditions to an application for Medical Staff Membership, the continuation of such membership, and to the exercise of clinical privileges at this Hospital.

12.2 Confidentiality of Information

12.2-1 General

Discussions, deliberations, records and proceedings of all Medical Staff committees having responsibility of evaluation and improvement of quality of care rendered in this Hospital shall, to the fullest extent permitted by law, be confidential. This confidentiality protection includes, but is not limited to, information regarding any member or applicant

to this Medical Staff, meetings of the Medical Staff, meetings of Clinical Services, meetings of committees of the Medical Staff, and meetings of ad hoc committees created by the Medical Executive Committee.

12.2-2 When Disclosure is Permitted

- A. Dissemination or disclosure of discussions, deliberations, records and proceedings shall only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff or, where not officially adopted policy exists, only with the express approval of the Medical Executive Committee.
- B. In all other cases, access to such information and records shall be limited to authorized members of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentially be maintained.
- C. Information which is disclosed to the Governing Body or its appointed representatives in order that the Governing Body may discharge its lawful obligations and responsibilities shall be maintained by that body as confidential.
- D. Information contained in the credentials file of any member may be disclosed with the member's consent to other medical staffs, hospitals, professional licensing boards, or medical schools.

12.2-3 Breach of Confidentiality

Effective quality of care activities, peer review, and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions within a quality improvement process. Any breach of

confidentiality of the discussions, deliberations, records or proceedings of Medical Staff Clinical Services or committees is outside appropriate standards of conduct for Medical Staff members, violates these Medical Staff Bylaws, and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate. In particular, and without limitation, a breach of confidentiality includes any unauthorized voluntary testimony or unauthorized offer to testify before a court of law or in any other proceeding as to matters protected by this confidentiality provision.

12.2-4 Immunity from Liability

A. For Action Taken by the Medical Staff and Hospital.

Each representative of the Medical Staff and Hospital shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or Hospital.

B. For Providing Information.

Each representative of the Medical Staff and Hospital and all third parties shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the Medical Staff or Hospital concerning such person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this Hospital.

12.2-5 Activities and Information Covered

The confidentiality and immunity provided by this Article shall apply to all acts,

communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

- A. Application for appointment, reappointment or clinical privileges;
- B. Corrective action;
- C. Hearings and appellate reviews;
- D. Utilization and quality assurance reviews;
- E. Activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and.
- F. Queries and reports concerning the National Practitioner Data Bank, peer review body or organization, the Medical Board of California, and similar queries and reports.

ARTICLE XIII: CONFLICTS AND DISPUTE RESOLUTION

13.1 Conflicts and Disputes between the Medical Staff and the MEC

- A. The Chief of Staff shall convene a meeting to resolve a conflict or dispute between the MEC and the Medical Staff upon receipt of a written petition, signed by at least twenty percent (20%) of the Active Medical Staff members, that sets forth the rule, policy, or other significant matter at issue.
- B. The meeting shall include up to five representatives of the Active Medical Staff selected by the petitioners and an equal number of MEC members selected by the Chief of Staff. The meeting shall be chaired by the Chief of Staff who will not

be considered as one of the MEC representatives and who will not have voting privileges at this meeting.

- C. The representatives of the Medical Staff and of the MEC shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the position of the Medical Staff, the leadership responsibilities of the MEC, and the safety and quality of patient care at the Hospital.
- D. Resolution at this level requires a majority vote of the representatives of the Medical Staff and a majority vote of the representatives of the MEC.
- E. Unresolved matters shall be submitted to the Joint Conference Committee for final resolution.

13.2 Conflicts and Disputes between the Medical Staff and the Governing Body

- A. The Chief of Staff shall convene a meeting to resolve a conflict or dispute between the Medical Staff and the Governing Body upon a majority vote of the MEC or petition of at least twenty percent (20%) of the Active Medical Staff Members. The Chief of Staff shall work with the Secretary of the Governing Body to ensure compliance with public notice requirements.
- B. The Medical Staff shall be represented by the two officers of the Medical Staff and three Active Medical Staff members selected by the Chief of Staff. The Governing Body shall be represented by the Governing Body members on the Joint Conference Committee. The Hospital Chief Executive Officer shall also be invited to attend this meeting.

- C. The meeting shall be chaired by the Chair of the Joint Conference Committee.
- D. The meeting participants shall gather and share relevant information and shall work in good faith to resolve differences in a manner that respects the position of the Medical Staff, the governing responsibilities of the Governing Body, and the safety and quality of patient care at the Hospital.
- E. Resolution at this level requires a majority vote of the representatives of the physicians and a majority vote of the representatives of the Governing Body.
- F. Unresolved matters shall be submitted to the Governing Body for final resolution. The Governing Body shall make its final determination giving great weight to the actions and recommendations of the Medical Staff, shall not be arbitrary and capricious, and shall be in keeping with its legal responsibilities to act to protect the safety and quality of patient care and to ensure the responsible governance of the Hospital.

ARTICLE XIV: RULES AND REGULATIONS

14.1 Rules and Regulations of the Medical Staff

The Medical Staff will be governed by such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Practitioner in the Hospital. Agreement to abide by the Bylaws includes agreement to abide by the Rules and Regulations. The Rules and Regulations are incorporated into these Bylaws as if set forth herein. Accordingly, amendments to the Rules and Regulations are subject to the same requirements as amendments to these Bylaws.

14.2 Rules and Regulations of the Clinical Services

Each Clinical Service shall formulate its own rules and regulations and proctoring protocol for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall be consistent with these Bylaws. Substantive changes shall be reflected in the biennial clinical services report to the Medical Executive Committee and approved by the MEC and the Joint Conference Committee.

ARTICLE XV: ADOPTION AND AMENDMENT

15.1 Medical Staff Responsibility

15.1-1 The Medical Staff shall have the initial responsibility and authority to formulate, adopt, and recommend Medical Staff Bylaws and amendments thereto, which shall be effective when approved by the Governing Body. Such approval shall not be unreasonably withheld. This responsibility shall be exercised in good faith and in a reasonable, timely, and responsible manner, reflecting the interests of providing quality and efficient patient care and maintaining a harmony of purpose and effort with the Governing Body. Neither the Governing Body nor the Medical Staff may unilaterally amend the Medical Staff Bylaws.

15.1-2 The Hospital Chief Executive Officer shall be consulted as to the impact of any proposed Bylaws amendments on Hospital operations and as to the feasibility of proposed amendments. The Hospital Chief Executive Officer may also develop and recommend Bylaws amendments to the Bylaws Committee or MEC for consideration.

15.1-3 Proposed amendments shall be reviewed and considered at a meeting of the

Joint Conference Committee prior to distribution to the Medical Staff for a vote.

The Governing Body members of the Joint Conference Committee have the right to have their comments regarding the proposed amendments circulated with the proposed amendments at the time they are distributed to the Medical Staff for a vote.

15.2 Amendments

The MEC shall vote on the proposed amendments and upon an affirmative vote of two-thirds (2/3) of a quorum shall submit the amendments to the Active Medical Staff for approval or disapproval as set forth in Section 15.3 herein.

Upon a petition signed by at least twenty percent (20%) of the Active Medical Staff, amendments to these Bylaws and Rules and Regulations may be submitted to the Medical Staff and the Governing Body (and without the approval of MEC) for a vote. In such an event, the proposed amendments shall be reviewed and considered at the next regularly scheduled meetings of the MEC and Joint Conference Committee prior to distribution to the Medical Staff. The MEC and the Joint Conference Committee have the right to have their comments regarding the proposed amendments circulated with the proposed amendments at the time they are distributed to the Medical Staff for a vote.

15.3 Method

15.3-1 The Medical Staff Bylaws may be adopted, amended, or repealed by the following combined action:

- A. The affirmative vote of two-thirds (2/3) of the Active Members of the Medical Staff who cast votes on the matter, provided at least 14 days advance notice accompanied by the proposed Bylaws or amendments (such notice and voting may be conducted electronically); and

B. The affirmative vote of a majority of the Governing Body.

15.3-2 The Governing Body shall vote on proposed amendments within forty-five days from the date of receipt. If the Governing Body does not approve the proposed amendments, it shall specify its reasons in writing and forward them to the Chief of Staff, the MEC, and the Bylaws Committee.

15.3-3 Amendments must be approved by both the Medical Staff and the Governing Body before they shall take effect, excepting the situations set forth in Sections 15.4 and 15.5 herein.

15.4 Corrections

The MEC shall have the power to approve corrections, such as reorganization or renumbering of the Bylaws, or correcting punctuation, spelling, or other errors of grammar or inaccurate cross-references. Such amendments shall be effective immediately and shall be permanent. The action to make such corrections shall be taken by motion and acted upon in the same manner as any other motion before the MEC. Substantive amendments are not permitted pursuant to this Section.

15.5 Urgent Amendments

In the case of a documented need for an urgent amendment to these Bylaws and Rules and Regulations necessary to comply with law, regulation, or deficiency issued by the Joint Commission or state or federal regulating body, these Bylaws may be amended for that sole purpose by a two-thirds (2/3) affirmative vote of the MEC and by an affirmative vote of each Governing Body representative on the Joint Conference Committee. In such an event, the amendment shall be submitted to the Medical Staff for retrospective review. If there is a dispute regarding such an amendment, the Medical Staff may pursue the conflict management process set forth in Article XIII of these Bylaws.